

University of Canberra

**Conformity and resistance:
Discursive struggles in the Australian mental health field**

by

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Abstract

This research explores areas of contention in the mental health field in Australia through a qualitative analysis of voices and practices that can broadly be seen as *talking with* and *talking back* to psychiatry. The thesis is informed by key shifts in thinking that underpin postpsychiatry and analyses a set of materials through an interpretive lens of reading psychiatry against the grain (Bracken & Thomas, 2005; Lewis, 2006). In particular, it examines a failed ethics application to conduct research with people diagnosed with a mental illness, an anti-stigma campaign, the practices of some prominent mental health organisations in Australia, a conversation with two members of an emerging consumer/survivor network in Australia, and a television documentary and online discussion forum about an antidepressant medication. The research draws from discourse analytic methods and concepts from social movement framing research to identify factors shaping conformity and resistance to psychiatric doxa in the Australian mental health field.

The research identifies the discursive repertoires that characterise the mental health field as a ‘game’ in which competing perspectives vie for recognition. In relation to research ethics committees, the thesis argues that deference to clinical expertise is a potential barrier to cultural studies of psychiatry and a more inclusive agenda in mental health research and practice. Some practices for ethics committees to consider when reviewing research that involves people who may have been diagnosed with a mental illness are proposed. The research also identifies problematic features of anti-stigma campaigns that direct their efforts toward protecting and promoting the discourse of biomedical psychiatry. A critique of this type of campaign is offered in relation to perspectives from postpsychiatry and social constructionism. On the basis of this research, it is argued that organisations that champion ‘mental health literacy’ are limited in their ability to give voice to the goals and priorities of those who are calling for a more open, reflexive and democratic debate in mental health. The central argument of this thesis is that elevating first-person and postpsychiatry perspectives is necessary in order to interrogate and address the dominance of the medical model in psychiatry and its consequences.

Form B

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Contents

Abstract	i
Form B Certificate of Authorship of Thesis	ii
Contents	iii
Acknowledgements	viii
Introduction	1
Rationale for the study	1
Historical context: the importance of a critical history	2
Contemporary context: a clash of churches	3
Tom Cruise’s sin.....	6
Thesis aims.....	7
Thesis statement	7
Limitations of the study	8
Terminology.....	8
Chapter summaries	9
Chapter One Theoretical framework: approaches to psychopathology.....	9
Chapter Two Contested practices in the mental health field.....	9
Chapter Three Research design and interpretive practices.....	9
Chapter Four Ethics creep: constraining mental health research.....	9
Chapter Five StigmaWatch: critique of an anti-stigma campaign.....	10
Chapter Six Resistance habitus: postpsychiatry at the grassroots.....	10
Chapter Seven Medication talk: ‘Hazards of the happy pill’	10
Future directions for research and practice	11
Chapter One Theoretical framework: approaches to psychopathology	13
Introduction.....	13
Psychiatric positivism and the medical model	14
The shift from dynamic to diagnostic psychiatry	15
Predecessors of social constructionism	17
Social causation	17
Societal reaction or labelling theory	18
Critical and anti-psychiatry	20
Foucault’s contribution.....	23
The Great Confinement.....	23
Psychiatry’s low epistemological profile.....	24
Disciplinary power and the psychiatric gaze	25
Biopower.....	27
Governmentality and ‘care of the self’	28
The political thrust of Foucault’s work.....	30
Social constructionism.....	32
A relational view of language	33
Historical and cultural specificity of knowledge.....	33
Emphasis on social processes in the production of knowledge	34
Knowledge and power are concomitant.....	34

Truth is produced rather than discovered.....	35
Criticisms of social constructionism.....	35
Critical realism.....	36
Material-discursive-intrapsychic approach.....	36
Mental illness as both discourse and experience.....	37
The ‘risk society’ perspective.....	39
Postpsychiatry: reading psychiatry against the grain.....	40
Shift in phenomenological approach.....	40
Methodological pluralism.....	41
Non-transparent view of language.....	41
Semiotic realism.....	42
Pragmatic epistemology.....	42
Indeterminacy of interpretation.....	43
Interpreting Van Gogh.....	43
Learning from Chekhov.....	45
Postpsychiatry: implications.....	45
Shift in knowledge structures: cultural studies of psychiatry.....	46
Reading the DSM against the grain.....	47
Rethinking the politics of mental health research and practice.....	50
Conclusion.....	54
Chapter Two Contested practices in the mental health field.....	57
Introduction.....	57
Resistance to psychiatry: counter-discourse.....	57
Transformation of the mental health service ‘user’ ‘voice’.....	60
Mental health ‘service user’ discourses.....	62
Disease mongering.....	64
Medicalisation.....	65
Pharmaceutical industry influence on psychiatry.....	66
Disease mongering in relation to psychiatry.....	67
Premenstrual Dysphoric Disorder.....	67
Attention Deficit Hyperactivity Disorder.....	68
Social Phobia.....	71
Depression.....	73
Mental illnesses in the media: some key findings.....	76
Framing the ‘dangerous other’.....	77
Disseminating contemporary technologies of the self.....	78
Overstating biogenetic evidence and explanations.....	80
From ‘mental hygiene’ to ‘mental health literacy’.....	81
Media reporting guidelines as ‘risk communication’ intervention.....	82
Other ways of playing the media game.....	84
Conclusion.....	85
Chapter Three Research design and interpretive practices.....	87
Introduction.....	87
The field of qualitative research.....	87
Self-reflexivity and theoretical reflexivity.....	88
The politics of interpretation.....	90
Cultural studies.....	92

Discursive research.....	94
‘Sociology of knowledge approach to discourse’	94
The value of a discursive approach	96
Social movement framing research	100
Data sources	100
Failed ethics application	101
StigmaWatch – <i>Sane Australia</i>	101
Resistance within the mental health field	102
Television documentary and online discussion forum	103
Limitations	104
Conclusion	105
Chapter Four Ethics creep: constraining mental health research	107
Introduction.....	107
The National Statement	108
The University of Canberra Human Ethics Manual	108
Proposed research and ethics application	109
The ethics committee’s concerns	114
Participant and researcher safety	115
My lack of clinical expertise	117
Screening participants.....	118
Provisions for medical arrangements in case of emergencies.....	120
Recruitment processes	120
My personal disclosure	121
‘Ethics creep’: characteristics and consequences	123
Protects the institution rather than participants.....	126
Reflects a tendency to base decisions on worst-case scenarios and imagined harms	127
Reflects unfair and unfounded assumptions about potential participants.....	128
Constrains non-clinical research.....	131
Maintains the illusion of detached research and researchers	132
Ethics committees: governing research in the name of risk	135
Conclusion	137
Chapter Five StigmaWatch: critique of an anti-stigma campaign.....	143
Introduction.....	143
StigmaWatch in context.....	143
Analysis of StigmaWatch	145
Table 1: The use of the extended family of ‘mad’ and ‘madness’ words.....	148
Tables 2 and 3: “Out of context” and “incorrect” uses of psychiatric terminology	154
Table 4: Stories actually about mental health and illness related issues	172
Table 5 – Miscellaneous StigmaWatch complaints.....	183
<i>Sane’s</i> Good News File.....	187
Discussion and critique of <i>Sane’s</i> StigmaWatch campaign.....	188
Reduces people to diagnostic labels	192
Fails to appreciate context of language use and etymology.....	192
Projects the views of a few onto the many.....	193
Perpetuates the homogeneous population myth.....	193
Reproduces the perception of stigmatised ‘other’	193
Fails to view psychiatric vocabulary and the medical model as stigmatising	194

Reflects an out-dated theory and a limited view of ‘media effects’	195
Prioritises spin over substance.....	197
Glosses over lived experience and first-person perspectives.....	198
Conclusion: challenging ‘stigma’ by reading psychiatry against the grain	199
Mental illness is not an illness like any other.....	200
Chapter Six Resistance habitus: postpsychiatry at the grassroots	203
Introduction.....	203
The counter-movement.....	203
<i>beyondblue</i>	204
Depression in the workplace program	205
<i>Sane</i> Australia.....	205
<i>Sane</i> ’s ‘Factsheets’	206
Summary of habitus and repertoires of establishment voices.....	210
Social change movement: voices of resistance	211
Consumer/survivor experience as social movement	211
Getting involved	213
Human rights and identity.....	215
Surviving the system.....	216
Who are the ‘users’ and ‘consumers’ of the Mental Health Act?	218
Elevating the first-person voice.....	220
‘Nothing about us without us’	225
Changing the way society thinks about madness	226
Challenging medicalisation	229
Mental health literacy versus non-diagnostic listening.....	232
Social model of disability.....	236
Valuing madness.....	238
Finding support outside of ‘the system’	241
Conclusion	244
Chapter Seven Medication talk: ‘Hazards of the happy pill’	247
Introduction.....	247
Depression and antidepressants.....	248
‘Hazards of the happy pill’	251
Key features of television documentary	252
Summary of documentary	255
<i>Four Corners</i> ’ online discussion forum	256
Recurring themes in comments on the program.....	257
Giving voice to experience: this is real!.....	258
Validating suspicions: knowing you’re not alone	261
Challenging medical ‘expertise’	262
Getting the message out there: making drug companies accountable	264
Lack of balance: what about people like me?	266
Sensationalism and selectivity.....	268
Perpetuating myths	270
Creating panic.....	272
Summary of responses to the program	274
Broader reception of the program	274
Response in the UK	274

Response from Australia’s leading mental health organisations.....	276
Conclusion	281
Future directions for research and practice	285
Introduction.....	285
Conformity with psychiatric doxa.....	288
Educating the public about mental illness.....	288
Resistance to psychiatric doxa	293
Changing the way society thinks about madness	293
Future research	299
Bibliography	303
Appendix A.....	365

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Introduction

I had adapted myself so totally to the concept of living without food that I just could not see any different. I was a new person in a new world that I had created for myself and the thought of leaving it scared me and made me feel like a failure. I was making a huge step – I knew it, even if nobody else did. (from a diary of a young girl)

This thesis is inspired, on the one hand, by my curiosity and interest in the way people talk about their ‘mental health’ and ‘psychiatric’ experiences in their own terms and, on the other, by my observation of a lack of scrutiny of biomedical discourse in Australia. The first is related to my personal experience of a psychiatric diagnosis and my attempts to make meaning out of a way of being that was medicalised as a ‘mental illness’. The second stems from my undergraduate research into newspaper portrayals of mental illness, through which I became interested in the taken-for-granted status of the medical model in psychiatry and the absence of critical and first person perspectives. These factors converge in my research focus on some of the dynamics at play in the mental health field in Australia and, particularly, my interest in the opportunities created by ‘postpsychiatry’ and its calls to read psychiatry against the grain (Bracken & Thomas, 2005; Lewis, 2006b).

Rationale for the study

Unlike any other branch of medicine, psychiatry’s claims to knowledge are notoriously controversial and productive of resistance and resistant identities. Nationally and internationally people who have first-hand experience of the mental health system are increasingly claiming the right to speak and act on their own terms in areas that have traditionally been the domain of others claiming to act ‘in their best interests’. There is a considerable history of recipients of psychiatry challenging the medical objectification of their distress and the, at times, dehumanising treatment that this has legitimated. Psychiatrists themselves have been some of the most active and committed critics of psychiatry, and this tradition continues in recent articulations of postpsychiatry, the ideas of which have helped to shape this research. Psychiatry’s vocabulary expansion and the increasing influence of the pharmaceutical industry in the mental health field are two of the important factors shaping contemporary resistance to psychiatry, and this is reflected in the focus of my research.

In this thesis I analyse and discuss a failed ethics application to conduct research with people who may have been diagnosed with a mental illness, an anti-stigma campaign, an interview with two members of an emerging network *insane australia* and its submission to the Senate Select Committee on mental health in 2005, and a prominent television current affairs program and the ensuing online discussion forum and public debate. These diverse materials provide the opportunity to examine the influence of the medical model of ‘mental illness’ and its consequences; to build on our understanding of resistance in the mental health field; and to identify some barriers to this resistance in the form of what might be termed a “counter-movement” in the mental health field (Crossley, 1998, p. 459).

Historical context: the importance of a critical history

The historical context of psychiatry and shifts in the field of mental health, although not recognised by mainstream psychiatry, is of obvious contemporary relevance (Scull, 1982). Historical accounts of any profession serve particular functions. Rose (1991) notes that recurrent histories use the past to help demarcate the ‘regime of truth’ that is contemporary for a discipline. Progressive or recurrent histories of psychiatry have been referred to as ‘whiggish’ in the way that they merely serve to justify the present state of practice as progressive in relation to past practices, which are usually derided as ‘primitive’ (Porter & Micale, 1994). According to Porter and Micale (1994):

Whig narratives were presentist, progressivist, and tenaciously internalist. They typically presented a dual historical movement, from cruelty and barbarism to organized, institutional humanitarianism, and from ignorance, religion, and superstition to modern medical science. They often consisted of dramatically juxtaposed dark ages, enlightenments, and revolutions that heralded the way to the present. (p. 6)

Foucault (1987) argues that all histories of psychiatry to the present seek to show that the madman of the Middle Ages and Renaissance was actually an unrecognised mentally ill patient (Foucault, 1987). He says:

According to this view, it was only with the arrival of the calm, objective, scientific gaze of modern medicine that what had previously been regarded as supernatural perversion was seen as a deterioration of nature. (Foucault, 1987, p. 64)

Major shifts in psychiatric thinking and practice have brought with them new forms of madness, new categories of mental illness. At the beginning of the twenty-first century, the problems identified and responded to by psychiatry in its asylum (institutional) and dynamic (psychoanalytical) forms have been reframed in terms of diagnostic (biological) psychiatry.

There may be a tendency, on a whiggish or linear view of history, to render moral treatment and psychoanalysis, the ‘treatments’ that respectively characterised these modes of psychiatry, inferior in light of the contemporary dominance of diagnostic vocabulary and biomedical, genetic and pharmacological discourses and drug treatment regimes. Yet, the expansion in psychiatric diagnoses requires us to question where these new forms of madness have come from and in whose interests they have been constructed. What has brought these new diagnoses into existence? What has changed in society?

To shed light on these kinds of questions it is important to cast a critical gaze over the history of psychiatry, rather than seeing its contemporary incarnation in reformist terms of ‘scientific progress’. The significance of a critical history is to ask how old truths have been replaced with new ones. A critical history can problematise psychiatry and psychopathology in terms of the way certain kinds of objects and subjects are brought into existence through discourse. It alerts us to the social, cultural, political, economic and technological contingencies of psychiatry and the subjects and objects of its gaze. One trait of publicly prominent pro-psychiatry voices is that they tend not to critically reflect on the history of psychiatry; a failure that I believe shapes contemporary discourse and constrains our ability to engage with mental illness as madness. This thesis assumes the proliferation of ways of being in the world that are diagnosed and diagnosable as ‘mental illness’ is best seen through the lens of constructionist and postmodern thought, rather than as the result of tangible ‘scientific’ findings about the the pathologies of the human psyche.

Contemporary context: a clash of churches

A useful introduction to some of the key issues I explore in this thesis and my rationale for doing so is provided by a 2005 event centred on actor Tom Cruise and his advocacy of Scientology. The comments that earned Cruise the ire of psychiatric and advocacy organisations were made in an interview on US television and subsequently reported in the Australian media. Cruise’s comments followed criticisms he had made of actor Brook Shields for taking psychiatric drugs for post-partum depression. In an interview on the National Broadcasting Company’s (NBC) *Today Show*, in response to a question about the firestorm he created, Cruise said:

I’ve never agreed with psychiatry, ever. Before I was a Scientologist I never agreed with psychiatry. And when I started studying the history of psychiatry, I understood more and more why I didn’t believe in psychology. (MSNBC, 2005, para. 54)

On antidepressants he said:

All it does is mask the problem, Matt. And if you don't understand the history of it, it masks the problem. That's what it does. You're not getting to the reason why. There is no such thing as a chemical imbalance. (MSNBC, 2005, para. 67)

And further on:

I'm not saying that that isn't real. That's not what I'm saying. That's an alteration of what I'm saying. I'm saying that drugs aren't the answer, these drugs are very dangerous. They're mind-altering anti-psychotic drugs. And there are ways of doing it without that so that we don't end up in a brave new world. The thing that I'm saying about Brooke is that there's misinformation, okay. And she doesn't understand the history of psychiatry. She doesn't understand in the same way that you don't understand it, Matt. (MSNBC, 2005, para. 73)

It is not my intention to provide an analysis of Cruise's comments; I am more interested in the response they received. The American Psychiatric Association (APA) issued a media release the following day. It included a quote from APA President Doctor Steven S. Sharfstein:

It is irresponsible for Mr Cruise to use his movie publicity tour to promote his own ideological views and deter people with mental illness from getting the care they need. (APA, 2005, para. 2)

Sane Australia, who describes itself as the national 'mental health charity', issued a media release in conjunction with The Royal Australian and New Zealand College of Psychiatrists. It included a quote from *Sane's* Executive Director Barbara Hocking:

It is reckless and potentially dangerous of Mr Cruise to make uninformed comments about the treatment of mental illness; many people are well because medication plays an important role in managing their health. (*Sane Australia*, 2005d, para. 3)

Sane expressed concern about the impact of Cruise's comments about antipsychotic and antidepressant medications:

Australians who use psychiatric medication are strongly advised not to make changes to their treatment and to see their health care professional if they have any concerns in light of recent comments by Tom Cruise about antipsychotic and antidepressant medications. (*Sane Australia*, 2005d, para.1)

This comment is underpinned by an assumption of the vulnerable masses at risk from an ill-informed celebrity, an observation that I build on in later chapters. *Sane* aligns itself with the Royal Australian and New Zealand College of Psychiatrists in stating that they believe that "all people with a mental illness have a right to the best possible clinical care to treat mental illness and its symptoms" (para. 2). *Sane* was more concerned about the possibility that Cruise's comments may have the effect of people stopping their medications than it was about

the substance of his comments, which could just as easily have provided an opportunity to remind people that harmony does not reign in the psychiatric and mental health community about ‘mental illness’ and its treatment.

In the US, Bratich (2005) observed what he refers to as the “cruise-bashing” that took place, about which he posed two questions: “Should mainstream society and its media be so univocally pro-psychiatry and pro-pharmaceuticals?” and “should the media only allow criticism of psychiatry by celebrities?” (para. 6). He suggests:

The treatment of Cruise mimics the psychiatric procedures that he deigned to challenge. Responses by journalistic sources were drawn directly from psychiatry’s black bag of pathology: manic, crazy, meltdown, in need of the very chemicals he criticizes, and even getting his own satirical “Tom Cruise Syndrome”. (Bratich, 2005, para. 13)

Bratich makes a number of insightful observations about the “scandal” that followed Cruise’s comments. Upon reading the transcript from the *Today Show* program he observes that “Cruise’s most scathing indictment of the social consequences of biochemical psychiatry wasn’t even shown in the 15 or so replays” of the clip he witnessed (para. 11). He writes:

When asked if he felt that problems aren’t real and that people don’t need help, Cruise responded by saying “there are ways of doing it without that so that we don’t end up in a brave new world.” (para. 11)

Of this Bratich said:

Invoking Huxley takes the discussion of psychiatry out of the individual realm (where Lauer, Shields, and others want to keep it) and into the political sphere. In an age where George Orwell is invoked incessantly (almost to the point of rendering him harmless as metaphor), Huxley seems like a breath of fresh air. Counterposed to the Orwellian nightmare of coercion and totalitarianism, Huxley gives us a world where utter control is achieved through benevolence and pleasure. (para. 11)

Cruise’s comments were fodder for the newspaper media in Australia. The headlines of stories included: ‘One in the baby blues for Cruise’ (*The Australian*, 2/7/05, p. 13), ‘Play acting at being the fountain of all knowledge’ (*Daily Telegraph*, 2/7/05, p. 21), ‘It doesn’t exist until seen for real’ (*Courier Mail*, 2/7/05, p. M14 Bam lift-out), ‘You don’t know the history of psychiatry. I do’ (*Adelaide Advertiser*, 5/7/05, p. 23). *The Australian* picked up on a reply from Brooke Shields that appeared in the *New York Times* in response to Cruise’s criticisms, and quoted her as saying “I’m going to take a wild guess and say that Mr Cruise has never suffered from postpartum depression” (‘One in the baby blues’, 2005, para. 8). An

opinion piece in the *Daily Telegraph* was satirical in its discussion about the expertise of actors on everything. Hildebrand wrote:

So how did actors get so smart? You'd best ask Cruise. The scintillating Scientologist told the US Today Show, "I started studying the history of psychiatry, I understood more and more why I didn't believe in psychology ... and I know that psychiatry is a pseudo science". (Hildebrand, 2005, para. 6)

One Australian observer welcomed Cruise's comments in a letter published in *The Australian* under the headline 'Cruise Control'. Klæbe wrote:

Psychiatric drugs are dangerous – as the US Federal Drug Administration recently announced with their new labelling warning on anti-depressants.

Tom Cruise is right – at best these drugs only mask a person's condition. Harvard Professor of Psychiatry, Dr Glen McMullen, has clearly stated that "chemical imbalance" of the brain is a theory and that there are no lab tests (such as a blood test) that can prove such a condition exists. (Klæbe, 2005, p. 12)

As these comments from a member of the public suggest, concern about the chemical imbalance theory in psychiatry and the dangers of medication are by no means restricted to the Church of Scientology. There was, however, no evidence of such concern in *Sane's* media release or news coverage of Cruise's comments.

Tom Cruise's sin

As early as 1973 long-time critic of psychiatry Thomas Szasz noted that "spreading the faith in mental health was considered appropriate and commendable for all groups" (p. 75).

Religion is a useful metaphor by which to view the power and authority conferred on members of the 'psy' professions (George, 1999). As with religion, the power of psychiatry depends ultimately on people's belief in it and the largely unquestioned assumption ('doxa') that madness is 'obviously' an illness (Crossley, 2004). The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has been referred to as the 'bible' of psychiatry.

Psychiatrists are the prophets of this holy book and their authority rests on the extent to which they can use it to persuade the masses that they know how to identify, classify, diagnose and treat 'mental illness' – that it speaks the 'truth' of science. It is in this context that reactions to Tom Cruise's expression of disbelief in psychiatry and psychiatric drugs can be seen to parallel reactions to those who seek to challenge any established doctrine. Like all religions, the church of psychiatry has its heretics.

Thesis aims

In spite of sustained criticism from above and below since its emergence, psychiatry's claims to knowledge continue to have a widely taken-for-granted status as representing reality rather than discursively constructing it. In Australia there are a number of organisations that operate in accordance with a pro-psychiatry and medical model position and, thus, fail to reflect on the problem of *knowledge* that is 'mental illness' (Fee, 2000a). Through their practices and claims they reproduce the power of psychiatry to diagnose and delimit the meanings of our lives, apparently oblivious to counter-discourses; to echo Szasz, they spread the faith. This thesis problematises those sites in which biomedical discourse and the power/knowledge of psychiatry and the other 'psy' professions is taken-for-granted. My primary aim is to identify some of the salient points of contention in the mental health field in Australia through an analysis of voices that can broadly be seen as *talking with* and *talking back* to psychiatry.

Thesis statement

This thesis problematises the reproduction and promotion of biomedical discourse on 'mental illness', as though it is beyond critique. This practice is particularly disturbing in the case of 'anti-stigma' groups who claim to speak for or on behalf of people diagnosed with a 'mental illness' and who often impose psychiatry's system of meaning onto the public at large. The apparent reluctance of such groups to address the value laden nature of psychiatry's diagnostic categories, psychiatry's claims to knowledge in general and the history of the psychiatric profession, make the strategies they employ to challenge stigma somewhat limited and even counterproductive. The social construction of 'mental illness' has become inextricably associated with 'stigma' in one form or another and, thus, my central argument is that taking the 'stigma' out of mental illness requires exposing and resisting the oppressive effects of biomedical discourse by elevating survivor and postpsychiatry perspectives. Moreover, I suggest that any attempts to intervene into public communication about mental illness, whether the goal is to challenge 'stigma', educate the public, or create awareness, should self-reflexively engage with the critical history of psychiatry as well as the views of critics and survivors of psychiatry, and assume these to be as important and useful as pro-psychiatry voices for achieving these goals.

Limitations of the study

This study has a number of limitations. These relate to its text-based nature and the small number of sites I examined. The interviews I conducted do, however, reflect the emergence of a new network in Australia and I have provided the reader with enough information to be able to follow and replicate the approach I have taken. With the exception of the ethics application, the letter from the ethics committee and the interview transcript, the data I examine is publicly available for readers to scrutinise my analysis and interpretation. The field of mental health is dynamic, and this thesis is necessarily a snapshot of a moment in time. My impetus for reading psychiatry against the grain is based on my own personal experience of a psychiatric diagnosis and my subsequent hospitalisation. This places both opportunities and constraints on my research and makes it crucial that I am self-reflexive throughout the research process.

Terminology

Language is itself one of the foci of my research and a source of debate among many people who have been diagnosed with a mental illness. Thus far I have referred to ‘mental illness’ in inverted commas to indicate the way in which the construct is problematised in this thesis. Throughout the thesis I use the terminology of ‘people who have been diagnosed with a mental illness’ to highlight the centrality of diagnostic practice in bringing it into existence. As such, when I use this terminology I do not use inverted commas. I also use the words ‘mad’ and ‘madness’ at times in recognition of the way in which many recipients of psychiatry choose to reclaim the language of madness in the name of Mad Pride. While recognising that the terms are “obviously unsatisfactory”, historian Roy Porter (1987) uses the term ‘mad’ as shorthand for the “whole range of people thought to be in some way, more or less, abnormal in ideas or behaviour” (p. 6). I do not use ‘madness’ throughout the entire thesis in recognition that many people do identify with the language of ‘mental illness’ and may find the language of madness unsatisfactory. There are also differences in people’s preferred ways of identifying themselves in relation to mental health services and psychiatry. These include ‘consumer’, ‘service user’, ‘patient’, ‘survivor’, ‘ex-patient’, ‘crazy’, ‘nutter’, ‘lunatic’, ‘person with depression’, ‘sufferer of bipolar disorder’ or ‘manic depressive’, for example. I discuss different perspectives on these terms in Chapter Two and Chapter Six.

Chapter summaries

Chapter One Theoretical framework: approaches to psychopathology

Chapter One discusses theoretical perspectives on psychopathology. This includes a discussion of the important contribution of Michel Foucault and scholars who draw on his ideas. Perspectives from critical and anti psychiatry, social constructionism and critical realism are discussed. Finally, newly emerging work within ‘postpsychiatry’, including its theoretical influences and practice implications, is discussed. Lewis’ (2006b) emphasis on postpsychiatry as cultural studies of psychiatry that in its simplest form reads psychiatric knowledges against the grain provides the primary theoretical framework that guides my research.

Chapter Two Contested practices in the mental health field

Chapter Two reviews recent research into social movement organisations in the mental health field and the way people diagnosed with a mental illness give voice to their experiences, particularly the ‘resistance habitus’ of the psychiatric survivor movement. It also explores the increasing influence of the pharmaceutical industry in psychiatry in the context of research into ‘disease mongering’ and ‘selling sickness’. Significant findings from research into media portrayals of mental illness are also reviewed.

Chapter Three Research design and interpretive practices

Chapter Three discusses my research approach in the context of the qualitative research tradition, with particular attention to cultural studies, discursive research approaches and concepts from social movement framing research. It discusses the rationale for my data collection, the specific interpretive methods used to analyse the empirical data in the chapters to follow, and the limitations of the approach.

Chapter Four Ethics creep: constraining mental health research

Chapter Four examines my ethics application and original research proposal along with the letter of rejection from the University of Canberra ethics committee. It discusses the ethics committee’s concerns in the context of ‘ethics creep’ and the lack of fit between existing ethical review standards and qualitative and other interpretive modes of inquiry. It discusses the implications of ethics creep for non-medical research with people who have been diagnosed with a mental illness and addresses the question of whether existing systems of

ethics review may pose a barrier to postpsychiatry's calls for a multidisciplinary approach to mental health research, and consumer/survivor/ex-patient (c/s/x) led and first-person research.

Chapter Five StigmaWatch: critique of an anti-stigma campaign

Chapter Five provides an analysis and critique of the StigmaWatch campaign of *Sane Australia*. Based on a sample of reports to this campaign, it examines the extent to which it constitutes a narrow approach to improving and challenging media coverage of mental illness. It identifies some of the consequences of this campaign, including that it may actually be counterproductive. The chapter is framed more broadly in the context of criticisms that have been made of the concept of 'stigma' itself and anti-stigma campaigns targeted at the media.

Chapter Six Resistance habitus: postpsychiatry at the grassroots

Chapter Six is framed around the dominant themes that emerged from a conversation I recorded with two members of a newly emerging psychiatric consumer/survivor network, *insane australia*, one of whom is also a 'consumer academic' and the other a member of the World Network of Users and Survivors of Psychiatry (WNUSP). It includes comments from some members of a consumer group in Melbourne about what 'consumer perspective' means to them, which were recorded at the 'Consumer Perspectives' conference facilitated by the Australian Mental Health Consumer Network (AMHCN) and held in Melbourne in 2006. Bourdieu's concepts of habitus, capital and field are drawn from in order to arrive at a deeper understanding of some of the factors shaping activism in the mental health field and the existence of a counter-movement.

Chapter Seven Medication talk: 'Hazards of the happy pill'...

Chapter Seven focuses on a British Broadcasting Commission (BBC) documentary that was shown on the Australian Broadcasting Commission's (ABC) *Four Corners*, followed by an online discussion forum. The documentary, titled 'Hazards of the happy pill', involved the antidepressant drug known in Australia as Aropax. The chapter examines the politics of representation that surrounds significations of antidepressants in the media with reference to the dominant themes to emerge from the documentary and discussion forum. It focuses particularly on how antidepressant users and health professionals variously described the functions and consequences of the documentary, and constructed their responses to it accordingly.

Future directions for research and practice

The final chapter identifies and discusses the polarised agendas that shape conformity and resistance in the mental health field on the basis of the analysis provided in the preceding chapters. In particular, it argues that the prominence in Australia of organisations who are predisposed to reading with psychiatry and the medical model poses a major barrier to changing the way society thinks about madness. On the basis of key insights to emerge from this research, some possible avenues for future research and practice in this area are suggested.

Chapter One

Theoretical framework: approaches to psychopathology

When I first came to hospital I was about to be admitted and a lady at the front desk said to me, “Kate, come this way, You’ve been losing weight, some girls would kill to lose weight”. Interesting choice of words, was this what I was doing? Killing myself all for the cause of losing weight – maybe, maybe not. My first few days were very emotional, I think I was coming to the realisation that I couldn’t do it by myself anymore, and perhaps I couldn’t control it, I hated that. It almost felt like I was admitting defeat. When I wasn’t eating I was controlling it, but in hospital my fate was more or less out of my hands, and in the hands of doctors, nurses, dieticians, psychologists and psychiatrists. I extremely hated being out of control, I always have. (from a diary of a young girl)

Introduction

This chapter discusses some of the ways in which the role of psychiatry and, therefore, the object of ‘psychopathology’ is theorised. Scholars from many academic disciplines have turned their attention to this area and this chapter is necessarily selective. It begins with a discussion of some of the key features of ‘medical naturalism’ (the medical model) that dominates modern psychiatry. Perspectives from within sociology and anti and critical psychiatry are briefly reviewed. Foucault’s contribution to the field of study, social constructionist and critical realist perspectives are discussed. The remainder of the chapter focuses on the critique of modern psychiatry offered by newly emerging work within postpsychiatry as articulated by Bradley Lewis (2006b) in *Moving Beyond Prozac, DSM, and the New Psychiatry* and Patrick Bracken and Philip Thomas (2005) in *Postpsychiatry: Mental Health in a Postmodern World*. This includes a discussion of the ontology of ‘semiotic realism’ and the epistemology of ‘pluridimensional consequences’, which Lewis suggests is the most useful approach for cultural studies of psychiatry. Some of the key shifts in thinking and practice called for by these writers are discussed.

Debates about psychopathology are characterised by two polarised positions, reflecting as they do the positivist paradigm of ‘medical naturalism’ and the nonpositivist or interpretive paradigm of ‘social constructionism’ (Pilgrim & Bentall, 1999). Although attempts are being made to overcome this polarisation, particularly in the context of postmodern thought, the ‘biology-versus-society’ logic remains central (Fee, 2000a). A third position that lies between

these two poles is known as ‘critical’ or ‘sceptical realism’ (Pilgrim and Bentall, 1999), while Pilgrim and Rogers (1999) have also used the term ‘social realism’ to describe this position. From postpsychiatry, Lewis (2006b) adopts the terminology of ‘semiotic realism’ to overcome and account for some of the perceived shortcomings of naïve realism and radical constructionism.

Psychiatric positivism and the medical model

From the perspective of postpsychiatry, psychiatry is a quintessentially modernist project, an application of Enlightenment aspirations of reason and order and human improvement and perfectibility through the twin goods of science and reason (Bracken & Thomas, 2005; Lewis, 2000, 2006b). Themes of modernism in psychiatry include the quest for objective truth, faith in method, and a telos of progress and emancipation (Lewis, 2006b). Bracken and Thomas (2005) identify three basic orientations at the heart of psychiatry since its creation in the Enlightenment. These include: that madness and distress need to be excluded and controlled, resulting in the growth of professional expertise and authority; that mental and emotional problems are best framed through a technical idiom; and that madness and distress are located ‘inside’. Inherent in psychiatry’s quest for objective truth is a belief in the transparency of language, which culminates in the view that psychiatric knowledge reflects the world ‘as it is’ (Lewis, 2006b). The route to objective truth is the ‘scientific method’ and legitimate knowledge for psychiatry in this regard is understood to be ‘value-free’ (Lewis, 2006b). Following from this, psychiatry’s justification for pursuing ‘objective’ knowledge is progress and emancipation and it is assumed that, in accordance with methodological individualism, psychological states can be examined in isolation from the world around them (Bracken & Thomas, 2005).

According to Bracken and Thomas (2005), modern psychiatry is locked in the embrace of ‘Cartesian dualism’, which is based on the ontological separation of the ‘inner’ world of mind from the ‘outer’ world, also known as ‘epistemological dualism’. They argue the dominant influence on twentieth century psychiatry’s understanding of phenomenology is Karl Jaspers’ *General Psychopathology*, published in 1913, which emphasises the form over the meaningful content of psychiatric symptoms and sets out to order, define and analyse these symptoms. It assumes that the *forms* of psychopathology are universal and that culture only influences the *content* of an individual’s symptoms. This phenomenology separates off

questions of meaning, narrative and ethics and attempts to enter the patient's mental world in isolation from his/her lived reality (Bracken & Thomas, 2005). According to Bracken and Thomas, Jaspersian phenomenology is about a science of 'the other': "It is ultimately about the doctor having a language, a framework, a knowledge about the patient that the patient does not possess" (p. 122).

The medical model of mental distress is underpinned by realist ontology and a correspondence epistemology. According to this model, psychiatric classifications and descriptions refer to natural disease entities and 'mental illness' is assumed to exist as an objective biomedical 'fact'. It is underpinned by a referential theory of language, which assumes that it is an "unproblematic medium for the transmission of observed categories and reasoned theories" (Lewis, 2000, p. 74). This theory of language is also referred to as representational or pictorial. Pilgrim and Bentall (1999) argue, "The logic of this position is that these entities are studied by diagnosticians with increasing sophistication, leading to a more and more accurate description of reality" (p. 261). This perspective is dominant in psychiatry and it buttresses the view that there is no need for a critical appraisal of the language of psychiatry because it refers to real facts about the actual world, rather than serving to bring these conditions into existence through discourse. As Lewis (2000) says:

The language of psychiatric discourse is not understood as creating knowledge, or perception, or even substantially effecting the transmission of knowledge; rather, psychiatric discourse only reflects the world 'as it is'. (p. 74)

From this perspective, madness and distress are situated within the individual and individualised medical procedures are viewed as the most accepted way of 'treating' what is diagnosed as 'mental illness'. Prior to the medical model, psychiatry was dominated by psychoanalytic theory and method and it is important to briefly consider the shift from dynamic to diagnostic psychiatry.

The shift from dynamic to diagnostic psychiatry

The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is a relatively recent addition to psychiatric practice and it is important to consider its evolution in historical and political context (Schacht, 1985). The reasons for its development are grounded in psychiatry's need to strengthen its alliance with the rest of medicine, to establish and maintain its expertise and, ultimately, to survive as a profession in the "mental illness marketplace" (McPherson & Armstrong, 2006, p. 58). Prior to the first

edition of the *DSM*, published in 1952, there was no standardisation within psychiatric practice at the level of diagnosis. The second edition was published in 1968 (*DSM-II*), the third in 1980 (*DSM-III*), the revised third edition in 1987 (*DSM-III-R*), and the fourth and current edition in 1994 (*DSM-IV*), although a text revision of this edition was published in 2000 (*DSM-IV-TR*). For a comprehensive account of the factors that have shaped the growth of the *DSM*, particularly the transformation to *DSM-III*, see Wilson (1993).

The shift from *DSM-II* to *DSM-III* has been described as a “watershed moment in contemporary psychiatry” (Lewis, 2006b, p. 97), marking a “revolutionary change” in the way psychiatrists and other mental health professionals approach mental illness (Kirk & Kutchins, 1992, pp.15-16). The shift has been linked to a power shift within the APA that saw psychoanalytic-oriented psychiatrists lose political ground to biological psychiatrists (Brown, 1990; Kirk & Kutchins, 1992; Lakoff, 2000; Miller & Leger, 2003). Dynamic psychiatry’s interest in the underlying meaning of symptoms did not appeal to the politics of institutions and groups whose decisions depended on the need for distinct categorisations of ‘mental illness’ (Horwitz, 2002a). Lewis (2006b) argues, while the DSM developers claim to use a neutral rhetorical frame, they actually use a very rigid ‘disease model’ (or ‘medical model’). The success of this shift from ‘dynamic’ to ‘diagnostic’ psychiatry (Horwitz, 2002a) was characterised by the slogan “You can’t talk to disease” (Miller & Leger, 2003, p. 16).

The diagnostic revolution in psychiatry is also inseparable from the move from inpatient to community care and the emergence of psychiatric drugs (Dain, 1989; McPherson & Armstrong, 2006). According to Forrester (1994):

...with the rise of drug psychiatry and social psychiatry as two sides of the same coin – the mid-century psychoanalytic hegemony, which had been so successful in part because it appeared to fuse attention to the symptom with concern for the patient, was undermined, set to one side, and, finally, with the rise of a victorious and philistine organic psychiatry of the 1980s, virtually eliminated. (p. 183)

The method of psychoanalysis could not compete with developments in the pharmaceutical industry and the need for distinct categorisations. Thus, it was in the professional interests of psychiatry to replace the idea of a continuum, which had characterised dynamic psychiatry, with a distinct disease classification system (Horwitz, 2002a). Horwitz (2002a) outlines the differences between dynamic and diagnostic psychiatry:

The basic dynamic principles that illnesses were continuous rather than discrete, that symptoms were symbols rather than indicators, and that therapy required deep

intrapsychic reflection, not just overt change in symptoms, were fundamentally at odds with the new scientific norms of medicine. (p. 60)

In short, psychoanalysis was not scientific enough and thus was supplanted by the biomedical model, and its associated diagnostic vocabulary, as the dominant explanatory framework in psychiatry. Healy (2000) suggests that ‘psychobabble’ began to lose ground to ‘biobabble’. It is, however, important to acknowledge that the psychoanalytic model was not entirely free from a biological component, although Freud did not believe that one needed to be a medical doctor to practice psychoanalysis (Gilman, 1988). The decline of psychoanalysis was also a result of the desire of the psychiatric community to situate itself in the “mainstream of the Western medical model” (Gilman, 1988, p. 225). The method of psychoanalysis posed a clear threat to this aspiration. As Dain (1989) suggests, “...if talk alone was applicable even to so-called psychotics, upon what logic could psychiatry claim to be a medical speciality?” (p. 1). Nonetheless, many of the criticisms of the medical model in psychiatry can be equally applied to psychoanalysis.

Before I discuss social constructionist and postmodernist critiques of the medical model, I review some of their predecessors, including perspectives from within sociology and anti and critical psychiatry.

Predecessors of social constructionism

Pilgrim and Bentall (1999) identify five major perspectives on mental health and mental illness within sociology: social causation, societal reaction (labelling theory), critical theory, social constructivism (also known as ‘social constructionism’ which is the terminology I will use herein) and social realism. There is not the space here to review the richness of the research and analyses that have emanated from within sociology and anti and critical psychiatry. This is a necessarily superficial glance at some of this work with the aim of demonstrating that, while a lot has changed in society and psychiatry in the past forty years, many of these insights endure.

Social causation

The social causation perspective accepts psychiatric diagnoses as legitimate, as facts in themselves, and focuses on how socially derived factors, such as class, social disadvantage, race, gender and age are causally related to mental illness. The predominant method used to establish these causal relations are epidemiological studies of populations, which has provided

an understanding of the social origins and distribution of mental disorder according to social class, poverty, gender, race and ethnicity (Busfield, 2000). Although these studies have produced substantial and influential data about the prevalence of diagnostic categories according to social variations (Pilgrim & Rogers, 1999), from the perspective of sociologists of a postmodern or post-structuralist persuasion much of this work is not well-respected because it takes the status of concepts of mental illness and mental disorder for granted (Busfield, 2000). Nonetheless, it would be a mistake to deny the importance of social factors, such as class, age, race, gender, education, sexual orientation and the like in the social distribution of psychiatric labels (Pilgrim & Rogers, 2005).

To varying degrees, the four remaining perspectives shift the focus away from psychopathology and onto the role of psychiatry in constructing it.

Societal reaction or labelling theory

Classic labelling theory and its modified version “draw attention to the demoralization and social exclusion arising from negative labelling” (Pilgrim & Rogers, 2005, p. 2547). Central to societal reaction or labelling theories are the concepts of primary and secondary deviation (Lemert, 1972). Primary deviation refers to variations in conduct that involve rule breaking and that are generally denied or rationalised by others in order that they can maintain the person in their existing role. For example, Horwitz (1982) identifies a range of techniques that people employ to normalise rather than pathologise ‘unusual’ behaviour. These include seeing another’s behaviour in oneself and other people, seeing behaviour as less important or severe as an outsider might, balancing strange with ‘normal’ behaviour and denying that anything is wrong with the behaviour. Lemert (1972) acknowledges that the tendency of societies to sustain deviance was recognised early within sociology, but he does not believe that it accounts for secondary deviance and its emergence at different times and places.

Secondary deviation refers to “deviant behavior or social roles based upon it, which becomes means of defense, attack, or adaptation to the overt and covert problems created by the societal reaction to primary deviation” (Lemert, 1972, p. 48). Scheff (1968) uses the concept of residual deviance to refer to violations of rules and norms for which society provides no explicit label and for which the violator may be labelled mentally ill. He notes, however, that most residual deviance is unrecognised and rationalised away, thus constituting a form of primary deviance. Scheff suggests that the most important factor in the stabilisation of

residual deviance is societal reaction. He says “Residual deviance may be stabilized if it is defined to be evidence of mental illness, and/or the deviant is placed in a deviant status, and begins to play the role of the mentally ill” (Scheff, 1968, p. 13). It is in this context, for example, that the treatment of the insane in asylums can be understood as exacerbating the apparent madness of inmates. As Lemert (1972) notes:

Feelings of hostility or deep frustration which may be entirely appropriate to a situation in which a person is abandoned by his family, incarcerated, and compelled to live by a completely new or different set of rules can be expressed only at the risk of validating the deviant definition already placed on the patient. (p. 71)

Horwitz’s (1982) work on the social control of mental illness picks up on one of the questions at the centre of labelling theory: Under what conditions are certain forms of deviance construed as symptoms of mental illness, while other forms of deviance are denied or rationalised? Horwitz identifies the following variables that predict the circumstances under which observers evoke labels of mental illness to explain behaviour; relational distance, cultural distance, professional status. He also identifies characteristics of observers, such as social class, culture and sex that predict the distribution of mental illness labelling.

Unsurprisingly, he notes that psychiatrists are far more likely than lay people to label people as mentally ill (Horwitz, 1982) and that, although close relations tend not to label family members as mentally ill, once a formal psychiatric diagnosis is applied future strange behaviour will be explained within an illness framework. There are, however, variations on these tendencies, such as when lay people label themselves or others as mentally ill because it is in their interests to do so or when psychiatrists have an interest in the denial of mental illness.

Labelling theory has made an important contribution to the sociology of mental health and illness. Erving Goffman’s (1961, 1963) work on the career of the mental patient, social interaction in a mental institution and stigma continues to be of value for understanding the micro-level processes involved in becoming and being a mental patient. It is suggested that the empirical data generated by research on the societal reaction to mental illness has not been surpassed (Horwitz, 1982), in spite of the weaknesses that have resulted in its loss of popularity (Pilgrim & Rogers, 1999). Moreover, critical psychiatrist Double (2004) suggests *DSM-III* (1980) was a response by the psychiatric establishment to Rosenhan’s (1973) famous study, which found that the process of identifying and diagnosing mental illness is strongly influenced by expectations and prejudices about the nature of patients and prone to massive

error. This body of research has clearly served as a major challenge to the psychiatric perspective, and has also been integral to research on the medicalisation of deviance, which I discuss in the following chapter.

In many ways the ‘social model of disability’ can be seen as an extension of labelling theory, although it emerged within the disabilities movement and is also influenced by social constructionism and postmodernism. One of the defining characteristics of this perspective is that it challenges individualist and deficit views of disability and understands disability as the “social barriers, discrimination and oppression experienced by people with impairments” (Beresford, 2002a, p. 583). The social model of disability is a developing field and there are disagreements about some of its key features (Mulvany, 2000). Theorists disagree on how best to theorise ‘impairment’ in such a way that does not reduce a person’s lived experience to either biological or social factors. It is important that the subjective experience of ‘impairment’ not be glossed over by an emphasis on disabling social and political structures (Meekosha, 2003). These disagreements parallel those within labelling theory, one of the criticisms of which was that it did not pay enough attention to the causes of primary deviance and over-emphasised the power of psychiatric labelling. Nonetheless, Beresford (2002a) says, “Survivor activists are increasingly considering how such a social model might apply to their situation” (p. 583). The influence of this perspective on shaping contemporary activism in the mental health field is discussed further in Chapter Six. It could be suggested that the social model of disability is to the consumer/survivor/ex-patient movement and postpsychiatry what labelling theory was to critical and anti-psychiatry.

Critical and anti-psychiatry

Pilgrim and Rogers (1999) include the critical theory to emerge out of the Frankfurt School in the 1930s in their typology because “it has been an influential framework for connecting the psyche and society” (p. 18). They say it is found in a variety of Freudo-Marxian projects that explore the relationship between economics, culture and the psychopathology of the individual, as well as anti-psychiatry sentiments. Critical theory has also had an important influence on mass media and communication theory, particularly ‘effects’ and ‘uses and gratifications’ research. The work of Adorno, Frenkel-Brunswik, Levinson and Nevitt Sanford (1950) on the ‘authoritarian personality’, for example, was an important predecessor to this research and shares with it the underlying assumption of “the mass mind and its gullibility” (Blackman & Walkerdine, 2001, p. 63). Criticisms have been made of the

psychological assumptions embedded in critical theory and the media research it has influenced: Through a combination of Freud and Marx, it is argued this work paved the way for an “understanding of the mass as the gullible consumers of the mass media” (Blackman & Walkerdine, 2001, p. 181). One of the problems with critical theory was its psychological reductionism and methodological individualism, owing to the tradition of psychoanalysis from which it emerged. Unlike the perspectives to which I now turn, most of the work of the school did not focus on mental illness but the “pathology of normalcy” (Pilgrim & Rogers, 1999, p. 17).

I now briefly consider some of the ideas of two scholars who have provided important critiques of psychiatry and, through the work of Crossley (2005), identify some of the key features of the anti-psychiatry movement.

Thomas Szasz is a long time critic of psychiatry and the concept of mental illness. He inaugurated his critique in 1960 in an essay titled “The Myth of Mental Illness”. According to Szasz (1974), “Psychiatrists are not concerned with mental illnesses and their treatments. In actual practice they deal with personal, social, and ethical problems in living” (p. 262). Szasz argues that mental illness is a metaphor that has been made literal in psychiatry’s attempts to validate the medical model. He argues psychologists and psychiatrists deal with moral problems that cannot be solved by medical methods and that, “so long as the moral dimensions of psychiatric theories and therapies remain hidden and inexplicit their scientific worth will be seriously limited (Szasz, 1974, p. 263). Szasz is, perhaps unsurprisingly, categorised as anti-psychiatry, even though he repudiated many of the views of anti-psychiatry (Vatz & Weinberg, 1994). For Szasz, psychiatry and anti-psychiatry constitute two sides of the same coin and both jeopardise the self-determination of individuals. Just as he is anti involuntary psychiatric treatment, he is also opposed to anti-psychiatry methods if they do not accord with a person’s wishes (Vatz & Weinberg, 1994).

David Ingleby’s (1981) critique of psychiatry centres on its positivist origins and assumptions: in particular, the ideal of objectivity and the censorship of theories. He argues “The social function of psychiatry can be summed up as the social control of deviance; that is, the norms of mental ‘health’ and ‘illness’ are essentially matters of cultural judgement, although positivism misrepresents them as matters of empirical fact” (p. 43). He argues that to understand the process of labelling ‘mental illness’ it is necessary to understand the political

motivations invested in such a label or description of behaviour because decisions about what constitutes a ‘warrantable’ or expectable response to one’s situation are unavoidably political:

...what one thinks psychiatrists are up to depends critically on what one thinks their patients are up to; and the latter question cannot be answered without taking an essentially political stand on what constitutes a ‘reasonable’ response to a social situation. (Ingleby, 1981, p. 55)

Crossley (2005) examines developments in the UK field of psychiatric contention and provides a useful reading of the anti-psychiatry movement in the UK. The movement formed in the 1960s around two psychiatrists, Ronald Laing and David Cooper, who achieved fame for challenging the notion that ‘mental distress’ is an illness. They suggested instead that it could be “rendered intelligible in terms of conflicts and tensions both within the family of the distressed individual and within their wider society” (Crossley, 2005, p. 27). Crossley describes the impact of the anti-psychiatry movement:

Psychiatry was delegitimized and a disposition to challenge it had been cultivated. The interactional dynamics that gave birth to anti-psychiatry sedimented qua schemas, taken-for-granted belief and investment in the ‘game’ of critiquing and contesting psychiatry: an oppositional habitus and *illusio*. (Crossley, 2005, p. 28, original italics)

Parallel developments in anti-psychiatry were also taking place in other parts of Europe (Basaglia, 1981, Crossley, 2005; Turkle, 1981) and a counter-movement in the form of the mental hygiene movement was also developing internationally (Crossley, 1998; Kovel, 1981). Needless to say, attempts to demedicalise psychiatry were not successful and the scope of the medical model extended to disease and health in terms of psychic and social causes as well as physical ones (Kimsma & Van Leeuwen, 2005). The mental hygiene movement aided this process by highlighting that social and environmental factors had to be controlled in preventive medicine. Crossley’s research on the psychiatric survivor and mental hygiene movements is discussed in more detail in the following chapter.

In general, these criticisms of psychiatry are concerned with the ideological nature of a profession that dislocates individuals from their social and biographical context of existence and then pathologises them, thereby effectively ignoring the pathological nature of society. In response to recent articulations of postpsychiatry, Barker and Buchanan-Barker (2003) suggest “Clearly, the maverick, Szasz, arrived at this postpsychiatric way station forty years ago” (p. 3). It is not my intention to compare the claims of Szasz and Ingleby with writers on postpsychiatry because I am more interested in the value they have for understanding the role of psychiatry and the construction of mental illness. Postpsychiatry acknowledges its origins

in critical psychiatry, and the difference between anti and postpsychiatry that I see as being of most importance is also perhaps the most obvious - sociohistorical context. Just as these contextual factors were important in shaping anti-psychiatry, articulations of postpsychiatry must also be understood as being shaped by contemporary practices in the field of mental health. Moreover, the influence of Michel Foucault's ideas on postpsychiatry is arguably one factor that distinguishes it from anti-psychiatry (see Bracken, Khalifa & Thomas, 2007). As Thomas and Bracken (2004) suggest:

The analysis of the power of psychiatry mounted by the anti-psychiatrists is simplistic, because it crudely equates power with the suppression of subjectivity. It says nothing of power and the *creation* of subjectivity. ... The power of psychiatry is to be found in the possibilities it creates for us, especially in terms of regulating our behaviour. (p. 365, original italics)

Foucault's contribution

It is suggested that few aspects of the social sciences or humanities are the same in the wake of Foucault's interventions (Frank & Jones, 2003) and this is particularly the case in regard to discursive approaches to psychopathology. Foucault wrote a number of works that deal directly with madness and psychiatry and some of his more general insights have been highly influential. In regard to madness and psychiatry, it is important to acknowledge two recent translations of his work in this area. These are translations of *Madness and Civilisation* as *History of Madness* (Foucault, 2006a) and *Psychiatric Power: Lectures at the College de France 1973-1974* (Foucault, 2006b). Foucault's work invites us to view the objects of psychiatric discourse not as consequences of a discovery but as products of "the relation between planes of specification" (Foucault, 1972, p. 43). These relations are established between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification and modes of characterisation (Foucault, 1972). I limit my review to those of his ideas that are of particular relevance to my research.

The Great Confinement

Foucault's history of psychiatry emphasises its birth as an institution for the social control of 'unreason' (Foucault, 1961/2001). According to Foucault's historical account, 'The Great Confinement' of the seventeenth century subjected an undifferentiated selection of people, united by their social rejection, to the 'gaze' of medicine. Foucault (1961/2001) drew attention to the relationship between lack of work, or idleness, and decisions to treat people as mentally inferior or a threat to the social order. While Foucault's interpretation of 'The Great

Confinement' has been refuted as simplistic and over-generalised (Porter, 2002), the view that psychiatry developed to manage the inmates of asylums is one that is generally accepted (Porter, 2002). As Porter (1987) says, "Psychiatry could flourish once, but not before, large numbers of inmates were crowded into asylums" (p. 17). Madness was constituted by and within the asylum.

Psychiatry's low epistemological profile

Central to Foucault's work is his observation of the low epistemological profile of psychiatry (Foucault, 1980). From Foucault's perspective, the birth of the asylum was paralleled by the discourse on treatment and the role of psychiatry was based on the perceived authority of what he called the 'clinical gaze'. Foucault argued the shift from madness to mental illness was not the result of psychiatry's discovery of an objective truth but of the convergence of internment and medicine (Holmes & Warelow, 1999). The monopolisation of the care of the mad in asylums by the medical profession enabled doctors to redefine the category of 'madness' to that of 'mental illness' (Morall & Hazelton, 2000), in what was understood as a natural extension of the general model of somatic pathology (Gilman, 1988). In light of the link between psychiatric practice and a whole range of institutions, economic requirements and political issues of social regulation, Foucault (1980) asked:

Couldn't the interweaving of effects of power and knowledge be grasped with greater certainty in the case of a science as 'dubious' as psychiatry? (p. 109)

Foucault (1982) was interested in disciplinary apparatuses and his aim was "to create a history of the different modes by which, in our culture, human beings are made subjects" (p. 777). On the basis of his interest in the rules of possibility that constitute certain truths and falsehoods at any given point in time, Foucault viewed psychiatry as one of the modes by which human beings are made subjects through the production of truths. In Foucault's work the close link between truth and power is developed in his notion of 'regime of truth', which refers to the way in which power generates particular types of knowledge and cultural order (O'Farrell, 2005). This is also encapsulated in Foucault's (1972) notion of discourse, which he refers to as "practices that systematically form the objects of which they speak" (p. 49). His aim in analysing discourses was to loosen the embrace of words and things, which is not to say that discourses are not composed of signs but that they do more than use signs to designate things (Foucault, 1972). As George (1999) writes:

Foucault holds that in each discourse there is an elaborate set of rules and procedures for acquiring knowledge, which accord intimately with us and thus capture the 'being' or reality of what members of the discourse undertake to investigate. (p. 234)

Foucault does not presuppose some fixed, unchanging reality that is 'out there' accessible to human thought and action by means of one, proper epistemological method (George, 1999). On one level Foucault's concept of discourse consists of a systematic understanding of knowledge and reality, but it is also laden with various other systems that govern who is authorised to employ, manipulate and develop these rules of knowledge and concepts of reality in the first place (George, 1999). These rules, concepts and practices determine who is authorised to decide what counts for knowledge, truth and falsehood in a given discourse, and authorise these same people to prescribe values and modify behaviour based on their knowledge and station (George, 1999). The rules of 'discursive practices' are specific to a particular time, space and cultural setting that allow certain statements to be made (O'Farrell, 2005). Psychiatry is a discursive practice with a field of objects, "which are things presented to thought" as well as "the occasion or matter on which thought is exercised" (O'Farrell, 2005, p. 79). These objects (i.e. mental illnesses) "are constructed in relation to a whole set of physical, social and cultural occurrences" (O'Farrell, 2005, p. 79). Because of its low epistemological profile, psychiatry's 'regime of truth' and the subjects it creates, rather than being statements about some assured reality, are only temporary views embedded in a network of authorities, institutions, schools and values (George, 1999).

Disciplinary power and the psychiatric gaze

In the context of the increasing need to regulate the population (at the end of the eighteenth century and onward), Foucault saw various practices of confession as central to self-surveillance and self-discipline and to the construction and emergence of new categories of abnormality that could be managed. This marks a shift from the 'macrophysics' of 'sovereign power' to the 'microphysics' of 'disciplinary power' (O'Farrell, 2005). For Foucault (1961/2001), the shift from physical restraint responses to madness to those of penetrating the psyche known as 'moral treatment', practiced by Samuel Tuke and Philippe Pinel, constituted a "new relation between insanity and medical thought" (p. 256). While the physician played no part in the life of confinement, he became the "essential figure of the asylum" (p. 256), not as a scientist on the basis of a body of objective knowledge, but as a wise man whose authority was based on the moral and social order of bourgeois society and its values (Foucault, 1961/2001). Disciplinary power was central to moral treatment as practiced by

Pinel, who Foucault says freed the mentally ill of some of the material bonds that physically restricted them but

... he reconstituted around them a whole network of moral chains that transformed the asylum into a sort of perpetual court of law: the madman was to be supervised in his every movement, to have all his pretensions shattered, his ravings contradicted, and his mistakes ridiculed; sanctions were immediately applied to any departure from normal behavior. (Foucault, 1987, p. 71)

The architectural figure of the Panopticon, as elaborated by Jeremy Bentham, is symbolic of Foucault's notion of disciplinary power. It encapsulates the kinds of practices that function within a range of disciplinary regimes, including the psychiatric asylum (Foucault, 2006b). Psychiatry, by way of the asylums, can be seen to have constructed the objects of its gaze out of a veritable smorgasboard of people who had been socially rejected. It may well be that moral treatment saw a shift away from physical restraint techniques, but it was also born out of these very techniques. In this sense, moral treatment is no less restrictive for the asylum inmate than physical restraint, with the addition of the former involving heightened self-regulation, surveillance and normalising practices and values.

For Foucault, the 'examination' captures the factors of surveillance and normalisation that are central to modern disciplinary power (Burr & Butt, 2000; O'Farrell, 2005). The examination allows people to become 'cases' and the data that it produces "can be generalised and statistical 'norms' can be established with the resultant knowledge being used to tighten control over both populations and individuals" (O'Farrell, 2005, p. 105). Disciplinary power – as epitomised by the Panopticon, is so effective because of people's willingness to submit to normative expectations; it is literally self-discipline (Burr & Butt, 2000). As Foucault (1980) says:

There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself. (Foucault, 1980, p. 155)

This form of power came at minimal economic and political cost compared to monarchical power (Foucault, 1980). In this sense, the power of psychiatry is not oppressive but productive; it produces 'regimes of truth' through which people come to see themselves as subjects. To paraphrase Foucault, psychiatric discourse is a practice that systematically forms the objects of which it speaks (Foucault, 1972). Meaning and reality is produced in psychiatric discourse by a sanctioned 'method' that is granted the capacity to discern the truth

about the reality being investigated in psychiatric discourse (George, 1999). Behaviours, thoughts and feelings - ways of being in the world - assume a new meaning and significance when subjected to the psychiatric gaze (Holmes & Warelow, 1999).

Echoing Foucault's observation of psychiatry's low epistemological profile, Rose (1991) argues psychology also constitutes its object in the process of knowing it. By this he means:

Contemporary scientific reality – and this goes for a science like psychology as much as any other – is the outcome of the categories we use to think it and procedures we use to evidence it, the statistical tools and modes of proof we use to justify it. (Rose, 1991, para. 15)

Rose (1991) identifies in the 'psy' knowledges an "interpenetration of practicability and epistemology" (para. 29), which is to say that its concepts could only be established as truthful so long as they could be translated back into the disciplinary requirements of the apparatus and its authorities. The institutional spaces of the prison, the courtroom, the factory, the schoolroom and other similar spaces provided the objects that psychology would seek to render intelligible (Rose, 1991).

Biopower

The disciplinary regimes of the 'mental' sciences were fundamental to the production of the person as a knowable individual (Rose, 1989b). Following Foucault, Rose (1989b) argues the mental sciences played a key role in making problematic sectors of the population visible by providing the "devices by which human capacities could be turned into information about which calculations could be made" (p. 121). The policing of sexuality was of particular interest to Foucault and it marked a shift in his ideas on power toward the technologies used to manage populations, which he referred to as 'biopolitics' or 'biopower' (O'Farrell, 2005). The focus of biopower was the "life, death and health of entire populations", of which sexuality was a key factor (O'Farrell, 2005, p. 106). His work on this illustrates the discursive power of psychiatry in producing the concept of infantile sexuality through the production of a vast array of books about child sexuality (George, 1999). It also illustrates Foucault's interest in 'technologies of the self' and their relations to 'technologies of power', which characterises his later work on ethics and governmentality. Disciplinary power becomes a subset of Foucault's formulation of biopower (O'Farrell, 2005).

Rose (1989b) describes the mental sciences in terms of “*techniques for the disciplining of human difference*: for individualizing humans through classifying them, calibrating their capacities and conducts, inscribing and recording their attributes and deficiencies, managing and utilizing their individuality and variability” (p. 123, original italics). He argues the inscriptions of individuality invented by the mental sciences are fundamental to programmes for the government of subjectivity and the management of individual difference as they are accumulated in the file or case notes and pored over in the case conference, the courtroom or the clinic (Rose, 1989b).

Governmentality and ‘care of the self’

Foucault’s notion of ‘governmentality’ is integral to disciplinary power and to understanding technologies of the self and their relations to technologies of power. It “implies the relationship of the self to itself” and it includes “the whole range of practices that constitute, define, organise and instrumentalize the strategies that individuals in their freedom can use in dealing with each other” (Foucault, 1997b, p. 300). According to Foucault (1997b), ‘care of the self’ is “an exercise of the self on the self by which one attempts to develop and transform oneself, and to attain a certain mode of being” (p. 282). For Foucault ‘ethics’ is a sense of self, which is developed through self-regulation and self-discipline (Coveney, 1998). These technologies of the self, as Foucault called them, depend on ‘truth games’ (Frank & Jones, 2003, p. 183) or ‘regimes of truth’, which can be understood as “expert discourses through which we understand ourselves and our motives, our desires and our behaviours” (Bracken & Thomas, 2005, p. 93). Rose describes ‘subjectification’ as:

...regimes of knowledge through which human beings have come to recognise themselves as certain kinds of creatures, the strategies of regulation and tactics of action to which these regimes of knowledge have been connected, and the correlative relations that human beings have established within themselves, in taking themselves as subjects. (as cited in Ussher, 2003, p. 133)

Thus, psychiatry’s inscriptions of individual and sexual variability subject people to particular valuations of normality that makes people amenable to having things done to them and doing things to themselves in the name of their subjective capacities (Rose, 1989b). From a Foucauldian perspective, psychoanalysis is a distinctively modern technology of the self, which was based on confessional techniques through which talk about sexuality could be codified and recognised as being at the core of the subject’s being (Forrester, 1994).

Psychoanalytic practice produced new registers within which to render intelligible aspects of

our being, new forms of subjectivity and new techniques of self-discipline and self-regulation. From this perspective, psychiatry's 'regime of truth' can be seen as a form of governmentality, which makes some forms of activity thinkable and amenable to action by both practitioners and those upon whom it is practiced (Petersen, 2003).

Frank (1998) provides a useful reading of Foucault in regards to how the modern subject is produced from technologies of power and technologies of the self:

Power is sustained because it produces, and what it produces is the truth of the subject. The ethical demand on the subject to produce his or her own truth – in practices from the confessional to the contemporary illness story – is thus viewed with suspicion as a technique of power. (p. 332)

Frank (1998) says this leads us to ask "whether any evocation to tell the truth of one's self – including first-person illness stories – is panopticism in a benign disguise" (p. 331). Frank delves further into the humanist and anti-humanist aspects of Foucault's work in an attempt to come to grips with what to make of first-person illness stories. The humanist understanding of illness stories is one in which ill people's experiences are granted a privileged status among competing realities, including medically defined realities (Frank, 1998). The anti-humanist, or the archaeological, interpretation "rejects the humanist transparency of what subjects can say about themselves, asking instead what kind of a story can be told by a subject who is manufactured" (Frank, 1998, p. 333). In seeking to reconcile this apparent dilemma, Frank makes a distinction between Foucault's concepts of 'care of the self', which describes a situation in which individuals do transform themselves in order to attain certain states, and 'technologies of the self', in which certain knowledges posit modes of self-transformation that are strategies of power. Yet he says the distinction is somewhat arbitrary because technologies of the self are the practices used in the care of the self (Frank, 1998). He elaborates on this:

Stories that ill people tell are a technology of the self: yet another strategy of power in which illness becomes truth-game, an occasion to know oneself as the subject of certain social knowledges, thus reaffirming the legitimacy and self-evidence of these knowledges. And these stories are also care of the self: a practice of reclaiming a voice that bodily trauma and institutional treatment have caused to be silenced. (p. 336)

The self is both an object and an instrument of power. We govern ourselves while also being governed by others. As Foucault (1997b) says, practices of the self are models that we find in our culture that are proposed, suggested and imposed by our culture, society and social group. But this does not discount the potential for resistance because power relations are "mobile, reversible and unstable" and "possible only insofar as the subjects are free" (Foucault, 1997b,

p. 292). Foucault argued that power can only be exercised over free subjects, by which he means subjects who are free to act and behave in different ways (O'Farrell, 2005). As Frank and Jones (2003) suggest, "What Foucault calls 'care of the self' is the process of becoming a subject who is capable of choosing which truth games and technologies to be subjected to" (p. 184). It is suggested that Foucault's work on governmentality "provides a more flexible set of analytical tools than students of medicalization possessed in the 1960s and 1970s" (Nye, 2003, p. 120).

The political thrust of Foucault's work

Foucault has been criticised on the basis of what some suggest are misreadings and misunderstandings of his work (Moussa & Scapp, 1996; O'Farrell, 2005). For example, his critics have accused him of reducing everything to 'discourse', a view that Foucault saw as nonsensical (O'Farrell, 2005). Indeed, it was the relationship between discourses and 'non-discursive' elements, such as practices, institutions, social relations and political relations that intrigued Foucault (O'Farrell, 2005). Thus, it is suggested that accusing Foucault of positing that there is nothing outside discourse misreads Foucault's aim, which "was to draw attention to the way that discourse brings some aspects of our world into view as objects for us and hides other aspects from us" (Burr, 2003, p. 89).

The accusation that Foucault did not believe in any kind of truth, or provide any criteria for deciding between different interpretations, also seems to be misplaced. O'Farrell (2005) says that Foucault strongly refuted questions about the historical and empirical accuracy of his own work. Indeed, O'Farrell argues that what prevents Foucault's work from floating off into a vague 'anything goes' stance "is its attachment to history, to the practicalities of concrete existence and the material existence of things – even when those things such as words and ideas have traditionally been regarded as insubstantial" (p. 86). Truth, knowledge and power in Foucault's work are concomitant, as is suggested in his comment that "the discovery of truth is in reality a certain modality of the production of truth" (as cited in O'Farrell, 2005, p. 93). Thus, it is not that Foucault denies truth but, rather, he problematises it in order to explore the relations of its production.

Other criticisms of Foucault that have been identified include that he: lacks a theory of 'agency' and thereby restricts the possibility for social critique or revolutionary political action; lacks a normative justification for the exercise of power; lacks a sense of history as

progressive; and lacks a notion of freedom (Moussa & Scapp, 1996). Moussa and Scapp (1996) argue that these criticisms are misguided and ignore the “practical and political thrust in his work” and the practical value of his notion of “counter-discourse” (p. 87). They contend that Foucault’s work aims to clear a space for the voiceless to begin to articulate their desires – “to *counter* the domination of prevailing authoritative discourses”, which credits Foucault with a real-world political sensitivity that is often denied by his critics (p. 88). Frank and Jones (2003) are careful to point out that Foucault is no relativist, but rather that he rejects groups of experts imposing a set of overarching principles that determine which truth games and technologies of the self people must pursue. The possibilities for resistance lie in the subject’s power to decide on what terms to play the game (Frank & Jones, 2003). As K. Phillips (2006) says:

On the one hand, the subject comes to act by being positioned within broader and impersonal systems of discourse and these positions, in turn, help to craft one’s sense of self. (p. 313)

It is possible to destabilise discursive positioning by moving from one discursively constructed position to another (K. Phillips, 2006).

It is suggested that one of Foucault’s aims was to bring to the fore previously marginalised discourses (Burr, 2003) and to draw attention to “forgotten people and forgotten forms of knowledge or those otherwise deemed to be unimportant” (O’Farrell, 2005, p. 86). According to Moussa and Scapp (1996), counter-discourse is produced when those who are usually spoken for and about by others begin to speak for themselves. This concept is particularly relevant to postpsychiatry and also to the activism of the psychiatric survivor movement, as I discuss in later chapters. Indeed, it seems that the political thrust of Foucault’s work is what attracts many people to it. On the other hand, Crossley (1998) suggests that the Foucauldian perspective is vague on the question of resistance and has not informed discussion on the various organisations and social relations which regulate or operationalise psychiatric technologies. For his analysis of social movement organisations in the mental health field, which I discuss in the next chapter, he finds the work of Pierre Bourdieu more useful. Crossley’s reading and application of Bourdieu is particularly useful but I do not think this precludes the conceptual and practical value of Foucault’s ideas.

The systems of knowledge that prevail at any given historical moment marginalise other discourses that are important sources of resistance for challenging the legitimacy of prevailing

‘regimes of truth’. The institution of psychiatry, Foucault argued, and the knowledges it selects are based on the elimination of other knowledge or even its own history (O’Farrell, 2005). This is a position shared by Scull (1982), whose historical works on madness and psychiatry have sought to challenge ‘whiggish’ historical accounts, or what in Foucault’s terms might be referred to as the ‘continuity’ of history. As O’Farrell (2005) says:

By unearthing all the knowledge rejected by these institutionalised disciplinary systems and examining the historical and sometimes quite scurrilous reasons for the rejection of some knowledge and inclusion of others, Foucault’s work challenges the idea that knowledge proceeds by the mere systematic accumulation of self-evidently ‘true’ ‘facts’. (p. 87)

Foucault’s ideas have been taken up by many scholars and applied to a range of research topics, some of which I have drawn from in my discussion thus far. Also of interest to this research is the application of his ideas to an analysis of informed choice (Ells, 2003), meta-narrative ethics (Goldstein, 2003), ethics and health promotion (Coveney, 1998), health communication (Lupton, 1994), risk discourse and health education campaigns (Lupton, 2005) and health care (Petersen, 2003). More generally, his ideas influence social constructionism and postpsychiatry, the first of which I now discuss.

Social constructionism

The Foucauldian concept of ‘discourse’ is central to social constructionism, though it is approached in different ways in accordance with micro and macro social constructionism. In an apparent departure from Foucault’s (1972) insistence that discourses are not reducible to language and speech, discursive psychologists refer to discourse as “an instance of situated language use” and analysts focus on the way language is used to build successful accounts for the speaker or writer (Burr, 2003, p. 63). For those who take a more deconstructionist stance, or what Burr (2003) refers to as macro social constructionism, the meaning of discourse extends beyond that of the immediate context in which language is being used. Whereas discursive psychologists tend to focus on the freedom of the speaker or writer to use language to achieve their own ends, deconstructionists focus on “the way that forms of language available to us set limits upon, or at least strongly channel, not only what we can think and say, but also what we can do or what can be done to us” (Burr, 2003, p. 62). This refers to discourse as both language and practice and is often described as the Foucauldian approach.

As I now discuss, some of the key interrelated assumptions of social constructionism provide a strong basis for a critique of traditional psychology, psychiatry and positivism in general.

A relational view of language

Social constructionism requires that we take a critical stance toward our taken-for-granted ways of understanding the world, including ourselves (Burr, 2003). In a sharp break with the reference theory of language (i.e. psychiatric positivism), a critical stance toward taken-for-granted knowledge manifests in the social constructionist position that language is relational (or discursive) and works through internal semiotic relations, rather than through external reference (Lewis, 2006b). Language does not correspond to the world as it is but gains its meaning from its relation to other concepts (Lewis, 2006b). This position is influenced by Saussure's distinction between *langue* and *parole*, which was built on and reworked by Foucault's notion of discursive practice, which combines the terms *langue* and *parole*. *Parole*, as a particular statement or linguistic production, is made possible by *langue*, which is the background grid of semiotic distinctions, rules, norms and expectations (Lewis, 2006b). In Foucault's work, *langue* is replaced by discourse and *parole* by practice but, as Lewis (2006b) notes, Foucault's notion of discursive practice involves not only representation but a range of human actions that involve real connections with the world. It is also important to acknowledge the work of Ludwig Wittgenstein as a philosophical underpinning of social constructionist ideas, particularly his concept of 'language games', which can be likened to Foucault's notion of 'discursive practice'.

Historical and cultural specificity of knowledge

Social constructionism, postmodernism and poststructuralism posit that the categories and concepts we use to understand the world are historically and culturally specific. This means that our knowledge of the world and ourselves is always partial, limited and shaped by the "systems of linguistic categories and relations from which the world is perceived" (Lewis, 2000, p. 77). In this sense, language is a pre-condition for thought, rather than a straightforward expression of thought (Burr, 2003) and psychiatric categories can be viewed as representations that construct these conditions rather than merely express a pre-existence. Psychiatric categories are products of particular relations between "planes of specification" (Foucault, 1972, p. 43) that have been adopted for use in psychiatric discourse and these are culturally and historically specific.

Emphasis on social processes in the production of knowledge

Because our knowledge of the world is not derived from the nature of the world as it really is, social constructionism posits that it is through social interaction that our knowledge of the world is fabricated (Burr, 2003). This means that what we regard as truth can be understood as “our current accepted ways of understanding the world” (Burr, 2003, p. 5). In this sense, social constructionism opposes essentialism and the way that it can trap people inside personalities and identities that are limiting for them (Burr, 2003). This is particularly pertinent to psychiatry and psychology because it means that the language of the mind loses its “truth-bearing” capacity and it is possible to question the kinds of social patterns (relationships) enabled or constrained by existing vocabulary of psychological or ‘mental deficit’ (Gergen, 1994b, p. 147). From a social constructionist perspective, language itself is a form of social action because it has practical consequences. In regard to psychopathology, the value of a constructionist perspective is that it enables us to “direct our gaze not at the mad but at the culture, institutions, and language which makes madness matter so much” (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995, p. 14). This is the thrust of some of the perspectives discussed earlier in the chapter, including labelling theory, the social model of disability perspective and anti and critical psychiatry.

Knowledge and power are concomitant

One of the reasons that Foucault’s work has had such a significant influence on social constructionist, postmodernist and poststructuralist modes of inquiry is his problematisation of all claims to knowledge as concomitantly claims to power. Foucault’s coupling of ‘power/knowledge’ relates to his view of theory as itself a form of practice. He holds that knowledge is always shaped by power and, thus, it is essential to examine the relationship between knowledge and the political, social and historical factors that produce and constrain it (O’Farrell, 2005). And what counts as knowledge “refers to the particular construction or version of a phenomenon that has received the stamp of truth in our society” (Burr, 2003, p. 68). In this sense, power is an effect of discourse and discourses are seen as suppressing or sustaining forms of cultural life. While there are numerous possible constructions of the world, each construction brings with it or invites a different kind of action from human beings. Following Foucault’s coupling of power/knowledge, our constructions of the world are “bound up with power relations because they have implications for what it is permissible for different people to do, and for how they may treat others” (Burr, 2003, p. 5).

Truth is produced rather than discovered

As suggested, ‘truth’ from a social constructionist perspective is problematic. There is no one single truth to be discovered about the world. There are multiple interpretations or constructions of the world that are products of social processes and interactions and that sustain some patterns of social action and exclude others (Burr, 2003). Our knowledge always comes from somewhere and is in the service of some interests rather than others and we cannot assume that our ways of understanding are any nearer the ‘truth’ than any other ways (Burr, 2003). Some scholars perceive this as a weakness of strong social constructionism (Horwitz, 2002a, Ratner, 2006).

Criticisms of social constructionism

At its base, social constructionist thought serves to critique the positivist/realist assumptions of traditional biomedical and psychological research and calls for reflexivity in scientific theory and practice. But in its most radical version it has been accused of anti-empiricism and a lack of attention to individual agency and experience, including biological and psychological factors as well as material factors such as gender, race, class and various forms of capital, and an overly pessimistic view of the power of dominant discourses (Horwitz, 2002a). It is also accused of reducing people’s experiences of psychic or bodily pain, or emotional suffering, to discourse (Williams, 1999); being unable to propose any criteria for making a choice between different interpretations of reality (Horwitz, 2002a; Ratner, 2006); failing to account for the emotional investments people make in particular discursive positions; and being unable to explain individual differences in the subject positions people habitually adopt and why people sometimes position themselves in ways that are disadvantageous to them (Burr, 2003; Burr & Butt, 2000). Bourdieu’s concept of ‘habitus’ is useful for shedding light on questions of why people emotionally invest in particular discursive positions and in the next chapter I discuss Crossley’s (1999, 2004, 2005) application of Bourdieu’s general theoretical framework.

These perceived shortcomings of social constructionism in its strong version have led some scholars to adopt alternative standpoints. These standpoints, which I will consider under the problematic heading of ‘critical realism’, share the view that there are many issues that potentially remain unaccounted for within a social constructionist epistemological frame, without collapsing into the naïve realism and biological reductionism of the medical model (Lewis, 2006b; Pilgrim & Bentall, 1999; Ussher, 2000; Williams, 1999). Their proponents

recognise that scientific concepts must be viewed in the context of the social and historical conditions and the discursive practices from which they emerge, but they do not discount biomedical and psychological aspects of experience (Pilgrim & Bentall, 1999; Ratner, 2006; Ussher, 2000). There is nothing in these alternatives to social constructionism that rejects the view that knowledge and meanings are socially constructed, but there is also an awareness that reducing everything to the level of the discursive or social is no better than the biological reductionist approaches that it critiques (Pilgrim & Bentall, 1999; Ratner, 2006; Ussher, 2000; Williams, 1999). While some of the perspectives I now review are explicit in their opposition to strong social constructionism, others overcome the constructionism-realism duality.

Critical realism

Critical realism is a position often adopted by social constructionists who disagree with some of the assumptions of a relativist position (Burr, 2003). Pilgrim and Bentall (1999) write:

In a critical realist account it is not *reality* that is seen as socially constructed (the axiomatic radical constructionist position), rather it is our *theories of reality*, and the methodological priorities we deploy to investigate it. (p. 262, original italics)

While social constructionism proposes certain methodological approaches and critiques methods that are grounded in the positivist scientific tradition, critical realism uses the criteria of pragmatism to decide which methods are best suited to answer the research question being asked (Ussher, 2000). While accepting that all meanings are socially constructed, critical realism is not inhibited from interpreting the findings of existing research on mental illness, but it does so in a way that rejects many epistemological assumptions of these studies and the status given to them. It does not, however, reduce them to the realm of discourse alone (Pilgrim & Bentall, 1999; Ussher, 2000; Williams, 1999). Ratner (2006) suggests, “On important issues, everyone is a critical realist, not a social constructionist” (para. 25).

Material-discursive-intrapsychic approach

Ussher (2000) proposes a material-discursive-intrapsychic approach in response to the questions left unanswered by a social constructionist position. This standpoint implies a weaker version of social constructionism than that advocated by some scholars, and one that seeks to understand human experience as constituted by a combination of material, discursive and intrapsychic factors, none of which is privileged for their explanatory power (Ussher, 2000). Ussher describes critical realism and, in turn, feminist standpoint theory as exemplars of this approach. Deconstructing psychiatric discourse at the macro level is undoubtedly an

important and necessary exercise in order to expose the assumptions that underpin its ‘truth’ claims. However, as Ussher (2000) says, it is also important to reconcile this with the needs of individuals at the micro-level, many of whom are active in viewing themselves in psychiatric terms. She says:

Reconciling a deconstructionist critique at the macro-level with the needs of individuals at a micro-level is a problem facing all those who would put forward a radical critique of mental illness. (Ussher, 2000, p. 218)

In her work on Premenstrual Dysphoric Disorder (PMDD), Ussher (2000, 2003) argues that in addition to deconstructing psychiatric discourse it is important to examine the process by which women take up the position of PMDD or PMS sufferer in a form of subjectification. She says the material-discursive-intrapsychic approach is necessary in order to gain a deeper understanding and comprehension of this phenomenon (Ussher, 2000), although this approach is not unique to women’s madness. In order to move beyond deconstruction, Ussher (2003) proposes an alternative non-pathological framework for understanding premenstrual symptomatology by reconstructing it from Eastern models of mental health, which challenges Western notions of normal selfhood and is compatible with a critical feminist analysis of PMDD. I refer to Ussher’s work in more detail in the context of ‘disease mongering’ in the following chapter.

Mental illness as both discourse and experience

Fee (2000b) proposes an approach to psychiatric categories that views them as both discourse and experience. His work focuses primarily on depression, the meaning of which he says:

...is chiefly derived from engagements with intermixing elements of abstract systems – mass media, therapy, psychopharmacology, *DSM-IV* (on shelves at all major bookstores), (other) popular health references, and, perhaps portentously now, autobiographies (and even further, analysis of autobiographies?). (pp. 86-87)

Fee argues that reflexivity is increasingly crucial for conceptualising depression and perhaps other syndromes and pathologies. He situates his analysis in the context of Giddens’ (1991) concept of ‘institutional reflexivity’, a condition where “‘abstract systems’ of knowledges about self and living are continually incorporated into local environments of thinking and behaviour, which in turn feed back upon these permeating systems” (Fee, 2000a, p. 11). In this condition, information and knowledge is increasingly sought out by individuals in response to the challenge of sustaining a coherent and relatively continuous ‘narrative of the self’ (Fee, 2000b). This perspective recognises that languages of depression no longer exist

solely within the discourse of psychiatry or the mental health professions generally but, as with other diagnostic categories, they are *social objects* or a *discursive project* – “a reflexive process of self-definition and identity construction” (Fee, 2000b, p. 75, original italics). He says:

This does not deny the reality of depression, but it complicates dominant assumptions that entities like depression are completely external – that is, outside agents that unidirectionally invade the (otherwise healthy, unmitigated) self. (p. 75)

Fee (2000b) says within the context of institutional reflexivity “people are thrust into processes of signification and identity-work” (p. 87) when they feel that a condition could pertain to them, or even before. In this sense psychiatric diagnoses, like depression, can be seen as forms of culturally produced languages (Fee, 2000b). They are taken up as objects of self-understanding and decision-making that have certain narratives attached to them, which “provide a means for understanding the dimensions of depressive experience and anchoring it in the self” (p. 87). As a “commodified experience”, he says, depression comes with its own various ‘self-help’ manuals (p. 88). To illustrate the way in which “hyper-reflexive embodiments of depression bring matters of language and social construction into the heart of felt experience”, he examines Elizabeth Wurtzel’s *Prozac Nation: Young and Depressed in America*, published in 1995 (p. 76). He suggests personal accounts such as these are now crucial to what we understand as depressive illness and that what were once considered expert knowledges have spilled over into how lay people talk about and what they feel as depression. In this context, he considers the relationship between reflexivity and Foucault’s notion of discipline, in that self-monitoring and self-regulation “must be considered as a potential aspect or outcome of reflexivity around depression” (p. 95). He writes:

In a progressively more medicalized and ‘psychiatrized’ milieu, we no longer need to have the doctor sitting across from us; forms of mediation can be found while perusing a bookstore, being prescribed a pill (or simply exploring whether or not one needs a pill), or reading an autobiography. (Fee, 2000b, p. 95)

Discipline, in this sense, is one possible trajectory of reflexivity (Fee, 2000b). Fee links the discourse of depression, and the same could apply to other psychiatric diagnoses, to the project of self-production, whereby the social object of depression forms an intrinsic part of one’s self and social identity, often providing a thread by which people anchor their life experiences/narratives (Fee, 2000b). He says the implication of understanding the reflexive reality to depression is not the rejection of organic processes but the loosening of positivism’s “supposed objective grasp of the underlying essence of depression” (p. 96).

The 'risk society' perspective

There are clear parallels between Fee's application of reflexivity and the 'risk society' thesis, owing to the mutual influence of Giddens (1990, 1991, 1994), and it is worthwhile discussing briefly some features of the latter perspective. The concept of 'reflexive modernity' is central to this perspective and refers to a society which has come to reflect on and critique itself, which leads to an emphasis on risk, particularly the risks produced by the central institutions of late modernity – government, industry and science (Lupton, 1999). Leading theorist of 'risk society' Ulrich Beck (2000) writes:

I consider realism and constructivism to be neither an either-or option nor a mere matter of belief. We should not have to swear allegiance to any particular view or theoretical perspective. The decision whether to take a realist or constructivist approach is for me a rather pragmatic one, a matter of choosing the appropriate means for a desired goal. (p. 211)

Perspectives within the sociology of risk shed light on the realism-constructivism binary, in some sense rendering it inapplicable (van Loon, 2000). It is suggested that risks are necessarily constructed and that risks are "revealed in their construction" (Adam & van Loon, 2000, p. 2). This requires theorists to transcend the choice between realism and constructivism and also the "reliance on the empirically accessible world of social facts" (Adam & van Loon, 2000, p. 3). Risks, as with all constructions, are realised in their mediation or fabrication and it is on this basis that risks have effects. The notion of 'virtual risk' in this regard is particularly useful not only for understanding risk but knowledge, because, as with the notion of 'virtual reality', the boundaries between real and representation are displaced (van Loon, 2000). Beck's (2000) distinction between *impact* and *knowledge* of a risk is also applicable to an understanding of 'mental illness', which, like manufactured risks, is immaterial and, in that sense, unreal until it materialises as symptoms, which are then open to interpretation.

This position shares many similarities with Parker's combination of 'epistemological relativism', which is the view that our knowledge about the world is constructed through discourse, and 'ontological realism', which accepts that our constructions are "based on reality as it is actually structured" (Burr, 2003, p. 96). From this perspective, mental illness is constructed by psychiatric theories and practices but it also has real effects on people who fall into this category, and it becomes their reality (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). This resonates with van Loon's (2000) comment that "In risk society, all we have are reality effects and they are real enough" (p. 178).

There are clear parallels between these standpoints and the position of semiotic realism, which Lewis (2006b) proposes to overcome the limitations of realism and constructionism.

Postpsychiatry: reading psychiatry against the grain

Postpsychiatry is the manifestation of the views of critical psychiatry, with the addition of further elements of the postmodern critique of modernism and its institutions, values, methods and forms of knowledge (Bracken & Thomas, 2005; Lewis, 2006b). According to Thomas and Bracken (2004):

Postpsychiatry is not yet another model to compete with the ‘medical’ and ‘social’ models of psychiatry; instead, it points to the possibility (and the growing reality) of a new direction for mental health work, which moves beyond the theories of the 20th century. (p. 368)

Postpsychiatry clearly shares philosophical orientations with social constructionism as well as interrelated themes of postmodern psychology (Burr & Butt, 2000) and postmodern social theory (Denzin, 1986; Richardson, 1991). This is a necessarily selective overview of some key aspects of postpsychiatry. For a comprehensive discussion see Bracken and Thomas (2005) and Lewis (2006b).

Shift in phenomenological approach

For Bracken and Thomas (2005), Heidegger’s phenomenology is of particular relevance to postpsychiatry because it stresses the primacy and irreducibility of human experience or ‘being-in-the-world’. It is through our human experience that the world is revealed to us, and our attempts to illuminate human reality can only be at best an *interpretation*, rather than a form of scientific *explanation* (Bracken & Thomas, 1999b, original italics). Thomas, Bracken and Leudar (2004) refer to the philosophical distinction made by Hubert Dreyfus between ‘epistemological phenomenology’ and ‘ontological phenomenology’. The former is concerned with how the mind represents external reality and the latter with how human beings relate to the world. Following Heidegger and Merleau-Ponty, Bracken and Thomas (2005) react against the separation of phenomenology from hermeneutics and the ontological separation of the ‘inner’ and ‘outer’ world, in favour of Heidegger’s vocabulary of ‘being-in-the-world’ to describe our reality.

Methodological pluralism

According to this phenomenological view, human reality resists analysis through the gaze of empirical science and is influenced by cultural factors that make it possible for us to understand and make sense of our world in particular ways (Thomas et al., 2004). In contrast to the methodological individualism of modern psychiatry, Bracken and Thomas (2005) call for a methodological holism that recognises the importance of social and cultural factors. They put forward hermeneutics as a way to overcome reductionism in psychiatry. They refer to hermeneutics as a process of interpretation that aims to make sense of things and they present this as a central organising principle of a “positive postpsychiatry way of thinking about mental health issues” (p. 123). Bracken and Thomas (2005) rightly point out “the world of meaning resists analysis through the methods of positivist science whether this is biological, psychological or social” (p. 168). In order to investigate the world of meaning, methods other than those provided by positivist science are required. In the spirit of methodological pluralism this does not deny the relevance and value of positivist methods, and nor does it preclude medical explanatory frameworks, but it recognises their limitations.

Non-transparent view of language

Lewis (2006b) identifies the postmodern philosophies of Foucault, Lyotard and Derrida, particularly Lyotard’s extension of Wittgenstein’s notion of *language games* and Foucault’s *discursive practices*, as having particular relevance for postpsychiatry. These philosophical perspectives challenge the representational view of language as reflecting the world as it is, by viewing linguistic constructions as inseparable from other constructions, human perception, practice, power relations and actions (Lewis, 2006b). Thus, rather than understanding psychiatric knowledges as universal truths, from a postmodern perspective psychiatric knowledge is always mediated through non-transparent language, or in Derrida’s terms *sous rature*, as “under erasure”. This is a process of writing a word, deleting it and then writing both the word and the deletion to draw attention to the “inherent incompleteness and instability in representation”, but also its necessity for articulation and communication (Lewis, 2006b, p. 70).

Semiotic realism

Lewis (2006b) describes his departure from realist and relativist ontological positions as ‘semiotic realism’, which draws on both referential and relational theories of the sign. Semiotic realism, like critical realism, accepts that there is a real world out there that “grounds our ideas” and that our ideas are “in touch with”, while acknowledging that “the specific points of contact between our ideas and the world are determined by the semiotic relations from which our ideas are structured” (Lewis, 2006b, p. 30). These ideas are relative to a given community or specific tradition of thought. Like critical realism (Pilgrim & Bentall, 1999; Ratner, 2006), semiotic realism allows an appreciation of actual conditions without automatically preventing us from grasping the social construction of the definition and treatment (Lewis, 2006b). According to Lewis (2006b), “From a semiotic-realist perspective, ideas are grounded in the real world, but how and why they are grounded remains relative to diverse semiotic communities” (p. 30). In accordance with semiotic realism, the world is not entirely constructed and nor is it entirely ‘out there’ for us to discover as some objective truth.

Pragmatic epistemology

Lewis (2006b) says semiotic realism is underpinned by a pragmatic theory of the sign, which he says is consistent with the epistemology of ‘pluridimensional consequences’, a concept he borrows from Barthes’ use of the notion of “pluridimensional order” to articulate the limitations of language in capturing the world (as cited in Lewis, 2006b, p. 30). Semiotic realism posits a relationship between concept (interpretant), signifier (sign) and thing (object), which connects signs to both the world and the linguistic system from which they arise. Thus, while a sign or linguistic representation, such as ‘mental illness’, does not refer to objective facts about the world, it does evoke some thing (object) in the world on the basis of the semiotic relations from which the concept of ‘mental illness’ is constructed. As assumed by social constructionism, these semiotic relations are relative to a given community or a specific tradition of thought.

While language does not mirror the world, it does evoke connections with the world and these different connections yield different consequences for practice and lived experience.

According to Lewis (2006b), these consequences are the key for pragmatic theories. From a pragmatic perspective, the criteria for what constitutes good ‘knowledge’ is not that of ‘truth’, but the consequences of knowledge for action. Lewis (2006b) argues:

This consequentialist perspective is the most comprehensive of the three philosophies of the sign because the pragmatic focus does not erase the importance of either correspondence or social construction as criteria for knowledge. (p. 31)

In this sense, the specific criterion for what is good knowledge is that of consequences and “good consequences depend partly on correspondence with experience and partly on relations with community and tradition” (p. 31). From the position of a consequential epistemology, the important point is that both radical social constructionist and naïve realist epistemologies of mental illness have consequences in and for professional practice and lived experience. Lewis (2006b) describes the pragmatism of this position:

If two beliefs seem equally plausible based on grounds of reference and grounds of tradition, but one has better consequences than the other, then the one with best consequences is the one to choose. (p. 31)

Indeterminacy of interpretation

The most important aspect of this emphasis on consequences is that it brings together ontology, epistemology and ethical values, and requires us to consider that “the interpretations we choose and the knowledge-making communities we join determine who we become and the kind of life-worlds we create” (Lewis, 2006b, p. 34). Different interpretations are based on attendance to different aspects of the data, which means that interests, desires and consequences partly determine what counts as legitimate knowledge (Lewis, 2006b). Our perceptions are always interested (Hick, 1999).

Interpreting Van Gogh

Lewis (2006b) distinguishes between realism, constructionism and pragmatism in relation to contemporary interpretations of Vincent Van Gogh. He examines the different ways in which Van Gogh’s life has been interpreted and draws a distinction between those that *pathologise* him and those that *celebrate* him. He identifies the pathologists as mainly clinical writers who agree that Van Gogh was “sick” and that his mental pathology explains his psychic suffering and much of his art. They retrospectively diagnose Van Gogh with manic-depressive illness based on a *referential* theory of the sign, which views the meaning of signs as corresponding to real-world features (i.e. psychiatric symptoms). These are taken to reveal the truth about Van Gogh (Lewis, 2006b).

Thomas and Bracken (2001) also provide an example of the pathologisation of Van Gogh and its consequences. In an article titled “Vincent’s bandage: The art of selling a drug for bipolar disorder” they observe the image of Van Gogh painted by the pharmaceutical industry to promote a drug for bipolar disorder. The advertisement shows four identical images of Van Gogh, which also appeared in the *British Journal of Psychiatry* and the *British Medical Journal*. Each of the images, renditions of his famous self-portrait with the bandaged ear, has a different coloured background: scarlet red, blue, green and purple. The text above the images is “First Line Mood Stabiliser” and below “Proven across a spectrum of today’s bipolar patients”. The message conveyed is that Van Gogh suffered bipolar disorder and with the help of the drug being advertised, his mood would have been stabilised and he would not have cut off his ear to still his tormenting voices (Thomas & Bracken, 2001). Thomas and Bracken satirically write:

Yes, if Vincent had been on valproate he might still have painted. If he were alive today and on valproate Vincent would be driving around in a white transit van, painting houses battleship grey. But then at least the bandage wouldn’t be necessary. Madness is okay, as long as it’s kept in its place, on the canvas, in the asylum but, either way, under drugs. (p. 1434)

Van Gogh’s bandaged ear becomes symbolic of his madness, his extreme and unstable moods, a psychiatric symptom from which today’s drugs could have saved him, like they have been proven to do across a spectrum of today’s bipolar patients, as the advertisement says. The retrospective pathologisation of Van Gogh reduces the ‘truth’ of Van Gogh’s art and his life to mental pathology in the interests of pharmaceutical company drug promotion.

In the context of a *relational* theory of the sign, rather than being pathologised, Van Gogh is celebrated (Lewis, 2006b). From a social constructionist perspective, there is no “single” truth of Van Gogh, and the claim that he had manic-depressive illness “depends less on the referent and more on the socially constructed categories and conceptual grids used by different interpretive communities” (Lewis, 2006b, p. 26). Thus, different semiotic communities will create multiple ‘true’ interpretations. As Lewis (2006b) writes, “For these interpreters, we should not pathologize Van Gogh; we should learn from him. We should not ‘cure’ him; we should let him cure us” (p. 27). However, Lewis suggests a social constructionist approach lacks criteria through which to make a choice about whether to pathologise or celebrate Van Gogh, in response to which he argues for a pragmatic approach. From this perspective, the criteria upon which we decide whether to pathologise or celebrate Van Gogh relate to our

desires and the consequences that flow from joining each of these interpretive communities.

Lewis puts it this way:

If a life of talking to psychiatrists and following psychiatric advice sounds best, then a clinical interpretation would be the way to go. If a life of intense creative striving sounds best, then alternative interpretations would be much better. (p. 36)

Learning from Chekhov

Lewis (2006a) makes a similar point in regard to a review by Peter Kramer, author of *Listening to Prozac*, of Anton Chekhov's play *Ivanov*, in which he hears of Ivanov's troubles "a straightforward case of clinical, or medical model, depression" (p. 50). He says this interpretation misses the complexity of Chekhov's play, which he argues "is not about medical depression at all but, rather, the indeterminacy of interpretation" (p. 51). He argues Chekhov uses this to structure the play and "to highlight the multiplicity of meaning and the possibility of respecting the interpretive diversity of the characters" (p. 51). Chekhov's play, according to Lewis, contains characters who each bring different and incommensurate interpretations to the troubles of the central character Ivanov. In regard to the relevance of this play to the dogmatic certainty evident in the contemporary psychiatric community, Lewis (2006a) argues:

If biopsychiatry listened more closely to *Ivanov* the play, rather than narrowly reading Ivanov the character, it would throw its DSM-led interpretations (and its drive for antidepressant "cures") into the ring with a myriad of other interpretations. It would not foreclose other, equally vital understandings of melancholia and suffering. (p. 56)

Lewis says that Chekhov's stories, such as *Ivanov*, are exemplary of the multiple and ambiguous interpretations that are at the heart of the epistemology of 'pluridimensional consequences'. From this perspective, he says, "the question to ask is not simply, which story is true? but, instead, what are the consequences of each story? and what kind of life will follow from inhabiting these stories?"(p. 59).

Postpsychiatry: implications

According to Lewis (2006b), "Postmodern theory... joins pragmatic theories of representation and Foucauldian theories of discursive practice and power to form the bedrock of a theorized postpsychiatry" (p. 79). He envisages four key aspects of psychiatry as a result of its encounter with postmodern theory. These include: a shift in clinical knowledge structures away from their recent exclusive focus on neuroscience and quantitative social science toward

the more qualitative approaches of philosophy, literary theory, anthropology, women's studies, Africana studies, cultural studies, disability studies and the arts; a grounding of clinical activities in the wisdom of practice rather than the 'objective truth' of research; a greater emphasis on ethics, politics and pleasure as guidelines and goals for clinical progress and knowledge production; and increased democratisation of all aspects of psychiatric practice (research, education and treatment) (Lewis, 2006b). Similarly, Bracken and Thomas (2005) call for a rethinking of the politics of mental health, which would be characterised by the lessening of the role of the medical profession in making key decisions such as removing a person's liberty. Bracken and Thomas (1999a) argue for a new relationship between medicine and madness, which requires a shift in the power relationship between doctor and patient and returning the ownership of madness to those who experience it.

Shift in knowledge structures: cultural studies of psychiatry

Lewis (2006b) calls for postpsychiatry to create alliances and coalitions with other postdisciplinary scholars to develop a new genre of "cultural studies of psychiatry", which in its most simple form would "read psychiatric 'knowledges' against the grain" (p. 81). He says the new scholarly genre of cultural studies of psychiatry would hold in tension two perspectives: "that psychiatric knowledges are real and have real effects on the world, and that they are simultaneously the products of social, cultural, and political relations" (p. 81). A cultural studies perspective understands that while scientific knowledge has real effects on the world, it is bounded by the limitations of materiality and must be understood as socially determined and culturally specific.

Lewis says cultural studies of psychiatry can look beyond the bioscience curtain to expose and critique the effects of medical discourse, as with other cultural phenomena (Lewis, 2006b). His work is informed by Donna Haraway's cultural studies of science approach to medical discourse as cultural constructions and, as I discuss in Chapter Three, Stuart Hall's (1980) cultural studies of television. In this context, Lewis says cultural studies of psychiatry can focus on language and the effects of social power on shaping language and the determining nature of language for cultural practices and formations (Lewis, 1998). It can cast its gaze to research materials that have previously been marginalised in the medical humanities, including popular media, advertisements, and the broader socio-political context of medical knowledge (Lewis, 1998). It requires a shift away from the exclusive focus on neurosciences and quantitative social science methods toward qualitative approaches.

Reading the DSM against the grain

Bracken & Thomas (2005) call for psychiatry to shift its focus from technology to ethics, which means recognising the role of values in research and practice, including the values and assumptions about the nature of the self and the world that are built into its diagnostic categories. Psychiatry's *DSM*, which Bracken and Thomas suggest is the best example of the technical framing of mental and emotional problems by psychiatry, provides an insight into the politics and values that underpin psychiatry's power/knowledge. Produced by the American Psychiatric Association (APA) the *DSM*, referred to as the "bible" of psychiatry (Kirk & Kutchins, 1992, p. 1), promotes and justifies psychiatry's accounts of what constitutes mental illness/disorder. It is the key volume about mental illness that all trainee psychiatrists, physicians, social workers, psychologists and psychiatric nurses must learn (Caplan, 1995). It is used in different ways by insurers, governments, professionals, patients and institutions (Manning, 2000). Its classifications are also included in the World Health Organisation's (WHO) International Classification of Diseases (ICD-10), textbooks of medicine, archives of legislation, regulation and litigation, as well as mass media and public beliefs (Brown, 1995). The current edition of the *DSM-IV* (1994) lists more than 300 mental illnesses, most of which have been identified in the past twenty years (Bracken & Thomas, 2001). From 1987 (*DSM-III-R*) to 1994 (*DSM IV*) the number of diagnostic categories increased from 297 to 374 (Baughman, 1997; Caplan, 1995).

Gergen (1994b) illustrates the consequences of the production and availability of an expansive vocabulary of mental deficit when he says, "Furnish the population with the hammers of mental deficit, and the social world is full of nails" (p. 158). Holmes and Warelow (1999) argue that due to the all-encompassing symptomatology of *DSM-IV* "it would be almost impossible to establish that one is not, to some degree, mentally disordered" (p. 173). This enables the "psychiatric establishment to extend its legitimate authority to everyone" (Holmes & Warelow, 1999, p. 176). While the APA defends and justifies this expansion on the grounds that it reflects a sharpening of diagnostic precision (APA, 1997), critics argue it has not produced any major new theoretical insights into the biological causes of mental illness and is more a product of professional, social, political and technological forces than any scientific progress in identifying new mental illnesses (Caplan, 1995; Kirk & Kutchins, 1992).

Critics argue that due to the efforts of a handful of influential psychiatrists, known as the *DSM* Taskforce, the manual masquerades as solid science and truth despite the fact that determinants of ‘mental disorder’ contain enormous scope for subjectivity and bias (Caplan, 1995). Lloyd and Morris (1999) suggest, “The *DSM* reflects the views of those who construct it, as well as reflecting changes in social attitudes over the years, for example, the presence and then removal in the twentieth century of homosexuality as a category” (p. 512). Scope for bias in the *DSM* definitions of mental disorder has been identified in relation to a number of factors. These include professional visions of what constitutes “healthy functioning” (Gergen, 1994b, p. 149), cultural discourses on the self (Kemp, 2003), political ideologies and assumptions about normal behaviour that relate to productivity, unity, moderation and rationality (Crowe, 2000), modernist assumptions about the self (Gottschalk, 2000) and common-sense and taken-for-granted social and cultural assumptions about plausibility of beliefs (Harper, 2004). This is by no means an exhaustive list but it does give some sense of the range of factors that have a bearing on decisions about what is and what is not deemed ‘reasonable’ or ‘expectable’, and the emergence of previously “unused registers” as objects of psychopathology (Foucault, 1972, p. 40). For a comprehensive review and critique of the politics of the *DSM* see Caplan (1995).

Caplan (1995) argues it is disturbing that despite psychiatry’s acknowledgement that there is no such thing as a discrete state called ‘mentally disordered’, separate from the state of not being mentally disordered, it publishes “an entire book of details that are purported to teach us exactly how to recognize not only when disorder is present but also precisely which kind of mental disorder it is” (p. 53). It is equally disturbing that this discourse is empirically over-valued in the health professions and by society (Wearing, 1994), especially in the face of evidence that a *DSM* diagnosis may actually cause more harm than good, to the point of being defamatory (Grover, 2005). Psychiatry’s expansionist project is discussed further in the context of ‘disease mongering’ and the influence of the pharmaceutical industry in the following chapter.

Postpsychiatry or cultural studies of psychiatry can be seen as bringing together postmodern and critical theory. The postmodern condition has been characterised as one of “hyperreality”, which refers to an information society saturated with ever increasing forms of representation and this is seen as having “profound effects on the construction of cultural narratives that shape our identities” (Kincheloe & McLaren, 2000, p. 292). In this context, Gottschalk’s

(2000) work offers an example of reading the *DSM* against the grain. He examines the affinities postmodern 'mental disorders' share with contemporary sociocultural trends, arguing that they manifest a normal response to the climate of postmodern culture. From this perspective, he considers the limitations of seeking to understand the psychological characteristics of individuals living in the postmodern moment on the basis of modernist assumptions about the self, on which he argues *DSM*-type diagnoses rest (Gottschalk, 2000). In particular, he argues that they reproduce the idea of a stable self-contained and isolated modern self and that they are ill-equipped to understand postmodern selfhood as a mutable, liminal, interdependent and interactive process. Drawing on the long-held wisdom of ethnopsychiatrists and critical theorists of the importance of knowing a patient's culture in order to understand their 'mental disorders', Gottschalk argues the same rationale must apply to postmodern culture and its diagnoses.

In this vein, Gottschalk (2000) proposes a different understanding of postmodern 'mental illness' to that enforced by psychiatric discourse. He argues the 'diagnoses' assigned postmodern individuals constitute psychosocial strategies that are deployed in response to postmodern culture, including its climate of low-level fear, its hyper-mediated screen-filled environment, its increasing surveillance and high levels of uncertainty and associated paranoia. He convincingly applies this point of view to a range of psychiatric diagnoses, including anxiety disorder, schizophrenia, multiphrenia or what he refers to as telephrenia, borderline personality disorder, anti-personality disorder, schizoid personality disorder and sociopathy. From this perspective, paranoia can be seen as a normal and expected mental state in a postmodern environment of constant surveillance and the circulation of information about private matters (Gottschalk, 2000). Like earlier critiques of psychiatry, this perspective shifts the locus of psychopathology away from the individual mind to the society in which we live, and closely resonates with the position that psychiatric diagnoses embody the madness of our way of life.

The shift in knowledge structures implied by postpsychiatry would mean reassessing the authority invested in diagnostic labels and letting go of the belief that 'clinical effectiveness' and 'evidence-based-practice' provide the only framework for answering the discipline's current problems (Bracken & Thomas, 2005).

Rethinking the politics of mental health research and practice

Postpsychiatry suggests a more inclusive and expansive research agenda to keep pace with the views and experiences of survivors of psychiatry and people who use mental health services. Bracken and Thomas (2005) acknowledge that in addition to a conceptual critique of psychiatry, postpsychiatry originates from the work of groups such as Survivors Speak Out, the National Self-Harm Network, the Hearing Voices Network, Mad Pride and Mad Women. While it does not reject the contribution of medicine, postpsychiatry draws attention to the need to pay more attention to the different ways in which service users and survivors understand their experiences, as well as to the harm that has been done to them by psychiatry and the other 'psy' professions in the name of help or treatment (Thomas & Bracken, 2004). Indeed, Thomas and Bracken's (2004) use of the term postpsychiatry as an organising principle for their work is a response to calls from some service users. Drawing on the work of Foucault in their elaboration of 'postpsychiatry', Bracken and Thomas (2005) suggest, "If postpsychiatry means anything, it means an end to the monologue of reason about madness" (p. 2).

The psychiatric consumer/survivor/ex-patient (c/s/x) movement is particularly concerned with the ownership of knowledge and the link between knowledge and social action. Participants in the movement challenge the dominant orthodoxies that have defined 'mental illness' within a medical paradigm and imply a different source of authority from which to claim a right to participation in public policy debates (Barnes, 2002; Bracken & Thomas, 2005). In regard to disabled people and psychiatric survivors, Barnes (2002) argues:

...if the bearers of such knowledges are to be included within a process previously determined by rules governing dialogue on the basis of scientific evidence, bureaucratic procedures and/or party political debate, then this may require rethinking those rules in order to accommodate them. (p. 323)

Opening mental health research up to perspectives that are not clinical involves changing the culture and politics of mental health research and shifting the boundaries of what is considered legitimate knowledge. Frustration with clinical academic research is often a key motivation of research by and with service users and survivors, who view it as fragmenting the experience of living with a diagnosis (Telford & Faulkner, 2004) and failing to engage with issues and outcomes important to them (Bracken & Thomas, 2005). The top research priority of mental health service users identified in a study by Thornicroft, Rose, Huxley, Dale and Wykes (2002) was to involve users at all stages in the conduct of research. There is

evidence that both academic (including medical and psychiatric journals) and more service-oriented journals are recognising the importance and value of non-clinical research and that the spectrum of what constitutes legitimate knowledge in the mental health field is beginning to widen. Clinical research of course has a place, but it is important to recognise that it is unable to capture the same kinds of knowledge that qualitative research can.

It is doubtful that the generation of knowledge in the field of mental health has ever been as eclectic as it is currently. The theoretical perspectives outlined in this chapter have given rise to discursive research in the field of mental health. This type of research does not accept psychiatric knowledge and diagnostic categories at face value and it seeks to understand narratives and claims to knowledge as situated in personal, social, cultural, political and historical contexts. Experiential knowledge is given equal status to that of professional knowledge. There is also evidence that the c/s/x movement is beginning to have an impact in both the academy and service provision and that the rhetoric of expertise by experience is becoming a reality. Qualitative research in the field of mental health, including research conducted with consumers, service users, survivors, ex-patients and patients and by researchers who also have these experiences is on the rise.

The best way to illustrate the depth and scope of research taking place in the mental health field and the kind of perspectives being put forward is to identify some of this work. It includes challenges to biomedical psychiatry (Bracken & Thomas, 2001; Double, 2002; Kaiser, 1996; Lewis, 2000; Thomas et. al, 2005; Thomas & Bracken, 2004); narrative approaches in mental health (Launer, 1999; Roberts, 2000); social model of mental health (Beresford, 2002a), paradigm shift in mental health care (Barker, 2003); critiquing ‘evidence-based practice’ in favour of ‘knowledge-based practice’ (Glasby & Beresford, 2006); user and survivor controlled services (Hölling, 2001); user involvement in mental health research (Wykes, 2003); a comparison of user led research and evidence-based medicine (Faulkner & Thomas, 2002); bridging the spirituality gap in mental health research (Webb, 2005a); user and survivor perspectives on force in mental health services (O’Hagan, 2004a); being a researcher who also has a diagnosis (Rose, 2003); service user views on stigma and anti-stigma campaigns (Green, Hayes, Dickinson, Whittaker & Gilheany, 2003); qualitative analysis of the views of in-patient service users (Goodwin, Holmes, Newnes & Waltho, 1999); action research about user involvement in mental health service development (Pilgrim & Waldron, 1998); the ways in which mental health user groups seek to influence health and

social care services within the public sector (Barnes & Shardlow, 1997); lay epidemiology and constructs in relation to mental health, and lay views about emotional support and the way in which material differences facilitate different patterns of emotional support (Rogers & Pilgrim, 1997); narratives of psychiatric consumers and survivors using participatory action research (Nelson, Lord & Ochocka, 2001); responses of service users and service providers to attempts to change the relationship between them (Barnes & Wistow, 1994); analysis of service user and provider perspectives on the diagnosis of 'personality disorder' (Stalker, Ferguson, & Barclay, 2005); different models of consumer participation and their impact on policy (R. Phillips, 2006), a critical exploration of different approaches to user involvement in research (Beresford, 2002b); and a qualitative review of user involvement in research (Trivedi & Wykes, 2002).

Researchers from a range of academic disciplines and theoretical perspectives, including mental health nursing, critical psychology, the humanities and social sciences, anthropology, disability and feminist studies are also conducting qualitative research in the area of mental health. This is evident in a review of the contribution of discourse analysis to research in mental health (Harper, 1995); a deconstruction of the concept of schizophrenia (Bentall, 1993); post-structural approaches in mental health nursing research (Crowe, 1998); discursive approaches to key texts of self-harm survivors (Cresswell, 2005), delusions (Harper, 2004), schizophrenia (Crowe & Alavi, 1999), women's experiences of premenstrual syndrome (Swann & Ussher, 1995), eating disorders (Hepworth, 1994), recovery from schizophrenia after medication change (Rudge & Morse, 2001), treatment experiences of 'the eating disordered patient' (Malson, Finn, Treasure, Clarke & Anderson, 2004); and mental health service user discourses (Speed, 2002, 2006).

This list is by no means exhaustive but it gives some indication of the many levels and the scope of attempts to shift the status quo in mental health care, psychiatry and related research. Some journals, such as the *Journal of Mental Health*, make it their explicit aim to publish research that is sensitive to the needs of service users and to encourage their role as more central to the efforts of the academic community (Wykes, 2003). What is significant, however, is that these topics and perspectives, even those highly critical of the dominant paradigm in psychiatry, are being published in psychiatric and medical journals. It is important for these perspectives to be published in a range of disciplinary and industry related journals so that the scope of what constitutes legitimate knowledge in this field of inquiry is

broadened. It is equally important to recognise the large amount of ‘grey’ literature in the form of websites, email lists, newsletters and other productions that circulate within local and global communities and that serve as important sources of knowledge and communication for members of the c/s/x movement, its allies, and the wider public.

The notion of postpsychiatry seems to be an apt way of accounting for many of the shifts that are taking place in the field of mental health and for imagining what the future after modern psychiatry could look like. The two postpsychiatry texts discussed in this chapter are evidence that at least some psychiatrists are seeking to change the conditions for what constitutes knowledge for psychiatry, to include the knowledge of the c/s/x movement. This aligns postpsychiatry with the long and continuing tradition of progressive practitioners who have joined with the survivor movement in critiquing psychiatry and who argue that professionals have a lot to learn from the movement (Burstow, 2004; Newnes, 2004). Critical psychiatry is certainly as strong as it has ever been, both among psychiatrists and recipients of psychiatry.

The most important aspect of postpsychiatry, as both a theoretical and practical orientation, is the importance it places on being grounded in and responsive to those it intends to talk with and about, particularly those who fall under its gaze. To the extent that postpsychiatry has been articulated by psychiatrists, it is understandable that it has been criticised for being revisionist and for not going far enough because it does not pose the fundamental question of why we need psychiatry (Rolfe & Cutcliffe, 2006). Even some of these critics, however, acknowledge that envisioning a ‘post-psychiatric’ society is a necessary part of addressing the “burgeoning catalogue of human misery (and social disruption) presently embraced by the concept of ‘mental illness/disorder/health problems’” (Rolfe & Cutcliffe, 2006, p. 622). On the other hand, some critics of Bracken and Thomas’ articulation of postpsychiatry suggest that it has little to offer many of the current problems in the mental health field (see Letters in *British Medical Journal*, August 25, 2001). In spite of criticisms such as “There is nothing postmodern in what people with schizophrenia want” (Bagley, 2001, p. 449), there is a strong sense of pragmatism to postpsychiatry.

Conclusion

In concluding this chapter it is important to recognise some of the limitations of my review and to restate my reasons for focusing on the chosen perspectives. My primary interest is in cultural studies of psychiatry and reading psychiatry against the grain and I discussed some of the theoretical perspectives that can inform such an endeavour. Foucault's historical interpretation of psychiatry, his observation of its low epistemological profile, and his ideas on governmentality and technologies of the self, along with his coupling of power/knowledge enable us to understand psychiatry as a discursive practice that produces and inscribes with meaning the objects of which it speaks. Sociological perspectives, particularly labelling theory and more recently the social model of disability, also continue to find support among sociologists of mental health and service users. Critiques to emerge from anti and critical psychiatry, particularly the latter, also continue to endure. The perspectives of social constructionism and critical realism are also useful for deconstructing psychiatric knowledges and for shedding light on how psychiatry's system of meaning is taken up or resisted by people. Lewis' framework of semiotic realism also provides a lens through which to explore the contingencies of the interpretations that we make and their consequences, which I elaborate on in Chapter Three.

My discussion of postpsychiatry is also limited on the basis of my research interest as a non-psychiatrist, and it is important to acknowledge that the authors of the two books on postpsychiatry I have drawn from are psychiatrists and they see postpsychiatry as having particular implications for mental health work. The theoretical underpinnings of postpsychiatry inevitably have the potential to impact mental health practice and are being applied by critical psychologists, psychotherapists, psychiatrists, mental health nurses and social workers as well as by researchers from a range of academic disciplines, whether with or without a postpsychiatry tag. While I have recognised the influence of critical psychiatry on postpsychiatry, it is important to differentiate it from anti-psychiatry. Postpsychiatry does not call for the abolishment of psychiatry and, for this, some critics have suggested that it does not go far enough (Barker & Buchanan-Barker, 2006). Anti-psychiatry was also criticised for excluding patients (Crossley, 1999) and the same cannot be said of postpsychiatry, which is explicit about its origination in the work of service user and survivor groups (Thomas & Bracken, 2004).

Postpsychiatry, on my reading, suggests a democratisation of all aspects of mental health work, including research, education, training and practice. In this sense, there is an important role for psychiatry if it is to take seriously some of the implications of the postpsychiatry critique. In taking these implications seriously I approach my research with an orientation towards reading psychiatry against the grain, which is variously informed by social constructionism, semiotic realism and postmodern theory. Parker et al. (1995) argue “Theoretical concepts are not there to be kept pure and be worshipped, but to be used in ways that enable alternative understandings and practices” (p. 131). This is the way I approach the perspectives I have reviewed in this chapter, each of which has value for enabling alternative understandings and practices to those enabled by positivism and the medical model in psychiatry.

Chapter Two

Contested practices in the mental health field

Max then proceeded to tell me that he still thinks I am “too weight conscious” and that I will have to stay in hospital for at least another week or more. “Too weight conscious” – it would be great if someone could tell me how the hell I am supposed to be anything other than weight conscious when my every action in hospital in some way is related to weight and eating. I mean I eat, I get weighed and I exercise, all of which have something to do with weight – because this is the God dam reason why I am in here. I think being weight conscious and being completely weight controlled are two very different things.

(from a diary of a young girl)

Introduction

This chapter builds on the theoretical perspectives discussed in the previous chapter by reviewing research into activism in the mental health field, disease mongering in relation to psychiatry, and research into the media’s portrayal of mental illnesses. It is beyond the scope of this chapter and my own expertise to do justice to the complex history of activism in the field of mental health. My modest aim is to review some research that has been done with members of social movement organisations in the field. In relation to disease mongering my focus is on alliances between pharmaceutical corporations, public relations companies, doctors’ groups and patient advocates, who often use the mass media to promote their views of health (Moynihan & Henry, 2006). The chapter also examines some key findings into the portrayal of mental illnesses in news media and provides a critique of the assumptions that underpin guidelines for media reporting.

Resistance to psychiatry: counter-discourse

The concept of ‘talking back’ was coined by hooks (1989) in her book *Talking Back: Thinking Feminist Thinking Black*, in which she describes it as “the expression of our movement from object to subject” (p. 9). Talking back has also been used to refer to resistance to psychiatry on a variety of fronts. Morrison (2005) uses the concept in her book *Talking Back to Psychiatry: The Psychiatric Consumer/Survivor/Ex-Patient Movement*, and the term has also been used in books by Breggin and Breggin (1994) titled *Talking Back to Prozac* and Breggin (2001) *Talking Back to Ritalin*. It is a concept that is central to identity politics, which Sampson (1993) describes as “a politics based on particular life experiences of

people who seek to be in control of their own identities and subjectivities and who claim that socially dominant groups have denied them this opportunity” (p. 1219). Moussa and Scapp (1996) suggest that ‘talking back’ is tantamount to the Foucauldian notion of ‘counter-discourse’.

The psychiatric survivor movement, and mental health activism generally, is not reducible to the anti-psychiatry movement (Oaks, 2006a). It is clear, however, that both these movements gained momentum within the counter-culture of the 1960s, most notably the civil rights movement. Crossley and Crossley (2001) suggest that the feminist and black liberation movements served as role models for the mental health movements. More recently, they identify the impact of the rise of an ethos of consumerism in the British health field, which is closely interwoven with the emergence of another social movement, the ‘New Right’. While the ideology of the New Right differs from that of the anti-psychiatry and the psychiatric survivor movement, its critique of the paternalism of medicine and championing of the voices of service users, “albeit qua ‘consumers’” has meant that New Right health policies have created a space for a user voice (Crossley & Crossley, 2001, p. 1488). A similar trend is evident in other Western countries. This is an important context in which to understand Morrison’s (2005) use of the abbreviation c/s/x to stand for the consumer/survivor/ex-patient movement.

Morrison views the c/s/x movement as a grassroots movement that is characterised by ‘talking back’ to psychiatry and claiming ‘resistant identities’ to the passive patient identity that psychiatry constructs for them (Morrison, 2005). The abbreviation c/s/x and the groupings of consumer/survivor/user and consumer/survivor that are sometimes used indicates that there is no single term that is adequate for describing the diverse relations to mental health services that this new social movement encompasses. It also reflects the desire of many for an inclusive membership (Oaks, 2006b). This is not to suggest, however, that there are not important differences between the experiences evoked by these linguistic constructs, some of which I discuss shortly and elaborate on in Chapter Six. These differences are implied in Morrison’s discussion of identity politics in relation to the movement:

In choosing its identity politics, the c/s/x movement has a choice: (1) reject the label by disqualifying the labelers’ expertise, thus avoiding the harm; (2) reject the linkage of the label with the harm, by promoting the development of other treatments; (3) claim the identity (madness) and celebrate it with mad pride, working to reclaim the meaning and redefine it for others in society; or (4) accept the expertise behind the

label, fight the stigma it entails, and welcome the treatments that approximate one's normalization. (Morrison, 2005, p. 165)

These choices need not be mutually exclusive and my particular focus in this chapter and in Chapter Six is on some of the ways in which the psychiatric survivor movement engages in the first three of these options. Like proponents of postpsychiatry who criticise anti-psychiatry for over-emphasising the power of psychiatry (Thomas & Bracken, 2004), Crossley's (2004) research derives from his recognition of the lack of research into resistance to psychiatry compared to the power of psychiatry. However, rather than turn to Foucault, Crossley draws on Bourdieu's (1992) theory of practice because of the value he believes it has for analysing social movements. He says Bourdieu's (1993) concept of 'field' is better able to capture "the dynamic, conflictual, pluralized and fluid nature of the world of mental health, past and present, than those favoured by Marxists and Foucauldians" (Crossley, 2004, p. 163).

Crossley's research (1998, 1999, 2002, 2004, 2005) explores the history of the survivor movement in the UK, shifting characteristics of the mental health service user's 'voice', and practices that comprise the oppositional habitus of psychiatric survivors. In his exploration of social movement organisations in the mental health field, Crossley (2002) says clear patterns of repertoire selection can be identified. This is reflected in different styles of protest, with some pursuing their objectives by way of petitions and public education campaigns, some developing self-help services and more empowering ways of living with mental distress, some working with services and some working against them. This prompts him to ask "What shapes repertoire choice at ground level?" (p. 51). To shed light on this question Crossley draws on Bourdieu's concept of habitus and argues that:

The concept of habitus allows us to reflect upon and explore the way in which agents' life experiences and trajectories shape the dispositions and schemas which, in turn, shape the ways in which they choose from the repertoires of contention that prevail within their society. (p. 52)

Crossley (2002) argues that habitus is a key factor in affecting activists' choice of repertoire: "their everyday sense of, and grasp upon, the world" (p. 60). Habitus is both a product of and productive of the forms of capital players in a given field have access to and the strategies and tactics they employ in these fields. Crossley (1998) says the "differentiated fields of action" (p. 463) in which social movement organisations intervene each have their own logic and rules, which means that strategies and tactics used effectively in one field may not be so effective in another.

Crossley (2004) identifies the psychiatric survivor movement as its own dynamic ‘field of contention’ in which interests align and compete. However, from its inception he says it has sought to challenge psychiatry’s symbolic power and the taken-for-granted acceptance of and belief in ‘the medical model’ that underwrites it. He focuses on the “practices and habits of resistance which attack psychiatric power at the point at which it impinges directly upon the subjective lives of those on the receiving end of it” (Crossley, 2004, p. 162). He conceives psychiatric power in large part in terms of the “symbolic violence of stigmatisation and disqualification” and views ‘being mentally ill’ as both a “social position and a socially shaped disposition or habitus” (p. 162). The symbolic power of psychiatry emanates from the cultural authority society grants to its classification system, on the basis of which people are defined and treated as mentally ill. In response to this, he says survivors of psychiatry

...have generated a radical or oppositional habitus; a socially distributed and disseminated disposition to interpret one’s experiences differently, to challenge and to refuse to play the role required by psychiatry; a disposition, as survivors see it, to think and see through the discourse of psychiatry and the medical model. (Crossley, 2004, p. 167)

Transformation of the mental health service ‘user’ ‘voice’

Crossley and Crossley (2001) view ‘voice’ as a function of “acquired and deeply ingrained schemas and habits”, which Bourdieu refers to as *habitus*. They note that habitus is defined as both ‘structuring structures’ and ‘structured structures’; “linguistic habits or habitus which structure the nature of experience in ways which remain largely imperceptible to those affected” (p. 1484). Their research examines the transformation in the ‘voice’ of mental health service ‘users’ through a comparison of two anthologies written by people with mental illness: *The Plea For The Silent* published in 1957; and *Speaking Our Minds* published in 1996. Given the length of time separating these anthologies, a change in voice may not seem all that surprising. However, Crossley and Crossley’s narrative qualitative analysis identifies some of the specific features of this shift and the broader contextual factors that have shaped it. They suggest the “transformation of voice” in the anthologies is illustrative of the “historically and socially constructed nature of voice” (p. 1478).

One of the more obvious differences they identify relates to the titles of the anthologies. *The Plea For The Silent*, they suggest, in making a ‘plea’, conjures up a sense that the authors were asking potential readers to do them a favour in reading about those who have previously remained silent. In contrast, *Speaking Our Minds (SOM)*, they suggest, is “intentionally

confrontational, ridding the text of any notion of apology or necessity for justification” (p. 1479). In the preface of the earlier book people giving their accounts were described as being a ‘certified patient’ and a ‘person of unsound mind’, whereas in the later anthology this shifts to a person who has experienced ‘mental distress’ and, more particularly, ‘mental health system survivor’ (p. 1480). The identities of contributors to the earlier book remained anonymous for what was described as ‘obvious reasons’, while this need for anonymity no longer held in the later book where each contributor is given the space to provide their own ‘biographical note’ (p. 1479). Crossley and Crossley argue:

These personally designated notes add to the sense of the intrinsic credibility of the accounts and preempt an important ‘framing’ theme for SOM – the challenge to ‘professional’ voices of authority which have historically enjoyed a monopoly within the field of mental health. (p. 1479)

In terms of the theme and tone of the personal accounts in the two anthologies, Crossley and Crossley distinguish between the “almost exclusively descriptive nature” of accounts in the earlier anthology, compared to the later anthology where accounts were framed in terms of general social categories such as sexual abuse, gender and race, which are inscribed under the wider category of ‘survivor of the mental health system’ (p. 1483). The importance of this, they suggest, is that:

Individual voices of indignity and shock have been replaced by a political discourse which locates such oppression and ill-treatment within a corrupt ‘system’, which it explicitly seeks to fight against and overturn. (p. 1485)

Crossley and Crossley say that *Speaking Our Minds* represents the emergence of a whole new critical discourse on psychiatry: “a collective and shared set of typifications and rhetorical strategies which function to challenge and contest psychiatric authority” (p. 1485). This, they suggest, constitutes the constructed voice of the psychiatric survivor, which is “shaped and focused by collective schemas of critique: an oppositional habitus” (p. 1485). Crossley and Crossley also consider the way in which anticipated audiences often play a part in shaping voice. They suggest, “Voices change because audiences are prepared to hear them in a new way” (p. 1487). This leads them to the question of why audiences have changed. Citing Blumer, they say that social movements are often constituted through critical forms of discourse and interaction that expose and challenge taken-for-granted assumptions and remove many of the usual inhibitions of discourse. They say this builds up new forms of ‘resistance habitus’. For example, up until the mid-1980s many users still identified as ‘mental patients’ despite their critical perspectives on the mental health system. But in the

mid-1980s the 'mental patient' label was problematised within the movement, and new groups, including Survivors Speak Out, emerged and introduced a different language into the movement (Crossley & Crossley, 2001).

Mental health 'service user' discourses

I mentioned earlier Morrison's (2005) use of c/s/x to refer to the consumer/survivor/ex-patient movement, and I suggested that it is important that the differences between these identities not be collapsed. The 'patient' identity is also distinctly absent from this construct and, while this relates to the resistance of the label within the movement, it seems that the activism of the movement speaks as much to this group as to those who identify as consumers, survivors, ex-patients or service users. Following Crossley's approach, Speed (2002, 2006) analysed government and mental health group literature in Ireland to identify different potential mental health service user dispositions and their associated discourses. He identifies two extremes of mental health social movement organisations (SMOs) in Ireland: 'consumer' and 'survivor' types, and three discourses used by mental health service users in the context of the mental health field: patients, consumers and survivors. He describes these respectively as 'passive accepting', 'negotiated' and 'active resistant' (Speed, 2006).

Speed (2002, 2006) identifies the patient discourse through the statement, 'I am a schizophrenic', which he says reflects the notion that psychiatry treats mental illness and not people. Speed (2006) argues, "This discourse is indicative of a passive acceptance of a diagnosis and an active choice to seek treatment for that diagnosis" (p. 30). He suggests that so long as the person remains a patient there is no real potential for any resistance to psychiatric or medical hegemony. Speed (2002) posits that the statement 'I am a person with schizophrenia' describes the consumer discourse, which he identifies as the dominant disposition in the Irish mental health field. He argues, "Implicit in this consumer definition is an acceptance of the biomedical basis of psychiatry, but with an addendum stating that 'this is not all that I am'" (p. 68). He says within this discourse there is potential for resistance but it is a form of resistance that works from within the predetermined medical model of 'mental illness'. In contrast, Speed (2002) argues that the survivor discourse is best described through the statement, 'I am a voice hearer'. He says, "The survivor habitus is one of resistance to the extent that diagnostic labels are often rejected and replaced by definitions of the survivors own choosing" (p. 70). This habitus locates the survivor within a space where the biological basis of modern psychiatry is rejected and replaced with an alternative model.

Speed (2006) acknowledges that the frameworks for the three discourses are ideal types and that these are not the only ways that service users have to talk about psychiatry and nor are they mutually exclusive. However, I am more sceptical about the possibility of identifying a discourse on the basis of a single statement because, depending on the context, the meaning and function of a statement may vary and may be used to subvert the power invested in it. Similarly, the statement ‘I am a voice hearer’ may be used by survivors but it does not preclude the possibility that it may also be used by people who accept a psychiatric diagnosis of schizophrenia, yet use these words to describe their ‘symptoms’. Nonetheless, Speed’s typology accords with what others have identified as the central difference between consumer and survivor movements: Consumers wish to reform psychiatry from the inside while psychiatric survivors want to replace it with varied, inexpensive, humane ways of alleviating human misery and rage (Everett, 1994). Thus, the survivor discourse is oppositional to notions of both patienthood and consumerism (Speed, 2006) and is best positioned to ‘talk back’ to psychiatry and produce counter-discourse.

Crossley (2004) examined the collective resistance to psychiatry mounted by the UK mental health survivor movement based on data from open-ended interviews with 31 key players from the main ‘social movement organisations’ (SMOs) in the survivor movement, and printed materials produced by these SMOs. He describes the survivor disposition or ‘oppositional habitus’ as one that thinks and sees through the discourse of psychiatry and the medical model. He says the practices that comprise the radical habitus of the psychiatric survivor movement/mental health activist community include rhetorical devices for deconstructing the images of mental illness and replacement schemas that lend a more positive significance to those who experience mental distress and its treatment. He says these “rhetorical set-pieces” (p. 167) are repeated within the survivor literature in slightly different forms and serve to reframe allegedly ‘insane’ experiences in order to reveal their sanity. In addition to these deconstructive habits:

The survivor movement has created alternative typifications and schemas of classification to those used in psychiatry, which reflect a different and preferred manner of conceiving of it. (Crossley, 2004, p. 168)

One manifestation of the oppositional habitus is the Hearing Voices Network (HVN) in the UK. The network encourages people who hear voices to explore their voices and to work out ways of living with and accepting them (Crossley, 2004). The network tries to deconstruct the experience of voice hearing and reshape it in a way that allows individuals to live with their

voices (Crossley, 2004) and to discuss their own explanatory frameworks (Bracken & Thomas, 2001). The practices of HVN, where they are successful, reshape the voice-hearers' habitus (Crossley, 2004). The potential implications of this deconstruction and reshaping are profound, as Crossley suggests:

As non-medicalized, non-pharmacological, self-help practices, the activities of HVN pose an important challenge to the authority of psychiatry and the economic interests of the pharmacological industry. (p. 172)

In the context of his analysis of the Prozac phenomenon, Lewis (2006b) argues that activism provides the only remaining opportunity to challenge biopsychiatry and, along with the c/s/x movement, he cites Prozac survivors' groups as examples of grassroots organisations providing an alternative discourse to psychiatric treatments. At the other extreme, however, are discursive practices that are structured around promoting medicalised interpretations and pharmaceutical interventions.

Disease mongering

The role of the pharmaceutical industry in promoting certain medical diagnoses has been described in terms of 'disease mongering' (Moynihan, 2003; Moynihan, Heath and Henry, 2002; Moynihan & Henry, 2006). The concept draws attention to the problematic relationship between the pharmaceutical industry and public health. Moynihan and Henry (2006) describe disease mongering as:

...the selling of sickness that widens the boundaries of illness and grows the markets for those who sell and deliver treatments. It is exemplified most explicitly by many pharmaceutical industry-funded disease-awareness campaigns – more often designed to sell drugs than to illuminate or to inform or educate about the prevention of illness or the maintenance of health. (p. 1)

Moynihan and Henry observe that the way in which one views awareness campaigns is very much dependent on perspective. For example, what an industry-linked professional group may see as legitimate "public education about an underdiagnosed disease", an activist group free from industry sponsorship may regard as a "crude attempt to build markets for potentially dangerous drugs" (Moynihan & Henry, 2006, p. 2). Research has focused on direct-to-consumer marketing of pharmaceuticals in the US, especially on television (Healy, 2006; Lacasse & Leo, 2005), but the practice is prohibited in Australia. Disease awareness campaigns and disease mongering practices are certainly not limited to the US and this may explain why they have received critical attention in Australia.

Moynihan, Heath and Henry (2002) describe five types of disease mongering, which are not mutually exclusive: the classification of ordinary processes or ailments as medical problems; the portrayal of mild symptoms as portents of a serious disease; the construal of personal and social problems as medical ones; the conceptualisation of risks as diseases; and the framing of disease prevalence estimates to maximize the size of a medical problem. One effect of disease mongering is to narrow the definition of 'normal' and set the scene for the "complaints of the healthy" to become the "conditions of the sick" (Moynihan, 2003, p. 46).

Medicalisation

Concepts of disease mongering and selling sickness can be seen as extensions of medicalisation research. Conrad (1992) suggests that medicalisation occurs on three distinct levels: the conceptual, the institutional and the interactional. On the conceptual level medicalisation involves medical vocabulary being used to define a problem at hand. At this level medical professionals need not be involved and medical treatments are not necessarily applied. At the institutional level medicalisation involves organisations adopting a medical approach in treating a problem in which the organisation specialises. It is at the interactional level that physicians, or psychiatrists, are most directly involved in defining a patient's problems as medical through giving a medical diagnosis or treating a social problem with a medical form of treatment (Conrad, 1992). While the interest in medicalisation has focused predominantly on nonmedical problems being medicalised, Conrad suggests that it must include all problems that come to be defined in medical terms.

Conrad suggests that before medical social control is possible some kind of medical definition is necessary. The *Diagnostic and Statistical Manual of Mental Disorders* (as discussed in the previous chapter) is a good example of the definitional power of psychiatry that gives legitimacy to pharmaceutical interventions. This is not to suggest that pharmaceutical technologies do not precede medicalisation, because this is often the case, but that medical social control loses its legitimacy and is more difficult to accomplish without medicalisation in a definitional sense. Pharmaceutical companies are unable to get approval to market new drugs without an official disease entity for them to treat and, as such, the emergence of new drugs may provide the impetus for the creation and inclusion of new diagnostic categories in the *DSM*. Horwitz (2002a) argues the growth in pharmaceutical research is responsible for creating new mental illnesses more so than it is for treating existing conditions, and Healy (1999) argues drug companies not only make drugs but they make views of illness.

Pharmaceutical industry influence on psychiatry

Psychiatry's vocabulary expansion has been linked to the increasing influence of the pharmaceutical industry on the profession and the need to protect the interests of mental health researchers and professionals (Horwitz, 2002). Exact figures vary depending on the definitional boundaries chosen, but psychiatry's vocabulary expansion has been rapid and, arguably, unparalleled in other medical specialities. It is suggested that the "expansionary project of psychiatry operates within a discursive environment in which human distress and difference are increasingly being defined in psychiatric terms" (Carpenter, 2000, p. 615; Kaiser, 1996). Critics of psychiatry's vocabulary expansion argue that the realm of the abnormal is encroaching on the province of behaviours and traits that fall within the experiences of the majority of the population (Caplan, 1995; Holmes & Warelow, 1999). Others have referred to the psychiatric colonization of the normal and medicating normality (Black, n.d.), 'the pathologization of everyday life' (Burr & Butt, 2000), the 'medicalisation of everything' (Newnes, 2004), the medicalisation of modern living (Moncrieff, 1997) and the medicalisation of life (Szasz, 1998).

Professor Loren Mosher (1998), psychiatrist, researcher and leader of the renowned Soteria Project, argues the American Psychiatric Association (APA) is too reliant on drug company money to be in a position to criticise the overuse and misuse of psychotropic drugs and psychiatrists, he argues, have forgotten the most important principle of the Hippocratic oath – first do no harm. He describes how members of Institutional Review Boards (IRBs) in the US have been found to be highly paid consultants to drug companies whose protocols they review in approving studies with psychiatric drugs. He argues, "What should be the most humanistic medical speciality has become mechanistic, reductionist, tunnel-visioned and dehumanising" (Mosher, n.d.a, para. 5). Mosher resigned from the APA in 1998 after nearly three decades as a member. In his letter of resignation Mosher (1998) wrote: "The major reason for this action is my belief that I am actually resigning from the American Psychopharmacological Association" (para. 1). Mosher is by no means alone. Criticism of psychiatry's reliance on medications and its close ties with the pharmaceutical industry is widespread (Baughman, 2000; Bracken & Thomas, 2005; Breggin, 2003; Halasz, 2004; Healy, 1999; Kaiser, 1996; Leo, 2004, 2006; Lewis, 2006; Moncrieff, 2003; Thomas, Bracken, Cutler, Hayward, May & Yasmeen, 2005).

Disease mongering in relation to psychiatry

Psychiatric diagnoses that have been the subject of disease mongering and medicalisation claims include Premenstrual Dysphoric Disorder (Gardner, 2003; Moynihan & Henry, 2006; Ussher, 2003), Attention Deficit Hyperactivity Disorder (Baughman, 2000; C. Phillips, 2006), Social Phobia or Social Anxiety Disorder, Depression and Bipolar Disorder (Healy, 2006; Moynihan & Henry, 2006) and post-traumatic stress disorder (Summerfield, 2001b). I limit my discussion to Premenstrual Dysphoric Disorder, Attention Deficit Hyperactivity Disorder, Social Phobia and Depression as exemplars.

Premenstrual Dysphoric Disorder

Premenstrual Dysphoric Disorder (PMDD) has come under considerable scrutiny since being included in the 1994 edition of the *DSM* (Caplan, 1995; Ussher, 2003). Moynihan and Henry (2006) refer to “The Eli Lilly-sponsored promotion of premenstrual dysphoric disorder to help sell a rebranded version of fluoxetine (rebranded from Prozac to Sarafem)” (p. 2). According to Gardner (2003), the soundbite slogan used by Eli Lilly in inviting consumers to use Sarafem was “Think it’s PMS? Think Again...It could be PMDD.” (p. 125).

Through interviews and examinations of representations of PMDD in scientific and popular discourse, Ussher (2003) identified five “hegemonic truths about PMDD” and their implications for the subjectification of women. These include PMDD is a thing that can be objectively defined and measured; PMDD is a pathology to be eradicated; PMDD is caused and can be treated by one factor; PMDD is a bodily phenomenon; PMDD is a cause of women’s problems or symptoms (pp. 134-135). She says:

The inclusion of PMDD in the *DSM* provides legitimation of a set of truths that clinicians and researchers draw upon in their interpretation of women’s premenstrual experiences as pathological. It legitimates the examination, diagnosis, and treatment of individual women. It acts to position certain women, those diagnosed, as ill, as unstable, or as ‘mad’. (pp. 141-142)

At the level of material consequences, Ussher argues this positions psychiatrists and psychologists as the knowers, as having the power to speak the ‘truth’ and women’s bodies as the object to be known, judged, treated and cured. She says:

So the woman who wishes to understand her premenstrual experiences is expected to turn to the experts for answers; to the regimes of objectified knowledge that provide the ‘truth’ about her experience. (p. 142)

Yet this truth tells a particularly narrow story, as she found in her interviews with women who met *DSM* criteria for PMDD. Caplan (1995) argues that prescribing antidepressants to women masks other problems that women experience. She also expresses concern about the latitude of the therapist in determining whether a woman's moods or feelings are 'marked' and, therefore, that she is psychiatrically ill. Caplan fought strongly to have Premenstrual Dysphoric Disorder removed from the *DSM*, arguing that there was no scientific justification for it. PMDD may represent an example of the classification of ordinary processes, in particular premenstrual experiences, as medical problems to expand the market for a particular drug albeit under a new brand name.

Attention Deficit Hyperactivity Disorder

Prior to *DSM-III* (1980) the diagnostic category of ADHD or Attention Deficit Disorder (ADD) did not exist (Livingston, 1997), although *DSM-II* (1968) included its immediate precursor, hyperkinesis. The exact nature of the diagnosis has shifted back and forth in successive editions of the *DSM*. In the 1980 edition a distinction was made between ADD with hyperactivity (ADD/W) and without (ADD/WO) but in the 1987 edition the APA decided there was a single dimension of disorder known familiarly as ADHD. In the 1994 edition it was decided that the initial distinction was closer to the mark and the current classification system with three sub-types was proposed (with hyperactivity only, with inattention only, and the combined form) (Livingston, 1997). This diagnostic instability, according to Livingston (1997), calls into question the very foundations of the APA's diagnostic system, namely that it uses a categorical system of classification, rather than a continuum or spectral framework that focuses on dimensions of difference.

Halasz (2004) refers to a book he co-authored in 2002 with Manne, Anaf, Ellingsen and Thompson Salo titled *Cries Unheard*, in which they argued that "at this unique moment in history, social, economic and medical cultures have converged to redefine childhood in a new image. Children have become 'commodities'" (p. 6). Some of the cries going unheard relate to questions about the safety and efficacy of the drug Ritalin (prescribed for ADHD), claims that Ritalin has the same effect on all people regardless of their psychiatric status, and the lack of concrete proof that ADHD even exists as a medical condition (Armstrong, 1996; Baldwin, 2000; Baughman, 2000; Black, n.d.; Breggin, 2001; Halasz, 2004; House, 2002-3; Livingston, 1997; C. Phillips, 2006; Rapley & McHoul, 2004; Smelter, Rasch, Fleming, Nazos & Baranowski, 1996). The title of the book seems apt in light of rising prescription rates of

drugs to children who are diagnosed as having ADHD (House, 2002-3) and suggestions that pharmaceutical companies exploit the internet to access teachers and influence their role in the brokerage of ADHD in schools (C. Phillips, 2006), as well as provide “massive funds” to parents organisations in the USA (Lloyd & Norris, 1999, p. 511).

It is suggested that the diagnostic category of ADD/ADHD is best seen as a socio-cultural construct (Timimi, 2004); a condition that could not exist without the formal social institution of the school (Rapley & McHoul, 2004); or a fraudulent creation of the psychiatric-pharmaceutical cartel (Baughman, n.d., www.adhdfraud.org/), rather than the discovery of an apparent epidemic of problem children or mentally ill or disordered children. Lloyd and Norris (1999) argue:

Our understanding of the phenomenon of ADHD has, therefore, to include a recognition of the powerful role of aggressive marketing and the influence of the drug companies on diagnoses and prescription rates, and therefore on estimations of prevalence. (p. 511)

In Western societies the diagnostic category of ADHD provides somewhat of a challenge to those who wish to undermine the biomedical model of mental illness. It highlights the productive nature of psychiatric discourse and the complicity of parents, teachers, school authorities and educational psychologists in getting children diagnosed and medicated (Baldwin, 2000; Black, n.d.; Smelter et al., 1996). According to Lakoff (2000), increasing interest in ADD, following *DSM-III*, helped to revitalise the discipline of child psychiatry and also saw the emergence of groups of patients and their families, who demanded “legislative recognition of their rights and lobbied for research funding in order to codify the existence of the disorder” (p. 162). Lloyd and Norris (1999) argue:

...the rejection of the medical model is challenged by the existence of a large group of parents asserting their ‘rights’, and the rights of their children to be classified as having a medically defined disorder and to be prescribed medication. (p. 505)

Lloyd and Norris cite one argument that views ADHD as a ‘label of forgiveness’, similar to ‘learning disability’ or ‘minimal brain dysfunction’, which encapsulates the view that “it may be in the interests of parents to select a label that implies a biologically-based cause, since this eliminates blame and may even produce financial help” (p. 508). To the extent that diagnosing ADHD in practice involves the use of behaviour rating scales (Livingston, 1997), which often depend on the subjective judgements of teachers and parents, it may be that they have a vested interest in getting a child diagnosed as they do not want to be seen as bad

teachers or bad parents (Armstrong, 1996). On the other hand, Baldwin (2000) suggests that parents can often do little to resist the lobbying of those who stand to benefit financially from the ‘special needs’ funding that ensues when children are “educationally redefined” as ADHD/ADD (p. 456). The medical diagnosis of ADHD puts the medical profession in control and makes it difficult for lay people or other professionals, who do not have access to this specialised discourse, to challenge (Lloyd & Norris, 1999). It is also suggested that dissenters to the view that ADHD is a legitimate disorder are dismissed as ‘unscientific’ and that dispute and dissent are buried in documents such as the *International Consensus Statement on ADHD* (Jureidini, 2002; Newnes, 2004).

According to the *DSM*, ADD/ADHD is supposed to be a ‘disorder of childhood’, yet adults are increasingly asserting their own rights to be diagnosed and treated for the condition. For example, in Australia ADDults with ADHD (NSW) was established in 1995 and its aim is to assert and protect the rights of adults with ADHD. This plays into the hands of pharmaceutical companies because, as Lloyd and Norris (1999) argue, “The new markets needed for the drug companies depend on its expansion to the adult population in the USA and/or the developments of new markets abroad” (p. 511). Expanding the diagnosis to adults also provides a challenge to suggestions that ADHD is a diagnosis that depends on the institution of the school. However, it is important to distinguish between adults recognising symptoms of ADHD in themselves and parents and teachers initiating the diagnosis for children (Lakoff, 2000).

Once a psychiatric diagnosis such as ADHD receives a certain currency, people from a range of perspectives, including the other ‘psy’ professions (Newnes, 2004), jump on the bandwagon and claim that they have the ‘cure’ for it, or that they can offer parents and teachers the tools to cure their children of ADHD. These cures, because ADHD is a diagnosis that is predicated on an individual, usually a child, are targeted at the individual – the problem child, for example, rather than their environment. For example, an entrepreneur in the UK has introduced an exercise program for children with ADHD that has made its way to Australia. Dore therapy, as it is known, is marketed as a “breakthrough treatment”, and users are charged \$4,500 for a year-long program that involves 20 minutes of daily exercise. Dore uses families who have been impressed with it to promote the product and targets those who would prefer drug-free solutions or who have not responded to drug treatments (ABC, 2006). Thus, although the diagnosis of ADHD increases the market for pharmaceutical interventions, it

also creates a market for a host of other ‘therapies’ or treatments claiming to have the ‘cure’ for it. The medical legitimacy that attaches to a diagnosis of ADHD gives rise to ‘treatments’ that, like their pharmacological counterparts, are predicated on correcting the behaviour or thoughts of the individual. This bandwagon effect occurs despite concerns that ADHD is a product of disease mongering, not to mention the lack of findings about the efficacy of both drug and exercise therapies.

Social Phobia

Cottle (1999) illustrates the type of disease mongering that involves recasting traits that were once considered ‘normal’ as symptoms of a treatable medical condition with the case of Social Phobia. In her article “Selling shyness: How doctors and drug companies created the ‘social phobia’ epidemic” Cottle (1999) writes:

... the rise of social phobia offers a glimpse not so much at the anatomy of a specific illness as at the still inherently subjective nature of psychiatric medicine and the cultural forces that help draw the boundary between what we are told to think of as normal and what we are told to consider pathological. (p. 25)

Like ADHD, social phobia has an interesting diagnostic history and it also did not appear in the *DSM* until 1980 (*DSM-III*). According to Cottle, this edition contained exacting standards for what constituted social phobia: A person not only had to fear a situation but the fear had to compel them to avoid the situation altogether. However, the revised edition published in 1987 (*DSM-III-R*) loosened the definition of social phobia to include any form of anxiety that caused ‘marked distress’. The phrase “a compelling desire to avoid” was removed from the diagnostic criteria, which led to a dramatic increase in prevalence rates (Cottle, 1999). Cottle argues that it was another step in the “culture’s crusade to medicalize any trait - physical or behavioural - that does not measure up to the elusive ideals generated by pop culture, advertising and shifting moral and political norms” (p. 29).

In a similar vein, Scott (2006) argues the medicalisation of shyness is an extension of a pervasive social attitude of disapproval towards those who fail to conform to certain values of contemporary Western culture. She identifies three dimensions of this process: biomedical approaches and the development of drugs to treat shyness; the application of cognitive behavioural therapy (CBT); and the disciplinary regimes of self-help books and websites. The biomedical approach to shyness, as with other conditions, reinforces the belief that shyness is a “problem of individual minds rather than a reflection of social norms and values” (p. 139).

Scott argues the use of techniques such as CBT in shyness clinics resonates with Foucault's notion of disciplinary power. She suggests, "In the longer term, one might argue, the ultimate aim of a shyness clinic is to retrain and resocialise deviant individuals towards more normative codes of behaviour" (p, 144). Moreover, she argues the principles upon which shyness treatments are based have become so embedded in the values of late-modern society that we are turning the clinical gaze onto ourselves through the consumption of self-help books and online resources.

The pharmaceutical industry directly funds research into social anxiety/phobia, funnelling money through organisations such as the APA and underwriting educational materials, conferences, websites, outreach programs and economic impact studies (Cottle, 1999). Moynihan et al. (2002) refer to the promotional activities of the Roche pharmaceutical company in promoting their antidepressant Aurorix as a valuable treatment for this alleged psychiatric disorder, and Moncrieff (2003) also discusses the promotion of depression in the form of social anxiety disorder. Cottle (1999) concludes her article with the following possibility:

...one wonders how much of the nation's social phobia epidemic stems from our growing sense that everyone should be aggressive, be assertive and strive for the limelight. (p. 29)

In interviews with self-identified 'shy' people Scott (2006) importantly found attitudes of both resistance and conformity to the medicalisation of shyness. She says the undercurrent of resistance, which she calls the counter-discourse of 'Shy Pride', can be detected in websites, internet forums and online support groups about social phobia and social anxiety. She says there are two main lines of argument that Shy Pride relies on, both of which can be seen as attempts to demedicalise shyness. The first depicts shyness as a positive, life-affirming experience and the second line of argument draws on labelling theories of deviance and the social model of disability to suggest that shyness is only a 'problem' when others define it as such (Scott, 2006). These are important findings because they demonstrate the way in which people are challenging medicalisation and adopting alternative discursive frameworks. Like the Hearing Voices Network and other survivor groups, Shy Pride is an example of what Gergen (1997) describes as 'poetic activism', one aspect of which relates to the need for discourses that "invite people into more valued modes of being, ways of constructing self and others that add to the sense of well-being and human welfare" (p. 732).

Depression

Fores (2003) argues that the public's belief in the 'chemical imbalance' theory of depression is because of the perpetration of a massive fraud. Prescription rates for both antidepressants and antipsychotics continue to rise in the face of evidence that they produce more severe psychiatric symptoms in a significant percentage of patients (Whitaker, 2005). Concepts of disease mongering and selling sickness provide a useful conceptual framework in which to explore some of the practices involved in the perpetuation of this fraud. Gardner (2003) analyses consumer depression manuals and argues that they promote the diagnosis and pharmaceutical treatment of behaviours ranging from mild symptoms to severe depression. She focuses on how dominant depression discourses of scientific and consumer literatures circulate through culture in tandem to construct a popularised "common sense" script of depression that is difficult for consumers to think outside of (p. 106).

The antidepressant drug Prozac, one of a class of Selective Serotonin Reuptake Inhibitors (SSRIs), has been the topic of considerable fanfare and academic analysis (Breggin, 1995; Fee, 2000b; Healy, 2006; Hewitt, Fraser & Berger, 2000; Lewis, 1998, 2003a, 2006b; Rose, 2003). Following his critique of the DSM, Lewis (2006b) asks another important question for cultural studies of psychiatry: *What in the world happened with the advent of Prozac?* He considers a number of factors, including the "incredible epidemic of Prozac prescribing" that took place between 1987 when it was first introduced to the market (7.6 million prescriptions) and 2002, the year after it came off patent (27 million prescriptions) (p. 122). Concurrently with the epidemic of prescriptions, Lewis says that an *epidemic of signification* around the medicine emerged in medical and psychiatric literature, the mass media and popular press, talk-shows, popular texts and even a video game called Virtual Prozac (Lewis, 2006b).

Lewis (2006b) notes that at the discursive or cultural semiotic level one major consequence of Prozac "was to support a new psychiatry psychopharmacologic discourse of human pain and suffering that has deeply conservative political ramifications" (p. 133). As Gardner (2003) argues:

With the broader diagnosis of depression and increasing antidepressant use comes increased respect for biopsychiatry, increased profits for pharmaceutical interests and increased consumer acquiescence to broad spectrum diagnoses in order to improve their productivity. (p. 127)

Based on the view that the contemporary experience of depression cannot be separated from the cultural knowledges that now proliferate about it, Fullagar and Gattuso (2002) explored the power/knowledge relations that shape current Australian mental health policies in relation to women's experience of depression and emotional distress (p. 10). They understand power as it is exercised in mental health policy in terms of Neoliberalism, which Petersen (1997) describes as a "form of rule that involves creating a sphere of freedom for subjects so that they are able to exercise a regulated autonomy" (p. 194). Thus, it is productive of the self:

The practices through which women govern their emotional lives exist in a complex relation to the technologies of governance (professional advice, pharmaceutical marketing, media stories etc) that mobilise contemporary constructions of depression as an illness of mind and body. (Fullagar & Gattuso, 2002, p. 4)

On the website and bulletin board of Australia's National Depression Initiative *beyondblue*, they identified the complex factors that women discuss in their attempts to make sense of and 'manage' their experiences of postnatal depression. However, with the 'expert' advice of psychiatrists, they argue, women are consistently guided to think about their emotional distress in pharmacological and psychotherapeutic terms and that the social, cultural and political dimensions of women's lives are ignored (Fullagar & Gattuso, 2002). These findings parallel those of Ussher in relation to PMDD and Gardner (2003) who, in regard to the biomedical paradigm of depression, argues:

The framings of mass media and consumer groups suggest that where health and productivity are virtues, reasonable citizens are expected to repair depression (that is, productivity problems) according to expert recommendations, without needing to inquire of the scientific theories or shortcomings, or to scrutinize generalizations. (p. 126)

Lewis (2006b) situates his analysis of Prozac in the broader context of new science and technology and the explosion of technomedicine that bombards us with the message that "technology enhances life and brings smiles ... for a price" (p. 125). Rose (2003) suggests these new self-technologies "oblige the individual to engage in constant risk management, and to act continually on him or herself to minimize risks by reshaping diet, lifestyle and now, by means of pharmaceuticals, the body itself" (p. 59). These technologies of the self are all connected to a culture of self-improvement or enhancement. In societies where the modification of thought, mood and conduct by pharmacological means is more or less routine, Rose suggests we have become "neurochemical selves".

Disease mongering is, of course, not limited to the psychopharmacological complex and is evident in many areas of public health. It has been implicated in relation to health issues ranging from obesity, acne and skin problems, ageing and anti-ageing, sexual performance (Moynihan, 2003), baldness, irritable bowel syndrome, osteoporosis, erectile dysfunction (Moynihan et al., 2002) and insomnia (Lieberman, 2005). The purpose of elaborating on these examples has been to draw attention to some of the ways disease mongering works in the mental health field. Many women do experience painful or otherwise troublesome premenstrual symptoms, many children do behave in ways that parents and teachers would prefer them not to, many people do experience shyness, get depressed and are sensitive to the ups and downs of their lives. Many people believe they have been helped by medications prescribed for these conditions. My aim is simply to highlight the role and financial interests of the pharmaceutical industry in creating a market for their pharmaceutical interventions by constructing these experiences as medical problems and promoting this view through various practices. It is also to recognise that the moment these life experiences are recast into treatable medical conditions, other discursive frameworks are relegated to the realm of ‘alternative’ or ‘complementary’.

In the field of mental health the consequences of disease mongering include not only people viewing their moods, thoughts, feelings and behaviours within a medicalised or ‘psychiatrised’ frame and disciplining themselves accordingly. The role of the pharmaceutical industry in setting the agenda of mental health policies and artificially creating grassroots coalitions to add credibility to this agenda has also been identified in Australia (Gosden & Beder, 2001). In particular, it is suggested that the shift in mental health policy toward biological interpretations and drug treatments is a result of “pharmaceutical industry-funded public relations activity” (Gosden & Beder, 2001, p. 5).

It can be seen from the foregoing discussion that the credibility of health and medical professionals and institutions as well as advocacy groups is called into question in the context of claims about the use of the mass media by pharmaceutical companies, doctor’s groups and advocacy groups to promote a certain view of health problems to the public and policy makers (Moynihan & Henry, 2006). The mass media is an important avenue through which the pharmaceutical industry and its allies promote their representations of ‘sickness’ and ‘disease’ to the public, as well as being a site through which various other stakeholders in the mental health field attempt to influence public opinion and policy makers in accordance with

their definitions and agendas. The assumption that people's attitudes and beliefs are influenced by media reporting underpins many studies into the representation of mental health issues in the media as well as initiatives directed at guiding media professionals toward reporting these issues in a particular way. Thus, it is important to identify some key findings about the media's portrayal of mental illness and the content of some of the initiatives directed at changing it.

Mental illnesses in the media: some key findings

One of the most important studies of mental illness across a range of media, conducted by the Glasgow Media Group and including audience reception studies, found that "the power of media images had apparently been so great that beliefs derived from the media could overwhelm knowledge which came from direct experience" (Philo, 1996, p. xiv). The authors argued that this provides strong evidence to question some of the assumptions that underpin communication and cultural studies about the ability of audiences to negotiate and resist dominant media meanings (Philo et al., 1996). This directs us to the type of images the media convey.

Numerous studies have examined how 'mental illness' and mental health related issues are portrayed and framed in a range of genres, including mass media such as newspapers, television news, entertainment programs, films and children's television and literature (Allen & Nairn, 1997; Blood et al., 2005; Blood & Holland, 2004; Byrne, 2000, 2001; Conrad, 2001; Cutcliffe & Hannigan, 2001; Diefenbach, 1997; Francis, Pirkis, Dunt & Blood, 2001; Hazelton, 1997; Olstead, 2002; Philo et al, 1996; Pirkis et al., 2001; Pirkis, et al., 2006; Rowe, Tilbury, Rapley & O'Ferrall, 2003; Sieff, 2003; Smellie, 1999; Wahl, 1992, 1996; Wahl, Wood & Richards, 2002; Wilson, Nairn, Coverdale & Panapa, 1999; Wood, 1998). For a review of the literature on the media's portrayal of mental health and illness see Francis, Pirkis, Dunt and Blood (2001) and Pirkis et al. (2001) for a discussion of how the Australian media portray mental health and illness. I limit my overview to key findings in regard to news media coverage, which I have categorised as framing the 'dangerous other', disseminating contemporary technologies of the self, and overstating biogenetic evidence and explanations.

Framing the ‘dangerous other’

Research has found that the most problematic type of news coverage of mental illness is that which includes information from courts and police because it often focuses on violence and graphic images of violence (Pirkis et al., 2001). Studies have found that although these kinds of stories are about relatively rare circumstances, in news reports they tend to be generalised to all people diagnosed with a mental illness (Holland & Blood, 2004; Pirkis et al., 2001). Some of the journalistic choices and news frames that tend to generalise to all people with a mental illness include ‘mentally ill criminals’, ‘violent mental patients’, the ‘violent mentally ill’, ‘insane killers’ and ‘psychiatric killers’. Many stories sourced to the police frame people diagnosed with a mental illness as a risk to the community about which something must be done (Blood & Holland, 2004). In an analysis of newspaper coverage of two forensic patients who had ‘escaped’ from a psychiatric facility Blood and Holland (2004) found that the majority of stories were written by police reporters, and ‘police sources’ were repeatedly referred to and quoted in support of the enduring news frame of ‘dangerous psychiatric patients on the loose’ (Blood & Holland, 2004).

A UK study of media coverage of mental health during March 2005 found that the majority of coverage (27%) was about homicides and crime. In order, the next most common topics were drugs and mental health, depression, wellbeing, other violent incidents, suicides, stress, the Mental Health Bill, mental health services and arts/culture and mental health (CSIP/SHIFT, 2006, 6-7). By far the most problematic stories that researchers identified were those that associated mental illness with crime, violence, dangerousness, unpredictability, untrustworthiness and general ‘otherness’ (CSIP/SHIFT, 2006). This research found that health, social care and related professionals were by far the most quoted in the articles, while the most common source of stories was the police and criminal courts (CSIP/SHIFT, 2006). People with mental health problems were only quoted in 6% of stories, which confirms other research noting the absence of lay voices in media reports about mental health and illness (Blood & Holland, 2004; Nairn & Coverdale, 2005).

On the basis of research findings such as these, it is concluded that people with a mental illness are predominantly portrayed in the news as violent, dangerous criminals; a threat to social order. The potential effect of this coverage, it is feared, is a more punitive mental health system, even though the majority of people affected by the system do not fit this media profile. Indeed, Beresford (2000) suggests that, fuelled by media coverage of a small number

of high-profile homicides linked to mental health service users, “‘Public safety’ is now explicitly the central concern of government mental health policy” (p. 168, see also Blood & Holland, 2004). There is also increasing emphasis on ‘compulsory treatment orders’ and provisions to imprison people included in the category of ‘personality disorder’ when they have not been convicted of any offence. Beresford (2002a) argues:

The increasing association of mental health service users with ‘dangerousness’ and the constant coupling of cruel and murderous activities with ‘mental illness’, as though ‘bad’ is tantamount to mad, is a defining feature of early twenty-first century discussion. (p. 581)

He also suggests that the survivor movement has had a marginal impact on these developments. Thus, with respect to the social model of disability (see Chapter One), these are some of the factors that set mental illness apart from other forms of disability, and must be accounted for within a social model of madness and distress. Interventions into the media field will no doubt be an important issue for the social model to address, particularly as many activists and consumers view the media as a major contributor to negative social responses to madness and, thus, a potentially disabling force.

While research has identified that schizophrenia and substance use disorders tend to be those most commonly reported in the context of crime and violence and framed around ‘community fear’ (Blood et al., 2005; Francis, Pirkis, Blood, Burgess & Dunt, 2003), most research in this area has tended not to focus on specific diagnostic categories. This may skew findings about the association between violence and ‘mental illness’ (Rowe, Tilbury, Rapley & O’Ferrall, 2003) and, therefore, it is useful to consider those studies that have focused on the reporting of a particular diagnostic category.

Disseminating contemporary technologies of the self

Rowe, Tilbury, Rapley and O’Ferrall (2003) used discourse analysis to examine the construction of depression in Australian newspapers, with particular attention to the ways that depression was constructed as a taken-for-granted category of illness, and the category membership cited for speakers reported in stories. Their study identified that depression was constructed via three broad and, at times, overlapping, discursive repertoires: the biomedical, the administrative/managerial and the psycho-social (Rowe et al., 2003). They also found that it was common for depression to be characterised as being like many other common medical disorders and that the terminology used in these stories constructed misery/depression within

an 'objective' medical discursive field. They suggest biomedical discourse reproduces the idiom of the patient as powerless and is also characterised by a lack of precision. For example, few articles that attributed depression to biomedical causes actually provided detail of the biochemistry involved in depression (Rowe et al., 2003). They argue this lack of precision constructs biochemical causes as so obvious that they need not be explained and, in the process, reinforces the "expert's expertness" (Rowe et al., 2003, p. 686).

This study is significant because it found almost equal coverage of biomedical and psycho-social explanations for depression. However, while stories reflecting the psycho-social discourse tended to focus on social causes of distress connected to the difficulties of modern life, they did not question the definition of depression as a mental illness. The authors say the discourses they identified were "sometimes juxtaposed as opposing approaches and sometimes interlaced with each other into a complex whole" (p. 689). They suggest, "Those with a stake in maintaining the dominance of the biomedical discourse occasionally make concessions to alternative positions, in order to sustain that position of dominance" (p. 693). Similarly, Harper (1999b) identifies the deployment of a biopsychosocial account as a rhetorical strategy to neutralise challenges to a biological account of depression in his work on accounting for medication failure. He argues:

The interests of the psycho-pharmaceutical complex are served by the flexible use of discourses about medication and by the existence of a repertoire of reasons accounting for medication failure. (p. 138)

Along Foucauldian lines, Rowe et al. (2003) argue that, rather than being in competition, biomedical and psycho-social discourses may be "subsumable under an overarching administrative/corporatist discourse of the late modern subject" (p. 693). They refer to Rose's (1999, 2001) concept of 'ethopolitics', which is a kind of politics under which the "psy professions function to provide persons with techniques by which to judge themselves and to guide persons in the ways in which to act upon themselves in the name of improvement" (Rowe et al., 2003, p. 693). They conclude that the overlap of discourses "makes sense when seen as part of this larger problem to determine and to specify appropriate ways of being, and appropriate pathways to treatment" (p. 694). On the basis of their analysis the part the media plays in this process is to construct depression as a condition about which something must be done, where control of the definition, diagnosis and treatment is located outside the individual. They conclude:

Media stories about depression, at least in Australia ... offer a useful pedagogic vehicle for the dissemination of contemporary technologies of the self. (Rowe et al., 2003, p. 694)

In support of their findings they noted an absence of lay voices and that those deemed qualified to speak tended to be medical professionals, researchers and politicians (Rowe et al., 2003). Specifically, they say the Australian press seem to rely on the following sources in reporting depression: press releases from government agencies; extracts from the medical media; and press releases provided directly to newspapers by researchers (Rowe et al., 2003). They found that it was extremely rare for lay people diagnosed with depression to be heard and that when they were “the supposedly lay message is supportive of expertise” (Rowe et al., 2003, 683). This is something that Gwyn (2002) also observed in relation to television health documentaries. Rowe et al. argue:

The privileging of medical or bureaucratic experts and the lack of voice of the lay person, produces depression as a condition outside the realm of everyday comprehension and within the domain of those with special knowledge and expertise. (p. 684)

Overstating biogenetic evidence and explanations

Lloyd and Norris (1999) analysed press coverage of ADHD in Britain over a five-year period and identified the alliance between enthusiastic professionals and parents as a dominant theme. They found the majority of news items included parents’ descriptions of the problems they had with their children prior to diagnosis and many often blamed professionals for not being informed and willing to provide drug treatment to their children. They suggest the message of these stories is that “good professionals prescribe Ritalin”, while more cautious professionals are criticised by parents’ groups as “out of touch and unsympathetic” (p. 509). Similarly, professionals who argue that there are arguments for and against the use of drugs tend not to have their views so prominently expressed (Lloyd & Norris, 1999). In this context, Lloyd and Norris argue for the need to make sense of the huge medical developments, which tend to be reported simplistically in the press, with phrases like “delinquency is in the genes” or “oppositional behaviour is caused by the brain” (p. 513). Conrad (2001) similarly identified the dominance of the ‘genetic optimism’ frame and a news bias against reporting disconfirmations in news coverage of the genetics of mental disorders in the 1980s. Findings such as these support the view that critics of biomedical and genetic definitions are marginalised in mass media coverage.

From ‘mental hygiene’ to ‘mental health literacy’

Crossley (1998) says that the expansion of the mental health service user movement has been paralleled by an expansion of a counter-movement, which “opposes what it perceives as the overly liberal views of some psychiatrists, anti-psychiatrists and users” (p. 459). He says in the UK this movement is chiefly represented by The National Schizophrenia Fellowship and Schizophrenia – A National Emergency (SANE). Crossley says that Bourdieu’s (1977) concept of ‘symbolic violence’ can account for some of the early activities of the National Association for Mental Health (NAMH) in the UK, which he identifies as a social movement organisation (SMO) from within the mental hygiene movement. He says:

Symbolic violence, in essence, involves an attempt by one specific group or agent to impose their discourse or symbolic system upon others, without discussion and in such a way that this discourse becomes accepted as legitimate. (Crossley, 1998, p. 464)

Crossley argues that hygienists all engaged in propaganda and “aimed to improve mental health by changing the attitudes and behaviours of the general public”, specifically the working class, partly because the behaviours they promoted were already accepted and practised among the middle classes (p. 468). Crossley notes that strong emphasis was given in the propaganda to trying to establish the “new” scientific view that mental illnesses are treatable illnesses. Crossley says:

...a strong concern was also expressed that this enlightened view had not spread to the (working class) masses and that public ignorance regarding mental illness was creating stigma, which, in turn, was causing delays in people coming forward for treatment, resulting in an unnecessarily high rate of incurable cases. (p. 469)

Crossley (1998) notes that NAMH adopted a paternalistic and censorial role in relation to the mass media, particularly cinema and they formed a committee to provide technical guidance to film makers to ensure that they avoided inaccurate representations of psychology, for example. In his analysis of the committee’s review of one movie Crossley argues “The sense of the review rests very much upon a taken-for-granted assumption of a distinction between lay and professional understandings of psychology and of the right, indeed the paternalistic duty, of the expert to protect the lay public from themselves” (p. 479). He also observes that prefacing remarks such as ‘once again...’ “indicate that this is not an isolated case but merely one more example of a worrying trend” (p. 479). NAMH also produced educative films on mental health. Crossley observes that many of the aims that NAMH formulated within the mental hygiene discourse are still pursued by groups and movements in psychiatry under different banners.

In the contemporary mental health field in Australia many of the goals formulated within the mental hygiene discourse are pursued under the banner of mental health literacy, which also positions the ‘lay’ public as lacking understanding and knowledge of the ‘reality’ of ‘mental illness’ and in need of education. For example, one study of mental health literacy identified a gap between public perceptions of depression and its treatment and the ‘expert’ knowledge of mental health professionals, and researchers concluded that this meant the population demonstrated low levels of mental health literacy because they did not concur with professional expertise (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt, 1997). This assumes that the public are merely ignorant and do not know the ‘truth’ about depression, and it fails to account for the fact that many people do not view their depression or emotional problems in medical terms and, as such, do not seek professional help, which is often also based on their evaluation and assessment of the services on offer (Fullagar & Gattuso, 2002; Pill, Prior & Wood, 2001). In mental health the ‘lack’ of concurrence with ‘expert’ knowledge is often glossed over as a product of stigma, yet it fails to account for people’s resistance to professional expertise and uptake of alternative sources of knowledge and meaning making. There are clear similarities between the goals of the mental hygiene movement and those who promote the importance of mental health literacy, which underpins media reporting guidelines.

Media reporting guidelines as ‘risk communication’ intervention

Assumptions about the possible impact and influence of media coverage of mental illness have given rise to guidelines for the media’s reporting in this area. In Australia resource kits have been developed to provide information to the media about mental illness and issues for journalists to consider when reporting it. The most recent revision of media reporting guidelines is *Reporting Suicide and Mental Illness: A Mindframe Resource for Media Professionals* (National Mindframe Initiative, 2006). This media resource was developed after consultation with peak media organisations, mental health organisations, consumers, and testing with media professionals. It is also based on some of the research findings discussed above. This resource says, “Negative reporting of mental illness appears to influence community attitudes” (p. 23). It also urges journalists not to use terms such as ‘cracked up’, ‘nutcase’, ‘psycho’ and ‘lunatic asylum’ because it “stigmatises mental illness and perpetuates discrimination” (p. 22). The resource also contains a section on issues for journalists to consider when interviewing a “person with a past or current mental illness” (p. 23),

definitions of mental illness, facts and statistics, and a section containing contact details for “recommended experts” (p. 24). It also advises the media to:

Make sure medical terms are used correctly – eg being down or unhappy is not the same as experiencing clinical depression. Using psychiatric and medical terminology out of context is inaccurate – eg ‘psychotic dog’ or ‘schizophrenic city’. (National Mindframe Initiative, 2006, p. 22)

The resource kit advises that people with a mental illness “are not inherently violent, unable to work, unpredictable, untrustworthy, weak or unable to get well” and that referring to someone with a mental illness as a victim, suffering with, or afflicted by, is outdated. It also advises against referring to a person who is currently experiencing, being treated for, or who has a diagnosis of schizophrenia as ‘a schizophrenic’ and urges journalists to be careful not to imply that all mental illnesses are the same” (p. 22). Variations on this type of resource kit have been developed in the context of national and international ‘anti-stigma’ campaigns (Rosen, Walter, Casey & Hocking, 2000). The World Federation for Mental Health (WFMH) has also produced specific guidelines for the media’s reporting of ADHD and it is notable that, in spite of debate surrounding this diagnosis, the resource refers to “strong agreement among the international scientific community that ADHD is a real neurobiological disorder whose existence should no longer be debated” (WFMH website).

Resource kits such as these can be seen to embody the goal of improving ‘mental health literacy’ (Jorm et al., 1997) by improving media coverage with the aim of ‘educating’ the public into thinking about ‘mental illness’ the way the ‘experts’ do. This reflects an acceptance of the expertise behind diagnostic labels and emphasises the need for the media to have the ‘facts’ about mental illness as they are constructed within the medical model. The media and the ‘lay’ public are positioned as lacking understanding and knowledge of the ‘reality’ of ‘mental illness’ and in need of education about the ‘facts’. This approach is common in the public health arena (Bradbury, 1989; Plough & Krinsky, 1987) and in mass media health education and health risk communication campaigns, and it can be likened to a form of social marketing (Lupton, 1994, 2005).

It is not difficult to see how Foucauldian ideas can be applied to this type of campaign. Andreasen (1994), for example, says the aim of social marketing is to influence voluntary behaviour, although he says it is distinct from health communication primarily because it applies marketing technology. The application of this technology depends on having

information about the “needs, wants, perceptions, and present behavior patterns” of the “target audience” (p. 112). This information is generated through research, which in turn feeds into disciplinary regimes through which individuals act in their own freedom. These campaigns are technologies of government that are effectively underpinned by a simplistic view of a direct link between media reporting and public knowledge and also a particular perception of the likely risks of certain kinds of media reports. The emphasis on risk is reflected in the resource kit where the role of the National Media and Mental Health Group is described as:

...to provide advice about and appropriate initiatives and methods to encourage the media to report and portray suicide and mental illnesses in a way that is least likely to cause harm, induce copycat behaviour, or contribute to the stigma experienced by people who have a mental illness. (National Mindframe Initiative, 2006, p. 49)

Media reporting guidelines are not enforceable and so they rely on convincing media professionals of the harm that can be done to people as a result of ‘inaccurate’ and ‘inappropriate’ media portrayals. In the case of reporting suicide, the risk is ‘copy-cat’; in the case of mental illness it is community stigma and what the experts suggest are the consequences of this. This kind of intervention is underpinned by a techno-scientific approach to risk and a ‘direct effects’ model of the media, one of the features of which is to over-emphasise the power of the media and expert knowledge and the passivity of media audiences and ‘lay’ people. Despite shifts in thinking away from top-down approaches to risk communication and the ‘direct effects’ theory of media communication more generally, the assumption that persuading ‘lay’ people of the ‘expert’ definition of risk continues to underpin a range of communication strategies. In contrast, Wynne (1991, 1996) argues that it is critical to explore how perceptions of risk are constructed by ‘situated’ knowledge, which requires an approach to risk communication that encourages dialogue and conversation and attends to the range of possible interactions between people’s existing understanding of a situation and those that emanate from science or other expert systems.

Other ways of playing the media game

Crossley (2004) found that almost all psychiatric survivors he interviewed commented on the importance of challenging media stereotypes. As the movement has grown, specialist organisations, such as London-based *Mental Health Media* and the now defunct Manchester-based *Schizophrenia Media Agency*, have sought to critique media practice as well as to campaign within the media field (Crossley, 2004). He argues a key emphasis of intervening in

the media field involves providing people with the skills to play the 'media game'. He identifies two aspects of this form of engagement, which he likens to the critique of psychiatry itself. Activists can lobby the media directly and work within it to bring about change or they can deconstruct media messages. However, he says there are dangers with the latter approach in that activists' critiques of media stereotypes deploy typifications regarding 'the media' and 'the public', which can serve to "further 'other' the other in such a way as to reduce the possibility of achieving the relations of mutual recognition that are, in the final instance, a key aim of most in the movement" (p. 176).

Crossley (2002) calls for a focus on groups that aim to target the media and an appreciation of the obstacles presented by the media field, such as the types of capital (economic, symbolic and social) required by it. For example, Crossley (2004) considers some of the effects of the media on the choice of 'repertoires of contention' within the 'resistance habitus' in the mental health movement. In particular, repertoires of contention from within this habitus are constrained by concerns about the way they and their actions will be reported as well as the impact of their protests on public opinion. In my analysis of an organisation's interventions into the media field in Chapter Five I argue its approach runs the risk of being counterproductive, both for reasons Crossley suggests and for others.

Conclusion

On the basis of the research reviewed in this chapter, there are many factors at play in the media and mental health fields that may interfere with the attempts of the c/s/x and activist movement to disseminate its messages to a wider audience. These include disease mongering activities and the tendency for the media to rely on 'official' sources, such as police, medical professionals, advocacy groups and government officials in reporting mental health issues. Moreover, in Australia at least, the media resource kit I discussed may in itself be counterproductive to some of the movement's goals. It does nothing to challenge paternalistic assumptions about people diagnosed with a mental illness, fails to highlight the need for the media to treat with caution new scientific findings or articles from medical journals that overstate the benefits of psychiatric drugs or genetic optimism, and reflects an uncritical acceptance of the biomedical discourse of mental illness. In light of the research reviewed in this chapter, the relationship between the mental health and media fields is a salient area of

inquiry. In the following chapter I elaborate on the specific interpretive practices I bring to bear in my own analysis of a range of empirical materials.

Chapter Three

Research design and interpretive practices

The more and more I try and understand the reasons behind the anorexia, the more I realise that its profundity is endless and that it's likely that I will never understand it. I want to though, I want to so much. (from a diary of a young girl)

Introduction

This chapter details my research design and interpretive practices in relation to the theoretical framework and research context established in the previous chapters. It situates my research within the field of qualitative inquiry, in particular cultural studies. After discussing some key features of qualitative research, including self and theoretical reflexivity, it focuses specifically on cultural studies of psychiatry. The chapter identifies some of the key questions asked by cultural studies, discusses the 'sociology of knowledge' approach to discourse to which I orient my research, and considers the value of a discursive approach in mental health. Some key concepts from social movement framing research are also discussed. The chapter then outlines the interpretive practices I use to analyse the research materials in each of the following chapters: a failed ethics application to conduct research with people who may have been diagnosed with a mental illness; an anti-stigma campaign; a transcript of an interview with two members of an emerging group *insane australia* and its submission to the Senate Select Committee on mental health in 2005; and a prominent television documentary and the ensuing online discussion forum and public debate.

The field of qualitative research

Qualitative research is a complex and evolving field in which many methodological practices are used and where there is tension among researchers who situate their work within different interpretive paradigms (Denzin & Lincoln, 2000). There are, however, some general observations that have been made about the nature of qualitative research and how it differs to quantitative approaches. Qualitative forms of inquiry reject many of the fundamental assumptions about research that underpin the positivist paradigm, including that research should be generalisable, replicable, objective, value neutral and detached from social, political and personal concerns. The distinction that is made between 'interpretivist' qualitative approaches and 'objectivist' quantitative approaches is often used to dispute the

value and rigor of qualitative research, even though it belies the fact that all research is interpretive (Angen, 2000; Denzin & Lincoln, 2000; Kincheloe & McLaren, 2000). Moreover, postmodernism and poststructuralism embody the “triple crisis of representation, legitimation and praxis” that confronts qualitative researchers and requires new ways of understanding the products of qualitative research (Denzin, 1997, p. 3).

Qualitative researchers are open about the way in which their research is influenced by their personal biography (Denzin & Lincoln, 2000). They stress the value-laden nature of their inquiry, the “socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry” (Denzin & Lincoln, 2000, p. 8). Qualitative writing is a method of knowing both the self and the subject of our research (Richardson, 2000). Denzin (1997) says, “Ethnography is a form of inquiry and writing that produces descriptions and accounts about the ways of life of the writer and those written about” (p. xi). Unlike its modern version, ethnography in the postmodern historical moment does not claim to represent an objective, stable reality about which generalisations can be made; ethnographic practices are always situated understandings. As Denzin (1997) suggests:

Self-reflection is no longer an option, nor can it be presumed that objective accounts of another’s situation can be easily given. Truth is always personal and subjective. An evocative and not a representational epistemology is sought. (p. 266)

Self-reflexivity and theoretical reflexivity

Poststructuralism directs us to “understand ourselves reflexively as persons writing from particular positions at specific times” (Richardson, 2000, p. 929). The notion of self-reflexivity is highly important in qualitative research because it serves as an internal check on the role of the researcher in selecting, collecting, interpreting, writing up and producing a piece of research. Reinharz conceives of three kinds of selves that we bring to and create in our research. These are research-based selves, brought selves (the selves that historically, socially and personally create our standpoints) and situationally created selves. Each of these selves has a distinctive voice (as cited in Lincoln & Guba, 2000). Lincoln and Guba (2000) write:

Reflexivity – as well as the poststructural and postmodern sensibilities concerning quality in qualitative research – demands that we interrogate each of our selves regarding the ways in which research efforts are shaped and staged around the binaries, contradictions and paradoxes that form our own lives. We must question our

selves, too, regarding how those binaries and paradoxes shape not only the identity called forth in the field and later in the discovery processes of writing, but also our interactions with respondents, in who we become to them in the process of *becoming* to ourselves. (pp. 183-184, original italics)

Rhoads (2003) argues that “Restoring the personal to the realm of scholarly research and writing thus may be understood as a challenge to modernist discourses stressing objectivity over subjectivity, neutrality over engagement, and distance (third person voice) over connectedness (first person voice)” (p. 237). In qualitative research it is important as researchers to reflect on our own role as co-producers of meanings or co-participants in the research settings within which we conduct our research. Lincoln and Guba (2000) suggest, “The *way* in which we know is most assuredly tied up with both *what* we know and our *relationships with our research participants*” (p. 182, original italics).

In this context, I would like to do what Rhoads (2003) refers to as “traversing the great divide” (p. 235) in qualitative research by writing myself into my research and reflecting on how my personal and scholarly lives intersect. I am an anglo-saxon female, from a working-middle class family, raised in a rural community, and I have a university education. I make no pretence to being a disinterested researcher whose personal experience does not influence my assumptions about the world and what counts as ‘knowledge’. Throughout my research I have questioned my own prejudices regarding the topic of this research and how it affects my selection and interpretation of research materials. I cannot separate my own personal experience of psychiatry and a psychiatric diagnosis from my academic research as if all this required was a change of hats. The best I can do is keep asking myself how I know what I know and retain the humility that comes with accepting that I do not know what I think I know.

I have experienced many internal conflicts during my research and I see these as reflecting my different selves. My research-based self, for example, has often been in conflict with my brought self as I have sought to reconcile the theoretical concepts with my own self-knowledge. Theory provides us with ways of seeing the world and the objects of our research while simultaneously constructing these objects. The title ‘Theoretical Framework’ that I gave Chapter One of this thesis is suggestive of the exclusive nature of theory; it brings certain domains of reality into view while blinding us to others. As Silverman (2000) puts it, “every way of seeing is also a way of not seeing” (p. 825). Not unlike the selves we bring to our

research, theory and method predispose us to impose meanings on to our research that are not there in the ‘data’ waiting for us to ‘discover’. The inevitable goal of theory and method is the production of ‘knowledge’, which as I have discussed is inextricably connected to power. Yet this knowledge does not replicate any reality, any essence that we have discovered in the objects of our study; it is always a particular construction of reality. In claiming to know something about reality we attempt to impose our power over it and this is the same for our self-knowledge as it is for our ‘academic’ knowledge.

In Chapter One I reviewed key theoretical perspectives that make sense to me, yet they are not of me and nor do they have any necessary bearing on the lives of people who are or have been diagnosed with a mental illness. Our experiences are embodied. They are not reducible to the language we use to talk about them and the theories we use to make sense of them. To assume this would be to take the same turn as diagnostic psychiatry by suggesting that its diagnostic vocabulary corresponds to the world as it is. I make no claims that this research represents the diverse views or experiences of people whose lives have been touched in some way by a psychiatric diagnosis or the mental health system. The assumption that these people are in the best position to speak on their own behalf underpins my research.

The politics of interpretation

This project replaces the criteria of replicability and generalisability that underpin positivist research with alternative criteria developed within social constructionist, postmodernist and poststructuralist qualitative research. In rejecting the assumptions underpinning positivist and postpositivist research, researchers who work within a constructivist, or constructionist, paradigm replace positivist criteria of internal and external validity, reliability and objectivity with terms like credibility, transferability, dependability and confirmability (Denzin & Lincoln, 2000). Cultural studies models, which I discuss shortly, privilege a “material-realist” ontology (Denzin & Lincoln, 2000, p. 21) or, to use Lewis’ (2006b) term, an ontology of ‘semiotic realism’ (see Chapter One). Empirical materials are valued in this paradigm for their emancipatory implications, and research focuses on the material and semiotic consequences of particular discursive frameworks.

Researchers who adopt a postmodernist or critical poststructuralist position propose alternative criteria for legitimating ethnographic practices, such as the “nature of the critical understandings it produces” (Denzin, 1997, p. 8). As Richardson (1991) suggests, the

“deconstruction of epistemic privilege” (p. 174) that characterises the postmodern sensibility brings with it the possibility of alternative criteria, such as moral implications, practical applications, aesthetic pleasure, fun, performativity and credibility, for choosing one discourse or interpretation over another. From this perspective, there are no foundational criteria for deciding on the plausibility of interpretations. Those who adopt this position suggest the idea of being rational needs to be deconstructed, they endorse a plurality of interpretations and claim that rhetorical criteria, such as whether an interpretation “invites, persuades, compels, entertains, evokes, or delights” are the only proper criteria for deciding whether one interpretation is better than another (Schwandt, 2000, p. 202).

In the hermeneutic tradition the politics of interpretation takes centre stage. According to Kincheloe and McLaren (2000), the purpose of critical hermeneutical methods of interpretation is to “develop a form of cultural criticism revealing power dynamics within social and cultural texts” (p. 286). Hermeneutical researchers can “produce thick descriptions of social texts characterized by the contexts of their production, the intentions of their producers, and the meanings mobilized in the process of their construction” (p. 286). In rendering the personal political, “critical hermeneutics provides a methodology for arousing a critical consciousness through the analysis of the generative themes of the present era” (p. 289). This form of inquiry presupposes a feminist communitarian ethical model that accords with the position of ethnographers as personally involved and politically informed, in contrast to the morally neutral observer of positivism, which is presumed by the Utilitarian model that currently governs research (Denzin, 1997). Following this tradition I strive for “interpretive sufficiency” and to create a text that may be a catalyst for “critical consciousness” (Christians, 2000, p.170; Denzin, 1997).

I concur with the view that the researcher in the interpretivist approach is “the instrument through which the topic is revealed”, which means the responsibility of the researcher to develop a sound interpretation is paramount (Angen, 2000, p. 390). This requires providing a detailed description of the theoretical positions that inform our work and the research techniques we use. Documenting the “chain of interpretations” in our research enables others to judge the trustworthiness of the meanings and conclusions we arrive at (Angen, 2000, p. 390). It does not, however, ensure that others will agree with our interpretations. As with my own text, each of the texts I examine in this thesis are open to multiple interpretations, some of which may be contrary to their producer’s intentions. My aim is to examine the techniques

deployed in these texts to persuade us that they do reflect the world, or an aspect of the world, as it is, without making any claims to the finality or superiority of my own interpretation. I am putting forward one among many possible readings in order to make a particular argument, and my own text is open to this same kind of reading.

Cultural studies

Lewis (2006b) describes postpsychiatry as a form of cultural studies (see Chapter One) that reads, or decodes, dominant cultural artefacts against the grain “to unpack the encoded culture and power dynamics of their production” (p. 95). Drawing on the work of Grossberg, Nelson and Treichler, Lewis says that cultural studies is not only the ground on which analysis proceeds but also the site of a political critique, in which scholars do not see themselves as simply providing an account but as politically engaged participants. In this sense, cultural studies is firmly embedded in the tradition of critical hermeneutics. We cannot abstract ourselves from the complex cultural fields within which we are situated and from which “we are culture, just as we oppose the culture” (Agger, 1992, p. 183). The interests of cultural studies “tend to involve the production and nature of the rules of inclusivity and exclusivity that guide academic evaluation – in particular, the way these rules shape and are shaped by relations of power” (Kincheloe & McLaren, 2000, p. 295). Researchers in the complex field of cultural studies tend to employ textual analysis and to make use of a diversity of sources and methodologies (Frow & Morris, 2000).

Drawing on the work of Hall (1980), Lewis (2006b) suggests that decoding is the “vital work” of cultural studies of psychiatry (p. 92). Hall’s work relates to the processes of encoding and decoding television communication, but Lewis (2006b) believes it is useful because it shows how critical and alternative “decodings” of psychiatry matter and can begin to effect change (p. 93). Lewis (2006b) argues Hall’s work usefully captures the mediated way in which the cultural ‘messages’ of psychiatry are encoded and decoded because, he says, “They, like television, are cultural messages that are produced and consumed within the fray of numerous social, political and economic relations” (p. 95). Hall makes a distinction between three kinds of decoding positions. These include the ‘dominant-hegemonic position’ in which the message is decoded according to the same reference code in which it was encoded; the ‘negotiated position’, which is when the reader uses the same larger social codes as the producers but uses alternative local codes; and the ‘oppositional position’ where the reader

demystifies and challenges dominant codes. Processes of encoding and decoding are mediated and framed by a range of social and political structures (Hall, 1973, 1980). Lewis (1998) refers to some of the questions that cultural studies asks:

Who is being advantaged by any particular constellation of beliefs and priorities? Who is being disadvantaged? What kinds of human subjects and social systems are created by the cultural products in question? How and why, and through what set of social manipulations, are particular cultural products (and not others) with their particular beliefs and priorities (and not others) the ones which are held up for praise and emulation? (pp. 9-10)

Postpsychiatry embraces postdisciplinary and multidisciplinary scholarship and methodologies and the insights provided by postmodern theory. At its core cultural studies of psychiatry requires reading psychiatric knowledges against the grain (Lewis, 2006b). The willingness of cultural studies of psychiatry to engage with an eclectic mix of disciplinary and non-disciplinary movements and its openness to a range of interpretive practices creates opportunities for diverse and critical readings of texts at work in the mental health field and, therefore, for shedding light in these questions.

Because of its emphasis on ‘ethics before technology’ (Bracken & Thomas, 2005) postpsychiatry calls for a pragmatic approach not only to people’s distress but to the methods that are used to understand and to make sense of it. This has clear implications for research that is undertaken with people experiencing distress specifically and, more generally, for research such as this, which is guided by a postpsychiatry framework. Specifically, putting ethics before technology means that we acknowledge that the psychiatric and medical professions do not have a privileged status in regards to the language of madness. Thus, as researchers we ought not to succumb to diagnostic terminology and the privileged status of clinical knowledge structures in understanding madness. To paraphrase Lewis (1998), cultural studies of psychiatry must be driven by a desire to imagine how the constructs of psychiatry might be otherwise. At the same time we must accept that there are multiple perspectives on madness and distress and acknowledge that for some people the constructs of psychiatry are welcomed. The important point is that the beliefs and priorities that inform our research, and those that we hold up for praise and emulation in our research, will be advantageous to some people and not others. It is, therefore, our ethical responsibility to be reflexive about our interpretations and analyses.

Discursive research

It is difficult to speak of ‘discourse’ or ‘discourse analysis’ because of the different brands and multiple origins of discursive research (Burman, 1991; Potter & Wetherell, 1990). Keller (2005) identifies six categories of discourse research in circulation in the humanities. My research straddles two of these approaches: the Foucauldian approach of *discourse theories*, which focuses on the social macro-levels of power/knowledge relationships or the articulation of collective identities; and *culturalist discourse research*, which can take the form of the analysis of the construction of social problems in public discourse (symbolic interactionist tradition), the investigation of language use and symbolic power inspired by Bourdieu, or the analysis of circuits of representation/culture, as in Cultural Studies.

In an attempt to bridge what he describes as macro and micro level approaches to discourse, Keller (2005) suggests it is preferable to integrate Foucauldian insights on discourse into the interpretive paradigm in the social sciences. He describes this as the ‘sociology of knowledge approach to discourse’, which, following Bourdieu, recognises discourses as “structured and structuring structures” (para. 11). He says, unlike some Foucauldian approaches, this recognises that social actors involved in different social fields and symbolic struggles perform actions or social practices, discourse itself does not. This resonates with Fairclough, Jessop and Sayer’s (2002) Critical Semiotic Analysis (CSA) approach to text analysis, which they say is compatible with critical realism and provides insights into the role of semiosis in social structuration. They argue:

Semiosis – the making of meaning – is a crucial part of social life but it does not exhaust the latter. Thus, because texts are both socially-structuring and socially-structured, we must examine not only how texts generate meaning and thereby help to generate social structure but also how the production of meaning is itself constrained by emergent, non-semiotic features of social structure. (p. 4)

‘Sociology of knowledge approach to discourse’

Keller (2005) proposes two main dimensions of the ‘sociology of knowledge approach to discourse’. The material dimension directs the researcher to look at the key actors performing a discourse (actor positions), their “standing” and role in the arena of discourse, the relations between them and the practices and strategies of discourse production and reproduction. Keller likens this to “ordinary” case study work in the social sciences. The second dimension involves analysing the symbolic dimension of discourse, for which Keller suggests tools from qualitative research are useful. He distinguishes between four analytical units or concepts to

bring to the analysis of textual data: interpretative schemes/frames; classifications; phenomenal structure; and narrative structure/plots, which he says taken together form what Potter and Wetherell (see below) refer to as an ‘interpretative repertoire’ by which a discourse tends to achieve its symbolic structuring of the world (Keller, 2005).

Keller (2005) describes interpretative schemes as “socially typified historically embedded interpretation devices” for occurring events or urgencies of action, which directs researchers to consider discourses as instances of the production and circulation of these interpretative schemes. The analysis of classifications in discourse involves considering all kinds of classification performed by a given discourse and should not be reduced to the classifications of subject positions, as important as these are in discourse research (Keller, 2005). The concept of phenomenal structure refers to the assumption that the structure of a phenomenon is constituted by discourse. This structure, according to Keller (2005), includes “cognitive devices like the concepts used to name an object, the relations between those concepts, the introduction of causal schemes and normative settings, the dimensions, urgencies and legitimations for action, as well as the kind of practices considered suitable to a particular phenomenon” (para. 29). For this level of analysis he suggests discourse researchers can use methods from ‘Grounded Theory’, such as coding and writing memos, to elaborate “condensed descriptions of phenomenal structures on the basis of empirical data” (para. 29). Narrative structure refers to the way in which each of the other elements is tied together by narrative elements such as story lines and plots.

Wetherell and Potter (1988) say ‘interpretative repertoires’ can be seen as the “building blocks speakers use for constructing versions of actions, cognitive processes and other phenomena” (p. 172). In addition to the elements identified by Keller, the presence of a repertoire is often signalled by certain tropes or figures of speech (Potter & Wetherell, 1990; Wetherell & Potter, 1988). The analysis of interpretative repertoires is, however, only part of a larger analysis of discourse, which ranges from addressing macro issues such as ideology and micro issues such as warranting devices used to fix accounts as factual, for example (Potter & Wetherell, 1990). Potter (1996) is concerned with the way accounts are established as literal and objective and what accounts are being used to do. He combines this approach to discourse with a concern for rhetoric, which directs analysts to alternative claims or arguments that are being undermined when people take a position. More specifically, he treats rhetoric as “a feature of the antagonistic relationship between versions: how a description

counters an alternative description and how it is organized, in turn, to resist being countered” (p. 108).

Concepts from Critical Semiotic Analysis (CSA) and Critical Discourse Analysis (CDA) also inform my textual analysis (Fairclough et al., 2002; Richardson, 2007). Like the ‘sociology of knowledge’ approach, a central feature of each of these approaches is that they aim to link linguistic analysis to social analysis. CDA, for example, “assumes that language is used to *mean* something and to *do* something and that this ‘meaning’ and ‘doing’ are linked to the context of its usage” (Richardson, 2007, p. 24, original italics). This means that to understand discourse, “we need to work out what the speaker or writer is *doing* through discourse and how this ‘doing’ is linked to wider inter-personal, institutional, socio-cultural and material contexts” (Richardson, 2007, p. 24, original italics). Intertextual analysis of discourse can also reveal how texts selectively draw upon orders of discourse. Fairclough et al. (2002) explain the concrete and abstract aspects of intertextuality:

Concretely, particular texts report, echo etc., particular other texts for both speaker and listener. More abstractly, texts may stand in complex relations to semiotic orders – they may articulate the discourses, genres and styles of different semiotic orders together in complex ways. (p. 7)

Thus it can be seen that both CDA and CSA parallel many aspects of the ‘sociology of knowledge’ approach proposed by Keller (2005) in linking the material and semiotic dimensions of discourse. CDA offers a range of conceptual tools for analysing texts, including referential strategies, predicational strategies, transitivity, modality, presupposition, rhetorical tropes, such as hyperbole, metaphor, metonym and neologism, puns and narratives. While my analytic approach shares many of the assumptions of CDA, I do not employ the method of CDA specifically.

The value of a discursive approach

I now discuss some specific research that demonstrates the value of a discursive approach for deconstructing and decoding psychiatric knowledge. According to Lewis (2006b), Foucault’s theory of discursive practice combined with his theory of power “provides an invaluable postpsychiatry tool for understanding how discursive practices like the new psychiatry hold together” as well as for understanding how it might change and evolve over time (pp. 58-59). There is a growing body of discourse analytic research that exposes and deconstructs the ways in which dominant social norms and values are upheld by psychiatric categorisations (Crowe,

2000). Much of this work elucidates the biases and forms of social control that underpin definitions of normality and pathology and demonstrates how they are produced as forms of truth by and within discursive practices.

Considering the work of discourse theorists, such as Potter and Wetherell, Sampson (1993) notes, “the discursive framework does not deny reality nor reduce everything to mere words” but that the way we understand material reality and its causes is constituted through our systems of discourse:

Discourse theorists are less interested in discovering the truth in some abstract, universal sense, than in uncovering the discursive processes by which certain matters are considered true while others are considered false. (p. 1222)

While these processes are of interest to discourse analysts, Sampson (1993) also suggests the discursive framework has great appeal for several identity movements. He describes this appeal in terms of the relationship between discourse and power and he suggests the discursive framework is of interest to advocates of identity politics in the mental health field because it challenges current psychological and psychiatric thinking and practice. It is through the discursive practices of psychiatry that certain ways of being are constructed as mental illness, and a discursive approach can identify some of the processes through which these practices are productive of what is considered real and true and what is considered false, and how we respond to them accordingly. Discursive research is amenable to deconstructing psychiatric power/knowledge.

Burman (1991) argues that it is important to acknowledge the political concerns that motivate our analysis of discourse, rather than regard them as a property of the approach itself. Although she addresses her argument primarily to psychology, she says that the same issues also arise in the social and other human sciences. Harper (1995) also argues that discourse analysis needs to be politically informed to be useful and that this is not at odds with a social constructionist position because the motivation of many who adopt such a position is that it allows for a better representation of human diversity than normative positivistic accounts (Harper, 1995). To the extent that particular interests are served by any construction of meaning and the meanings which are privileged in any culture will reflect the dominant interests of power (Crowe, 1998), the issue from a pragmatic perspective becomes whether the discourses through which certain forms of behaviour, thought and feeling are described and interpreted are the most useful and defensible ones to adopt (Holmes and Warelw 1999).

Harper (1995) says a practical deconstructionist approach to the discursive practices of psychiatry is able to expose the implicit oppositions in our talk about mental health. He combines micro and macro approaches to discourse in order to link talk of participants with “wider discourses available in culture and in a web of institutional power” (Harper, 1999b, p. 130). This approach “assumes that certain accounts may serve certain institutional interests”, though not necessarily intentionally (Harper, 1999, p. 130). This fits with his broader concern about the need for discourse analysis to be politically informed in order to be useful (Harper, 1999). Harper (1999) takes this approach in his analysis of talk about medication, which he says exists in a “matrix of other discourses and institutional relations”, of which drug companies are an important part (p. 127). He refers to some of the culturally available discourses that have been identified about medication, which relate to the variability of prescribing practices, the dangers of medication, and side-effects.

Harper (2004) also takes a discursive approach to psychiatry’s conceptualisation and response to delusions, which he argues is decided not on the basis of any systematic investigation of a person’s belief, but on whether a belief is plausible. From a social constructionist perspective, he identifies a number of problematic assumptions in the psychiatric definition of delusions: they are based on a naively realist view of the world; people said to have delusions are seen to vary in the conviction with which those beliefs are held; delusions are not meaningless and irrational; and conventional psychiatric theories see delusions as ‘abnormal’ in some way. In regard to the first point, to the extent that we all hold beliefs that escape evidence, it seems that a realist view is ill equipped to distinguish between what kind of belief is delusional and what kind of belief is plausible. In regard to the fourth point, he refers to opinion surveys that regularly show that substantial numbers of people believe in telepathy, life after death, ghosts, and the ability to predict the future. Thus he asks, “On what ethical and empirical basis are we judging the normality of beliefs?” (p. 56). Harper (2004) argues:

In large part, the impression of abnormality is maintained by researchers who focus exclusively on groups of psychiatric service users on the assumption that they are somehow categorically different from the rest of the population. However, as with research on hearing voices, when researchers move out of the psychiatric clinic and investigate the ‘normal’ population with no previous psychiatric history, ‘delusions’ appear to be more common than might be expected. (pp. 56-57)

From a mental health nursing perspective, Crowe (2000) argues discourse analysis can explore the power relations that underpin psychiatric knowledge and practice and the strategies used to maintain them. In her analysis of *DSM-IV*, she argues it “perpetuates a

western construction of normal subjectivity which emphasises individuality and requires an ability to distinguish self from others” (p. 73). She also challenges one of the assumptions of the *DSM-IV*'s definition of mental disorder as being a pattern or syndrome ‘that occurs in an individual’. She says the dominant view of the self-contained individual inherent in definitions of mental disorder precludes relationships with others from being given much consideration (Crowe, 2000). Such a view of the self is also at odds with the postmodern conception of the self as a project, rather than an inner essence. Crowe (2000) argues a person’s behaviour may be interpreted by the discourse of *DSM-IV* as a symptom of mental disorder if they fail to “demonstrate socially acceptable levels of stability, unity and consistency or if they fail to demonstrate appropriate differentiation between themselves and colleagues” (p. 73).

For the purposes of this chapter I have referred to these studies to illustrate the value of a discursive approach in the context of cultural studies of psychiatry. I share Harper’s view that discourse analysis needs to be politically informed and retain the potential to decide between the usefulness of the ways in which realities are discursively constructed (Harper, 1999b). He says that usefulness refers to “whether a particular idea or intervention leads to richer understanding and to just and socially responsible outcomes” (p. 128). This, of course, raises the question of on what basis do I decide what constitutes “richer understanding” and “socially responsible outcomes” and, therefore, how I decide what is useful.

There is no escaping the values that are inherent in the interpretations that we make. Some people will determine that certain discursive formations are useful or socially just, while others will deem them to be oppressive and harmful. Justifying the interpretations we make brings us inevitably into the realm of morality and values; ethical and political considerations, and “choices about how each of us wants to live the life of a social inquirer” (Schwandt, 2000, p. 205). Lewis’ (2006b) articulation of semiotic realism (see Chapter One) is particularly relevant because of its concern with the consequences of the interpretations we make. Focusing on the material and semiotic consequences of an idea, intervention or interpretation provides another layer of analysis that can help us to identify the practical and symbolic ways in which discursive formations have effects. This, in turn, can enable us to comment on the interests that are served by particular constructions of reality, including the implications of our own interpretations for different interest groups.

Social movement framing research

Concepts from social movement framing research also inform my analysis, particularly in Chapter Six. According to Benford and Snow (2000), “Collective action frames are action-oriented sets of beliefs and meanings that inspire and legitimate the activities and campaigns of a social movement organization (SMO)” (p. 614). They are characterised by “core framing tasks” and “interactive, discursive processes that attend to these core framing tasks and thus are generative of collective action frames” (p. 615). Core framing tasks include “diagnostic framing”, which involves problem definition and attributions; “prognostic framing”, which relates to proposed solutions to the problem; and “motivational framing”, which involves the construction of appropriate vocabularies of motive.

The two basic processes by which collective action frames are generated are frame articulation and frame amplification or punctuation (Benford & Snow, 2000). Frame articulation is a discursive process that involves assembling, collating, and packaging events and experiences to provide a “new angle of vision, vantage point, and/or interpretation” (Benford & Snow, 2000, p. 623). Frame amplification relates to highlighting issues, events or beliefs as more salient than others. Benford and Snow (2000) also identify some of the challenges that confront those who engage in movement framing activities, including counter-framing by movement opponents, bystanders and the media; frame disputes within a movement; and the dialectic between frames and events. They also identify three important elements of the socio-cultural context in which framing processes are embedded that affect framing processes and the character and continuity of the resultant frames: political opportunity structure, cultural opportunities and constraints, and the targeted audiences. These related features of collective action frames provide a conceptual framework within which I explore various aspects of framing in relation to organisations within the mental health field.

Data sources

The orientation of cultural studies of psychiatry toward reading psychiatric knowledges against the grain provides a framework within which to approach not only primary texts of psychiatry, such as the *DSM*, but also secondary texts, such as those produced by social movement organisations in the mental health field. In the context of intertextuality, we can examine those texts that draw on and reproduce psychiatric discourse in the service of particular interests. The aim of contributing to cultural studies of psychiatry motivates my

selection of texts to analyse, and the data that forms the basis of the following chapters is primarily textual. The kind of questions that cultural studies asks provide the primary framework for my analysis of a failed ethics application and the letter from the ethics committee; an anti-stigma campaign; a transcript of a conversation; and a television current affairs documentary and posts to a related online discussion forum.

Failed ethics application

When I began my doctoral program I submitted an ethics application to interview people diagnosed with a mental illness and people who wanted to talk about their mental health experiences more generally. This was rejected by the University ethics committee, which required me to make changes to my research design and procedure on the basis of the concerns it had. I chose not to resubmit the application but, rather, to explore the process of ethics review in greater depth. This exploration forms the basis of the following chapter. I approach my critique of the ethics committee's concerns in the context of concerns that have been raised about 'ethics creep' into the humanities and social sciences, and within the broader context of the shifts in thinking called for by postpsychiatry and the c/s/x movement. In reproducing some of the content of my original ethics application, this chapter reveals my shifting voice as a researcher as my research has evolved, and also responds to calls for researchers to scrutinise the decisions made by ethics committees.

StigmaWatch – *Sane Australia*

My analysis of *Sane Australia* is not an evaluation of its public and educational programs or any of its activities in the community. I am not in a position, nor do I have the expertise or resources, to complete such a complex task. My focus is limited to analysing the basis on which *Sane* publicly expresses offence on behalf of people diagnosed with a mental illness through its StigmaWatch campaign. I focus on all StigmaWatch reports in 2005 and 2006, which I accessed from *Sane's* website. I look at the content of *Sane's* annual StigmaWatch reports from 2001 to 2006 and include in my sample some specific examples from 2003 and 2004 that are no longer accessible on its website but which I had identified earlier in my research. I also examine *Sane's* 'Good News File' for 2005 and 2006. Wherever possible I sought to access and reflect on the actual media items that were the objects of StigmaWatch reports.

My primary rationale for critically examining the StigmaWatch campaign is that its assumptions about ‘stigma’, ‘mental illness’, people diagnosed with ‘mental illness’, psychiatry, psychiatric vocabulary and the relationships between all of these need to be exposed, rather than taken-for-granted, as being the most correct or the most useful interpretations to make of the ways in which language is used in various communicative contexts. My analysis situates this type of campaign in socio-historical context and is guided by a concern to identify the discourses and discursive positions that are made available to people by this anti-stigma campaign, and the perspectives that it excludes.

Resistance within the mental health field

In Chapter Six my aim is to identify the different discursive strategies deployed by those who talk with - and those who talk back to - psychiatry. In particular, I identify some of the ways the consumer/survivor/ex-patient (c/s/x) movement uses decoding and deconstruction as strategies in opposing the dominant paradigm in psychiatry and the mental health system. Documenting the strategies of decoding and deconstruction employed by members of the c/s/x movement is important in light of the failure of many prominent voices in the mental health field in Australia to make use of such strategies. Findings from social movement framing research, and Bourdieu’s related concepts of habitus, capital and field, are drawn from to provide an analysis of competing perspectives on mental health issues in Australia.

The chapter is framed around the themes that emerged from conversations I had with two people who are active in different ways in the mental health field and who are also members of a newly emerging group, *insane australia*, whose submission to the Senate Select Committee on mental health is also discussed. The aim of my conversations with these two participants was to gain an understanding of what was motivating them and what they saw as being key issues for the c/s/x movement in Australia and, indeed, internationally. The approach that I felt would be best suited to this aim was a semi-structured interview, in which my role was a co-participant in a conversation. It was important that the discussion was an organic process and that both participants felt that they could discuss things of importance to them. Thus, my role was more of a facilitator. This approach assumes that an interview is a “negotiated accomplishment” (Fontana & Frey, 2000, p. 663). The chapter contains lengthy quotes from participants, including my own voice to emphasise my active role as a co-participant in the conversation. This style helps to acknowledge the interconnectedness of my

own voice and the voices of my informants (Gilgun, 2005). Participants in the conversation were given the opportunity to review the final chapter and to advise me of any amendments.

This conversational method has limitations. In spite of every effort to make the conversation as unstructured as possible and to minimise my influence on the interview, both participants were aware that the conversation was part of my research and was being recorded for later transcription and to be included in my thesis. I also acknowledge the loss of the theatrical elements of talk as a limitation of the transcribed conversation and recognise that the very act of transcription is itself a mode of construction that displaces the conversation from its original, lively and spoken context. As Denzin (1997) says, “Every transcription is a retelling—a new telling of a previously heard, now newly heard voice” (p. 43).

My aim in this chapter is not to deconstruct the interview text but to learn more about salient issues in the mental health field as they are constructed in the accounts of these participants. I met both participants while researching for my thesis and I learned there were people who occupied a critical orientation toward psychiatry in Australia and who were each, in their own way, seeking to bring about change. In this sense, I take Burman’s (1991) point that the job of the progressive discourse analyst is surely to publicise the analysis presented by these groups, or participants, rather than presenting them as if they were ours. Thus, I approach the interview texts with the aim of exploring how participants’ accounts are constructed in response to the discourses being countered. To connect this talk to broader social structures I see it as being embedded in, responsive to and constrained by factors relating to political opportunity structure, cultural opportunities and constraints, and the targeted audiences. This approach is consistent with literature that supports the view that contextual factors constrain and facilitate framing processes within social movements (Benford & Snow, 2002).

Television documentary and online discussion forum

In April 2003 a documentary titled ‘Hazards of the happy pill’ was nationally broadcast on the ABC’s *Four Corners* program and followed by an online discussion forum. Prior to and after this time, antidepressants were prominent on the media and public agendas. My reasons for looking at this BBC produced documentary relate to the significant response it received from viewers to an internet discussion forum that followed it; the response it received in the UK when it was aired in 2002; the response it received from mental health organisations; and the fact that it took a particular position on antidepressants and sourced people with personal

experience of the drug that supported this critical position. This is significant in light of the observation that lay depictions that challenge medicine are less prevalent in television health documentaries than those used to support the medicalised perspective (Gwyn, 2002).

The documentary and discussion forum that I discuss in this chapter provides an opportunity to explore the way in which audiences read media messages about mental health issues, which is not always evident in analyses of media discourse. In attending to text and context I examine the ways in which people position themselves, the discursive resources they draw upon in constructing their accounts, what their accounts are being used to do and the way in which they are linked to wider culturally available discourses. This assumes that people are active in constructing meaning and also that these meanings are shaped by linguistic categories through which the world is perceived and bound up with power relations that have implications for action upon the self and in relation to others.

Limitations

It is important to acknowledge the limitations of this research approach and to identify the strategies I have employed to overcome these. Unlike in the UK and the US the survivor network in Australia is emerging and it is difficult to identify key people and members. The conversation that forms the basis of Chapter Six involved only three people, including myself. I do not claim, therefore, that the content of this conversation is representative and this has not been my aim. Having immersed myself in survivor and activist literature in the mental health field, it is clear that the themes to emerge from this conversation are widespread internationally. It was my aim to explore the local face of the c/s/x movement. A related limitation of this research approach is that the data I examine and my analysis is primarily textually based. Focusing on one television documentary may also be seen as a limitation. This was chosen from a larger corpus of media content examined, including newspaper reports, talkback radio and other television documentaries. Antidepressant medication was identified as a topic of widespread and sustained media coverage, and I deemed this particular documentary to bring together many of the salient issues in this coverage. The fact that it also facilitated an online discussion forum and instigated public debate also meant that insight could be gained into the reception of the documentary.

Conclusion

Research findings have no meaning outside of an interpretive context and to a large extent it is the responsibility of a researcher to make that interpretive context as transparent as possible. In this chapter I positioned my research in the context of cultural studies of psychiatry and identified the strands of discourse research and the analytic concepts that inform my approach to the research materials I look at in the following chapters. I view each of the texts I examine in this thesis as carrying with them particular discourses and discursive positions; they are “fragments of discourse” (Keller, 2005, para. 31). I also approach them as products of broader social and institutional practices from which they cannot be understood in isolation. The realities represented in these texts are thus socially constructed and understandable through discourse and it is my aim to identify the discourses through which certain realities are being constructed and the consequences of each discursive framework. I approach the units of analysis discussed in this chapter as a toolbox rather than a template that I impose on the data. Researchers differ about the preferred way to approach discourse and to do discourse analysis. Something that appears to be beyond dispute, however, is that our interpretations must be grounded in the texts we examine and also the context of their production, circulation and reception. Moreover, the materials that I bind together in the following chapters are the products of my social position, view of the world, and what I take to be important. We bring a particular lens to the way we interpret the world as we live our everyday lives, and it is a fallacy to proclaim that research is any different.

Chapter Four

Ethics creep: constraining mental health research

Does this mean that for the rest of my life whenever I don't feel hungry people are going to assume that I am falling back into the trap of anorexia. I just can't let people assume things about me and the way I am living. If I do this I am constantly going to feel as though I am at the judgement of others – which is definitely a bad thing because it is most probably something that I was too dependent on before I came to hospital, so I would not want to make that mistake again. (from a diary of a young girl)

Introduction

This chapter focuses on potential barriers to postpsychiatry's calls for a more inclusive research agenda and a shift away from clinical knowledge structures in the field of mental health. It takes as its point of departure the concerns of a University ethics committee about a research proposal that invited people who may have experienced a diagnosis of mental illness to participate. The chapter identifies some of the features of ethics review that have led me to conclude that ethics review committees may pose at least one significant barrier to cultural studies of psychiatry. I take as my primary source material my ethics application and the letter from the ethics committee outlining its concerns. The shifts in thinking called for by postpsychiatry and the activism of the consumer/survivor/ex-patient movement provide the broader framework within which I critique the ethics committee's concerns.

The chapter begins by providing a broader context in which to situate the ethics committee's concerns with reference to the Australian *National Statement on Ethical Conduct in Research Involving Humans* issued by the National Health and Medical Research Council (NH&MRC). I outline the role of the ethics committee as it is stated in the *University of Canberra (UC) Human Ethics Manual* and provide a detailed discussion of the research I proposed to conduct. The remainder of the chapter focuses on the ethics committee's concerns and, more specifically, my critique of the assumptions about research and potential participants that underpin them. Sections of this chapter were presented at the Communication, Medicine and Ethics conference (COMET) in Cardiff in 2006 and have been published in Holland (2007).

The National Statement

In Australia, the National Health and Medical Research Council is responsible for establishing the guidelines by which ethical research with human beings must be conducted in institutions, including universities. These guidelines are set down in the *National Statement of Ethical Conduct in Research Involving Humans (1999)*, known as ‘the Statement’. A revised version of this document was published in 2007 with the new title *National Statement on Ethical Conduct in Human Research*. The revised statement differs in some significant ways to the earlier version, which reflects the evolving nature of ethics review in response to the emergence of new technologies and research procedures, and new categories of people for which special provisions are made, as well as concerns that have been raised about ‘ethics creep’. For example, the Chair of the Handbook and National Statement Working Party for the revised Statement acknowledges that, “In trying to make the national statement genuinely applicable to the gamut of human research, the working party has been acutely aware of the need to avoid ‘ethics creep’” (Cordner, 2006b, para. 12).

For the purposes of this chapter I refer to the 1999 version of the Statement, as this was the document that governed the University ethics review committee at the time of submitting my ethics application in 2005.

The University of Canberra Human Ethics Manual

The *University of Canberra Human Ethics Manual* states:

The National Statement stipulates that all research proposals involving human participants must be reviewed and approved by a Human Research Ethics Committee (HREC). (Section 2.1.3)

It includes the exact wording contained in the National Statement about the primary role of the committee being to protect the welfare and rights of participants in research. The manual describes in further detail the role of the Committee for Ethics in Human Research (CEHR):

In the University Committee structure, the CEHR is categorised as a committee which assists in the management of the University. (Section 3.1)

The National Statement does not outline the relationship of HRECs to the universities or organisations within which they function, and I suggest this last sentence is significant for reasons that I will discuss later. This section also includes information about membership requirements and working procedures for the committee, which accords with the National

Statement. The manual contains university guidelines for responsible practice in research and the CEHR principles and guidelines for research with human participants. This includes details of which activities are classed as research involving humans and for which ethics approval is required:

Ethics approval must be sought if participation in the project involves, for participants, risk of physical or psychological stress, inconvenience or discomfort *beyond the normal experience of everyday life*, in either the short or long term. (Section 5.3, UC Human Ethics Manual, original italics)

This statement has the potential to be interpreted in an expansionist fashion by ethics committees. It also raises a number of questions, such as whose definitions are providing the standard for “the normal experience of everyday life”? What constitutes “normal”? What constitutes “everyday life”?

The manual contains information about ‘Making an application for approval’ where the issue of researcher qualifications is addressed. This section also details ‘Guidelines for composing an informed consent statement’, which includes a list of 17 items that should be included on forms used to seek consent. The final item on this list states:

If appropriate, include a form of words above the space for a signature such as ‘I have read and understood the information provided. I am not aware of any medical condition which would prevent my participation, and I agree to participate in this research’. (Section 6.4)

These are some of the features of the *UC Human Ethics Manual* that are directly relevant to my ethics application and the concerns the committee had, which I will expand on in the context of this discussion.

Proposed research and ethics application

According to Haggerty (2004), “Demonstrating ethics creep requires scrutiny of the decisions of regulatory bodies” (p. 394). He notes that ethics committees are not required to make their decisions public, which means that it is up to individuals to “scrutinize in order to discern the authoritative positions on research ethics matters” (p. 394). I will now detail my application and ethical concerns raised by the committee. The details of my proposed research are taken directly from my original ethics application form.

The ethics application form asks for *General Information* about the project, including the project title, duration, and academic discipline to which the project belongs. The title of my project at this time was “‘Destabilising’ stigma: An analysis of contested constructions of ‘mental health’ and ‘illness’”. The academic discipline was ‘Communication and Cultural Studies’. In relation to the categories of people I sought to participate I wrote “people with personal or indirect experience/knowledge of mental illness/health” who were 18 and over and who volunteered to participate. Under the heading of *Project Details* the application asks for a short statement about its aims and/or hypotheses. I wrote:

The project aims to explore the extent to which ‘mental illness’ and ‘mental deficit’ discourses are sources of stigma or defences against stigma.

On reflection, this statement could have been clearer and more succinct, although it does meet the criteria of being a short statement on which to expand in following questions. The next section of the form headed *Research Context* asks for a summary of the main research reported on the topic and how this supports the proposed study. I began by saying:

Most research into mental illness as a source of stigma has used quantitative survey methods to study community attitudes to mental illness. Quantitative research is limited in accounting for differences in experiences of mental illness as a source of stigma. The dominance of this approach has led to the assumption that stigma is experienced and enacted uniformly and that resistance is futile. Responding to a lack of person-focused research in the area, Knight et al. (2003, 211) explored accounts of life experiences of people with schizophrenia using the qualitative method of Interpretive Phenomenological Analysis (IPA). They argued these personal accounts “uncovered the various and multiple ramifications of mental illness,” in a manner not possible using aggregated quantitative methods. In accordance with this approach, this project will use IPA and other qualitative methods to uncover variations in people’s response to dominant constructions of mental health and illness. (para. 1, Question 11)

In this paragraph and the following I sought to describe the limitations of quantitative approaches and the benefits of the qualitative approach I intended to use:

There has been a tendency for research in the area to focus on ‘public’ stigma, in particular media portrayals (Wahl et al, 2002). This has been at the expense of research into ‘self’ stigma and the relationship between self and public stigma. The assumption has been that ‘stigmatising’ media portrayals have a ‘direct effect’ on the self-perceptions of people with a mental illness and on the wider community. Public stigma and self stigma are interdependent, but not necessarily in the direct manner assumed in much of the discussion on the dangers of stigma for those characterised as mentally ill. Such people often themselves contest notions of stigma, developing novel and at times resistant means of understanding their mental characteristics. (para. 2, Question 11)

My aim was to demonstrate that there has been an overemphasis on public stigma, such as the stigmatising effects of media portrayals, at the expense of research into how people with a mental illness perceive stigma and may actively engage in strategies to resist it:

In this context, there is a growing movement among researchers and advocates to challenge the dominance of mental deficit discourse for understanding mental health experiences, particularly mental illness (Double, 2004; Bracken & Thomas, 2004; Beresford, 2002; Herrman, 2001). From a social constructionist perspective, Launer (1999) and Gergen (1994) argue a psychiatric diagnosis is viewed as a linguistic construct and an agreed version of reality that serves the professional and technical needs of the psychiatric profession. Labelling research also supports the notion that diagnosing mental illness is highly problematic and no more valid than lay constructions of experiences (Goffman, 1963; Rosenhan & London, 1969). Research by McHoul & Rapley (2002), Scambler (1998), Hayward & Bright (1997) and Vatz (1996) also supports the need to defend against stigma by challenging the tendency inherent in psychiatry to see mental illness in terms of individual deficit and a diagnostic label. This project will make a critical case for 'destabilising' stigma through exploring alternative ways of talking about mental health and illness. (para. 3, Question 11)

The major shortcoming I see in this summary is that it could be read as being too polemical or as though I had an agenda that I was going to impose on my interview data no matter what participants had to say. For example, in the final sentence of the above paragraph, I state directly my aims to make a critical case and the ethics committee may have seen this as compromising my engagement with what interview participants said. However, I believe that the critical case I was referring to (and that was the impetus for my research) was at the level of privileging how ordinary people talk about their mental health and illness experiences in their own terms, and the meanings they give to them. In the context of the previous two paragraphs I believe I had made clear my view that this was an area that had not received sufficient research attention. This is the contribution that I hoped my research would have made.

There is no doubt that if I were to submit an ethics application today proposing to conduct interviews with people who may have been diagnosed with a mental illness I would do a number of things differently. At the time of submitting my application I was unaware of the body of c/s/x research, and I would certainly refer to this to support the value of research conducted with and by people with personal experience of a psychiatric diagnosis and of mental health services. I would have focused more on the value of first-person perspectives in mental health research for capturing aspects of lived experience and the relative lack of this research compared to the large amount of third person and quantitative research in this field.

The substance of my proposal, however, would be the same and I do not believe that any of these changes would have had an impact on the view taken by the ethics committee. As I discuss shortly, its concerns were not so much about the substantive content of my ethics application as they were about the assumptions they made about the people who might have been potential participants in the research.

In response to the section of the ethics application that asks about the *Methodology* to be used in the project I stated:

The first stage of the research involves understanding the everyday meanings people apply to ‘mental’ experiences. For this, I will undertake qualitative, open-ended interviews with lay people. I hope to interview between 10 to 15 people, one on one, for between sixty to ninety minutes. Interviews will take place at a time, date and location of the participant’s choosing. However, it is likely that most interviews will be conducted in Canberra, due to the localised nature of the project. I intend to interview approximately five people with a mental illness who responded to the newspaper advertisement about the project, five people with a mental illness who responded through a mental health support group or who volunteered to participate after discussions at the TheMHS conference, and up to five more people who have responded through any of these means, but who do not identify as having a mental illness. After I select volunteers according to the above criteria we will arrange a date, time and location for the interview. I will send them an information sheet confirming these details (Attachment), along with a copy of the Informed Consent form (Attachment). Interviews will be recorded on tape or cd. Only sound will be recorded, no video will be used. I will schedule interviews between April and July 2005. I will only schedule one interview per day to allow for immediate transcription. (para. 1, Question 12a)

TheMHS refers to the Mental Health Services annual conference in Australia that I planned to attend for my research, where the opportunity may have arisen to invite people I met to participate. This was only one possible mode of recruitment and, if it did not eventuate, five people who responded through a mental health support group would have been included. It was my view that people who attended the conference may be more active in mental health services than participants who responded to a newspaper advertisement or a mental health support group and that this would make for a diversity of perspectives.

The ethics committee may have looked more favourably on my application had I used the word ‘consumer’, in light of the observation that in mental health this term is “particularly apt in connection with research ethics committees . . . where consumer voices are increasingly given parity with those of professionals” (Herxheimer & Goodare, 1999, p. 5). Herxheimer and Goodare (1999) contrast ‘consumer’ with the more passive connotations of the words

‘patient’, ‘client’ and ‘user’. Other terms in use in the mental health field include psychiatric survivors, ex-patients and services users. Rather than restrict participation in an interview by imposing either of these labels, including ‘consumer’, I chose to focus on people first.

The central aim of the interviews, as part of a larger project, was to explore the similarities in the language people diagnosed with a mental illness and people who were not diagnosed with a mental illness used to talk about the factors involved with problems with living, or what they defined as their mental health. I reasoned that seeking participants who wanted to talk about their knowledge and experience of mental health more generally – rather than only people who had been diagnosed – would leave participation as open as possible, as well as being in accord with postpsychiatry’s call to deconstruct the distinction between mental ‘health’ and mental ‘illness’ (Lewis, 2000). The reason for in-depth, open-ended interviews was to allow participants to share stories and knowledge relevant and important to them, and to do so in their own terms, thereby avoiding the tendency of fully structured interviews or survey questionnaires to impose professional interpretations.

The *Methodology* section of the application also included details of how I intended to analyse the interview data:

Interview transcripts will be analysed using the qualitative method of Interpretive Phenomenological Analysis (IPA), which focuses on cognitions and experiences using qualitative examination of the text outcome, as in discourse analysis. Analysis will take the form of marking relevant items, identifying emerging themes and noting connections. ... IPA will identify the kinds of discourse that sustain particular ‘mental’ experiences, and variations in discursive content that may increase our understanding of how experiences of stigma are enabled or constrained for certain individuals. (para. 1)

Participants may be asked to check transcripts to verify dialogue and to comment on the interview experience, whether it was of value to them or the difficulties they faced. (para. 2)

As required by the ethics committee the additional documentation I submitted with my application included interview guides, a letter of invitation to prospective participants, an advertisement to be run in the local newspaper, and an ‘informed consent’ form. The letter of invitation included complete details about the project. I included information about the course I was undertaking, my qualifications and my employment as a research assistant on a project investigating suicide and mental illness in the media. I also thought it important to make a personal disclosure:

On a personal level, as a teenager I was diagnosed and hospitalised with mental illness. This is a major influence on my interest in exploring alternative ways of talking about and understanding what is constructed as mental illness.

I had followed the guidelines provided in the University's *Human Ethics Manual* in structuring an Informed Consent form. In terms of the *Principal Benefits* of the research I wrote:

The principal benefit of the project is that it will take an in-depth look at how people experience and talk about mental health and illness, in order to understand how 'mental illness' is experienced as a stigma and how this is destabilised through resistant discourses and contested constructions.

In terms of *Personal Risks* I said:

Some participants may feel uncomfortable talking about mental health, illness and stigma experiences. Participation in the project is voluntary and will cease at the request of participants who feel distressed.

In terms of *Safeguards* I wrote:

The interviewer can advise participants of available counselling facilities should they feel distressed during the interview.

I had advised participants that their identity would remain anonymous, as would the identities of anyone who they referred to in the interview, and that the research would be conducted in accordance with the Commonwealth Privacy Act (1988) and the guidelines established by the National Health and Medical Research Council under Section 95 of the Privacy Act. In accordance with the guidelines for an informed consent form contained in the *Human Ethics Manual* I included the following:

I have read and understood the information provided on pages one and two of this consent form. I am unaware of any medical or other condition that would prevent my participation in this research. I agree to participate under the conditions stated above.

However, as I argue later, the inclusion of such a statement on the Informed Consent form is made a mockery of if and when, as in my own case, ethics committees make the prior assumption that people may not be "well enough" to consent.

The ethics committee's concerns

The ethics committee rejected my proposal for the following reasons: the safety of participants and myself as the researcher; my lack of training and clinical expertise; the need to screen potential participants to ensure they were well enough to give informed consent; the

need for medical arrangements in case of emergencies; the appropriateness of the proposed recruitment procedures; and my disclosure of a past diagnosis of mental illness on the participant information sheet.

Participant and researcher safety

The first concern outlined in the letter from the ethics committee was:

The committee has a number of concerns with this proposal. The major concern is about safety of both participants and researcher, ie does the researcher have training and experience in interviewing people with mental illness and can you assure the committee that your supervision panel includes someone with clinical expertise? (University of Canberra Committee for Ethics in Human Research, 2005)

If one takes the view that a conversation between a person diagnosed with a mental illness or who wishes to talk about their knowledge and experience of mental health or illness poses a significant threat to the safety of the researcher and participants themselves, then the ethics committee has a point. Similarly, if one assumes that the researcher's clinical expertise would alleviate this threat to safety, again the ethics committee is justified in its concern. The unstructured nature of the proposed interviews meant the committee only had access to Interview Guides rather than pre-determined questions and, therefore, would have been unable to determine whether the questions posed a significant safety risk. This may explain their caution.

This double-barrelled concern implies that participants may have posed a threat to my safety as the researcher or that I may have posed a threat to participants' safety. Moreover, it suggests that concerns about safety would have been alleviated if I (as researcher) had clinical expertise or a member of my doctoral supervisory panel had this experience. This reflects a limited view of the potential participant population, a distrust of my own integrity and ethics, and a disregard for the nature of the research and the provisions I had made in regard to potential safety issues in my ethics application. It implies that potential participants are only able to safely interact with someone who has clinical expertise or some other form of specialised training or experience in interviewing this presumed 'high risk' population. If we assume psychiatry and the other 'psy' disciplines equate to 'clinical expertise', this concern can also be read as an insistence on maintaining their hegemony over madness.

Safety to participants is a major consideration in research with people. There are a number of sections of the ethics application that go to the issue of safety in research. In relation to *Unforeseen Events* I stated:

In the event that a participant experiences psychological distress during or after the interview, I will facilitate their access to a counselling service or other help-source of their choosing. This may involve making phone calls or arranging transport on their behalf. Participants may also be put in touch with the Mental Health Foundation ACT, which run various support groups as well as offering free telephone counselling. (para. 1, Question 13a)

Additionally, I wrote:

As part of their informed consent, participants will also be aware that they may cease the interview at any time or refuse to talk about any particular topic. If a participant shows distress I will back off immediately, ask them if they would like a break and check whether it is okay to continue. The fact the interviews will be conducted at a location of the participants choosing may minimise the likelihood that they will experience distress. (para. 2, Question 13a)

A major concern in qualitative research is to protect participants from breaches of confidentiality in research that may involve disclosing sensitive information (Campbell, 2003; Haggerty, 2004). Failure to protect the privacy of participants and the confidentiality of what they say in an interview may impact on their safety in the short or long term. My application stated:

No individual will be identified by name in any documentation to follow from this research. The real names and contact details of participants will only be available to the chief researcher and will be kept in a secure file for the duration of the project, after which time they will be destroyed. Participants will be asked to provide an alternative name to be identified otherwise a pseudonym will be used when necessary. (Question 21)

The ethics application form asks:

What, in your opinion, are the unique ethical considerations in this project? (You may wish to comment, for example, on issues relating to informed consent, confidentiality etc.).

I responded:

The primary ethical considerations relate to protecting the health, wellbeing and identity of participants. The confidentiality of the identity of participants is important on the grounds that disclosing a mental illness is a private decision. The issue of reinforcing stigma in the research process is also an important consideration, which will be avoided by the interviewer taking great care not to reinforce stereotypical attitudes and language. (Question 29)

Perhaps in relation to specific ethical considerations I could have said something to the effect that if participants are taking medication they could experience side-effects during the interview, to which I would be sensitive. However, I believe that the provisions I made for participants to take a break if needed, stop the interview at any time, or refuse to talk about any particular topic would have catered for the possibility of participants experiencing the side-effects of medication. I had also thought that allowing the participants to choose the location of the interview, rather than impose a location where they may have been unfamiliar or uncomfortable, would have alleviated the possibility of adverse reactions. Beyond this, I had not presumed that the research posed a substantial risk to the safety of participants and, as for my own safety, it is doubtful that any other illness, apart from contagious conditions, would raise the issue of safety to the researcher in the way that mental illness did for the ethics committee in this case.

Rather than viewing potential participants as a ‘clinical’ population, I took the view that people diagnosed with mental illness talk to people in their daily lives, just like anyone else. Thus, I had not presumed that voluntarily taking part in an interview, from which they were free to withdraw at any time, would have posed a greater risk than that which they would encounter in everyday life. Concerns for participant and researcher safety must be tempered by the minimal risk or harm posed by consenting adults engaging in a conversation, the parameters of which have been mutually agreed in advance. Perhaps I should have included this comment in my ethics application.

My lack of clinical expertise

It seems that the ethics committee’s concerns about safety would have been minimised or alleviated by my assurance that I had training and experience in interviewing people diagnosed with a mental illness, or that a member of my panel had ‘clinical expertise’. I did not deem these qualifications necessary for the type of research I was proposing and I made it clear in my ethics application that my qualifications were in journalism. Potential participants would have been under no illusion that I had clinical expertise: I identified myself as a PhD student who also has personal experience of being diagnosed and hospitalised with a mental illness. I could not provide the ethics committee with the assurances of clinical expertise that they needed and nor do I think having this expertise would have automatically held me in good stead if breaches of safety were to arise.

Screening participants

The second major concern of the ethics committee is closely related to concerns about safety and my lack of clinical expertise and sheds more light on these concerns:

Participants need to be screened to ensure they are well enough to consent and participate. There also needs to be more back-up than telephone counselling if people who can potentially become unwell during the research procedures are participants in the research. Please clarify what provisions will be made to handle any emergencies. (University of Canberra Committee for Ethics in Human Research, 2005)

If one is unable to attribute a certain degree of agency to people who may have wanted to participate in an interview to be able to decide for themselves, then the ethics committee's need for screening would seem to be warranted. Similarly, if one takes the view that being diagnosed with a mental illness automatically means that a person is not competent to make decisions for themselves and therefore unable to give informed consent, then the ethics committee's need for screening is justified. If one believes that the risks of qualitative research with people who have been diagnosed with a mental illness are too great, then screening them out of participation may seem appropriate. I stated in the application that in the event that participants experienced psychological distress I would facilitate their access to a counselling service, other help source of their choosing, or put them in touch with the Mental Health Foundation, which runs various support groups and offers free telephone counselling. As I discuss shortly, I also stated that there would be no need for medical arrangements to handle emergencies and this may explain the committee's concern.

The first question about screening is, by whom? The need for screening potentially imposes a number of constraints on the research and raises questions such as what does "well enough to consent and participate" mean? Who is qualified to screen, and what is the purpose of screening? One assumes that this screening would need to be done in accordance with clinical criteria and would effectively be based on the subjective decisions of other people about potential participants. This could have meant that people interested in participating may have been deemed not well enough to consent merely because they did not comply with clinical or other third-party assessments. At the extreme, it could have meant everyone who volunteered to participate would be deemed not well enough on the grounds that they are, have in the past, or could be diagnosed with a mental illness. If participation were to be decided on the basis of third-party screening, perhaps it would be more revealing to interview the screener in order to determine the criteria for 'well enough'. But who would attest to their wellness to consent?

The need for screening implies that some people are likely to be deemed more suitable than others to participate in research. But who makes these judgements and what are the criteria? Is it fair or ethical to presume incapacity to consent across the board and therefore to impose screening on people purely on the basis of a diagnosis of mental illness? Who has the power/knowledge to decide who is and who is not worthy of voluntary participation? Any number of factors might influence a person's decision to participate in research, and the presumption that they are not well enough to do so poses a serious threat to their participatory efforts. The practice of screening a person who had already agreed to participate in an interview prior to the interview or during the interview is likely to be seen by the participant as questioning their capacity for self-determination, and is unlikely to bode well for the trust and rapport that is needed for a successful qualitative interview. It is ironic that a test widely used to determine capacity or competence to consent to participate in research, the MacCAT-CR, uses the method of a semi-structured interview to assess and rate the abilities of potential participants. According to Tee and Lathlean (2004):

Participants answer questions about their understanding of disclosed information about the research, appreciation of the effects of participation on their own situation, and their reasoning about participation and ability to communicate a choice. (p. 539)

One wonders about the potential harm and distress that these tests in themselves may create, particularly if they are imposed on people who attest to their own capacity to consent. The decision to seek a capacity to consent test may be based purely on a failure to agree with the doctor. So who decides whether someone is well enough to consent to be subjected to a capacity to consent test?

The concept of "well enough" in the committee's concern is difficult to define, and third-party judgements of potential participants as *not* well enough could potentially be based on anything from perceiving people as too vulnerable, too emotional, too angry, too resistant, too passive, or too much of a threat to the researcher. The ethics committee gave no criteria upon which this should be based, other than implying that it would be ensured by screening. In light of some of the fears that have been expressed in relation to the risks of qualitative research with people with "special vulnerabilities", such as being susceptible to negative mood states and depression (Hadjistavropoulos & Smythe, 2001, p. 172), it is quite feasible that no-one who volunteered would have been deemed well enough to consent to participate.

A study by Stanley, Stanley, Lantin, Kane and Schwarz (as cited in Tee & Lathlean, 2004) found that mental illness/psychopathology does not equate to impaired decision making capacity or incapacity to consent. Unlike the ethics committee, I did not question people's ability to volunteer to participate and I had expected that they would do so in accordance with their own values, just as they make other decisions in their everyday life. This is not to say that I would not have been sensitive to the importance of and need for participants to be able to give 'informed consent'. I certainly would not have agreed to interview someone, albeit in my non-clinical judgement, whose understanding of the project and the interview process and whose decision to participate I had the slightest doubt about.

Provisions for medical arrangements in case of emergencies

The ethics committee directed me to the section of the ethics application that asks:

Does the project create a need for medical arrangements to handle emergencies? If so, briefly describe the provisions that you have made for these arrangements.

The ethics committee could well be on solid ground with this concern because any research could create the need for medical arrangements and there is the potential that people may "become unwell" in any type of research. I could have told the committee that I would obtain my Mental Health First Aid certificate or that I would hire a space in a hospital or mental health facility, so that medical arrangements would be on hand. In hindsight, perhaps I should have assumed the worst-case scenario. I simply did not presume that the interview would create the need for medical arrangements, at least any more so than in everyday life. If something did go wrong or if there was an emergency I would have dealt with it. As mentioned, I had thought that allowing participants to choose the location of the interview would enable them to choose a place where they were comfortable or where a friend, family member or carer was available, if they felt they needed it. This requirement presumes medical arrangements to be the only solution to any emergencies or unforeseen events that might have arisen in the research. Surely emergencies could occur that are beyond the expertise of medicine. What if someone had a spiritual emergency, for example?

Recruitment processes

In relation to recruitment procedures the ethics committee said:

There are concerns about the recruitment processes, ie is it appropriate to recruit conference participants, and if so, a letter of approval would be required from the THeMHS conference organising committee. In terms of recruiting from the Mental

Health Foundation a letter of approval is also required and if they are providing access to people who have experienced mental illness it would be appropriate for them to provide screening and back-up support. (University of Canberra Committee for Ethics in Human Research, 2005)

I can accept that seeking approval from conference organisers in order to recruit conference participants would have been “appropriate”. However, I do not see that recruiting participants from a conference is in itself inappropriate or unethical. One of the purposes of conferences is to enable people to network and I may have met people who were interested in my research and who wanted to be involved. Contrary to the suggestion of the ethics committee, the Mental Health Foundation per se would not have been “providing access to people who have experienced mental illness”. I stated in the application that I would contact the Mental Health Foundation asking if letters of invitation to participate in the project could be distributed among the support groups it runs and I provided an attachment with the names of these support groups. I thought this a suitable avenue through which to advertise my research and seek participants. Beyond this, I did not envisage that the Mental Health Foundation would play a direct role in the recruitment process, and it is not clear how the ethics committee’s suggestion that the foundation could “provide screening and back-up support” would have worked in practice.

My personal disclosure

The final concern of the ethics committee related to the participant information sheet:

The Information Sheet needs to be written in plain English at the appropriate level for understanding by participants. The Committee believes it is not appropriate to include information regarding your other research activities and personal disclosure of mental illness on this Information Sheet. Please refer to the UC ethics kit for the Guide to Participant Information Form. (University of Canberra Committee for Ethics in Human Research, 2005)

While I can accept that it may have been inappropriate to include information about my other research activities, the suggestion that my disclosure was not appropriate begs the question of why and for whom - potential research participants, myself, the University, people who might read the findings of my research, or just the ethics committee? If the role of the ethics committee is to require deception in research, or to guard against a University associated research project being conducted by a person who has been diagnosed with a mental illness, in order to protect the image of the institution, then this concern would seem to have a basis. If ethics committees’ decisions are based on what is deemed to be appropriate or inappropriate rather than what is ethical or unethical, then this concern can be justified.

Similarly, if ethics committees deem that having a personal interest in a research project poses a conflict of interest that should not be disclosed, then there is a case for this concern.

My personal experience of being diagnosed and hospitalised for mental illness is integral to my research interest in this area and continues to affect my view of the world. As I stated in the Information Sheet, this experience has been a “major influence on my interest in exploring alternative ways of talking about and understanding what is constructed as mental illness”. This form of ‘positional reflexivity’ is a central precept of qualitative research and is essential to “identifying the discourses that have impacted on the lenses through which the researcher views the worlds and participants under study” (Grbich, 2004, p. 71). According to the *Human Ethics Manual*, the participant information sheet should contain sufficient detail to allow people to make an informed decision about whether to take part, and material suited to the project. Apart from meeting these criteria, it seemed natural to locate myself in this way.

Failing to identify myself in this way, in my view, would have been a form of deception given the impetus it provided for my research project. To this extent, my past experience of being diagnosed with a mental illness is appropriate and I do not see any ethical reasons why I should not have disclosed it. According to the National Statement, the guiding value for researchers is integrity, which is “expressed in a commitment to the search for knowledge, to recognised principles of research conduct and in the honest and ethical conduct of research and dissemination and communication of results” (National Health and Medical Research Council, 1999, p. 11). I have struggled to find an ethical basis, or any other reason for that matter, for this concern. The least sinister reasons are either that the ethics committee believed it would bias the interview data I obtained or my interpretation of that data. The more sinister reasons relate to protecting the image of the University. I will discuss these issues further, but for the moment it is sufficient to say that the deemed inappropriateness of my disclosure raises questions about what other kinds of disclosures the committee deems to be “not appropriate” and for what reasons. It also raises questions about whether the approval process is based on standards of appropriateness or ethics and, if the former, whose standards of appropriateness are used?

The ethics committee’s rejection of my proposal and the concerns they expressed were undoubtedly a source of frustration for me, as I was keen to embark on this aspect of my fieldwork as soon as possible. This letter of rejection was dated 10 February 2005 and if I

took the path of addressing their concerns by providing additional information, it would have been more than a month before the committee next met and even longer before I would get a response. And, even then, there would be no guarantee that my ‘amended’ application would have satisfied their concerns. The thought of going back to the committee after addressing and acquiescing to concerns that I myself thought were unfounded and discriminatory, was a path that I was not prepared to take.¹ I also believe that a stronger case can be made against the concerns than for them.

‘Ethics creep’: characteristics and consequences

I now reflect more broadly on the ethics committee’s concerns in the context of ‘ethics creep’ into the humanities and social sciences. I consider these concerns as indicative of the epistemological bias of ethics review and barriers to a shift away from the dominance of clinical knowledge structures toward a more inclusive agenda in mental health research.

Haggerty (2004) writes:

I support the concept of ethical research. That said, supporting research ethics in the abstract displays all of the moral fortitude of unconditionally voicing support for motherhood. As with all regulatory matters, the devil is in the details, and as I demonstrate, some of the details about regulation in the name of ethics should give us pause. (p. 393)

From a Canadian perspective, Haggerty examines the nature and consequences of ‘ethics creep’ based on his experience as a member of the Faculty of Arts, Science and Law Research Ethics Board (REB) at the University of Alberta. Aspects of his analysis, however, as he suggests, are germane to Institutional Review Boards (IRBs) in the US, and I would suggest to the equivalent Human Research Ethics Committees (HRECs) in Australia and Research Ethics Committees (RECs) in the UK. Haggerty uses the term ‘ethics creep’ to encapsulate the dual process by which the ethics regulatory system “is expanding outward to incorporate a host of new activities and institutions, while at the same time intensifying the regulation of activities deemed to fall within its ambit” (p. 391). Other terms that have been used to describe the expansive role of research ethics committees include ‘mission creep’, ‘ethics drift’ and ‘bureaucratic creep’ (Fitzgerald, 2004; Gunsalus et al., 2005; Shea, 2000; Social Sciences and Humanities Special Working Committee [SSHWC], 2004). Haggerty argues that researchers in the social sciences and humanities are currently witnessing the emergence of a

¹ For reasons unrelated to the ethics application my Primary Supervisor and supervisory panel changed. At this time I had already decided not to submit an amended ethics application.

host of new fetters on knowledge production endeavours that are constraining scholarly research and structuring what truths can be spoken and by whom.

Many researchers argue that the current framework guiding research ethics in academic settings is not equipped to assess and respond to qualitative and/or interpretive research proposals in the humanities and social sciences and thus it restricts this field of inquiry (Gunsalus et al., 2005; Haggerty, 2004; Israel, 2005; Kellehear, 1998; Lincoln & Tierney, 2004; Singer & Levine, 2003; SSHWC, 2004; Tolich & Fitzgerald, 2006). It has been suggested that most ethics committees lack knowledge and experience of qualitative methods (Fitzgerald, 1994; Lincoln & Tierney, 2004; Tolich & Fitzgerald, 2006) and that qualitative research approaches are disadvantaged when ethics committees tie themselves to the health/medical model of ethical decision-making (Ramcharan & Cutcliffe, 2001). From a US perspective, Lincoln and Tierney (2004) argue that the stances of IRBs have shifted to monitoring, censoring and outright disapproval of projects using qualitative research, phenomenological approaches and alternative frameworks for knowing and knowledge.

A fundamental shift in the role of ethics committees, from their original purpose of assessing the risks to human subjects and assuring informed consent to protecting the institution from damage, has been identified. Three contexts in which this trend has been particularly noted include externally funded research, student dissertation research (equivalent to postgraduate research in the UK and Australia), and qualitative methods taught for graduate students (Lincoln & Tierney, 2004). As Lincoln and Tierney argue:

It is not that the risks of most social science research have gone up; rather, it is that the scrutiny of such projects has increased exponentially. (p. 221)

As a result of this trend, research ethics committees are increasingly giving attention to liability and legal issues, risk management for the institution and the researchers involved (Fitzgerald, 2004; SSHWC, 2004) and other topics, which may not be of immediate concern or relevance to the participants or the researcher and the type of research being undertaken. It is suggested that ‘moral panic’, as a result of abuses in biomedical research, occurs throughout the ethics review process and creates a problem for non-medical researchers (Fitzgerald, 2005a; van den Hoonaard, 2001). One of the problems it creates is the ‘just in case’ tendency for ethics committees to base their decisions on hypothetical worst-case scenarios (Haggerty, 2004; Fitzgerald, 2005b; Fitzgerald, Phillips & Yule, 2006) and the

dictum of ‘better safe than sorry’ (SSHWC, 2004). Based on their ethnographic research on the ethics review process in five countries, Fitzgerald, Phillips and Yule (2006) describe this as the ‘what if’ (p. 390) narrative, which generates hypothetical scenarios that take on lives of their own in ethics committee meetings.

Haggerty suggests perceptions of risk, like harm, may be limited only to the imagination of members of ethics review committees and that there are questions about how the line separating minimal from greater than minimal risk in research is drawn in practice. It is difficult to predict the physical and psychological effects that participating in research will have on different participants, which introduces an “expansionist dynamic into the regulatory structure” (Haggerty, 2004, p. 401). Haggerty makes a distinction between risk as entailing consideration of empirical evidence about the likelihood of untoward events and efforts to manage the risks of social scientific research, which he says involves no consideration of empirical evidence of risk. This leads him to conclude that “pronouncements about ‘risk’ of research projects are more akin to a subjective imagining of potential scenarios unconstrained by empirical evidence” (p. 402). This introduces into the review process the criteria of hypothetical worst-case scenarios, and Haggerty says this means that researchers are being asked to mitigate a range of imagined harms precisely because it is not known how likely or unlikely they may be.

Some of the actual and predicted consequences of ethics creep are that it threatens academic freedom; constrains knowledge production; discourages and frustrates researchers; creates unnecessary work for ethics committees, and diverts their attention from the necessary scrutiny of biomedical research; and may result in refusals to approve research that poses any difficult questions (Becker, 2004; Chalmers & Pettit, 1998; Fitzgerald, 2004; Fitzgerald, 2005b; Gunsalus et al., 2005; Haggerty, 2004; Israel, 2005; Lincoln & Tierney, 2004; Nelson, 2003; SSHWC, 2004). Features of ethics creep are also underpinned by a view of researchers as the source of ethical problems and reviewers as having the unique responsibility and power to prevent these problems arising. There are also fears that the expansion of the ethics regulatory system may place particular restrictions on non-traditional, qualitative, or critical social scientific research, and make it easier to produce certain forms of knowledge as a journalist than a university affiliated researcher (Haggerty, 2004).

Two characteristics of ethics creep are evident in the concerns the ethics committee had about my proposal, and these will be my focus. These are the tendency for committees to base their decisions on protecting the institution, rather than participants, and to base their decisions on hypothetical worst-case scenarios. Moreover, the concerns of the committee reflect paternalism; maintain the ideology that the knowledge gained through clinical expertise and research is more 'valid' than experiential knowledge and qualitative research; and reproduce the illusion of disinterested, value free research.

Protects the institution rather than participants

It is difficult to make the case that ethics committees make decisions on the basis of protecting the institution rather than participants because what is in the 'best interests' of the university can be construed as being in the best interests of participants also. However, it is possible to identify some of the ways in which the ethics committee's role may be compromised. According to the *University of Canberra Human Ethics Manual*, the ethics committee exists "to protect the welfare and rights of participants of research". However, it is also categorised within the University committee structure as "a committee which assists in the management of the University". I suggest that this may pose conflicting priorities for the committee. What exactly does assisting in the management of the university mean? How expansive is the definition of what constitutes management? Does it extend to refusing to give approval to ethics applications that pose any difficult questions? Does it extend to rejecting research proposals that may possibly cause distress to participants, so as to protect the institution from any liability, which could be deemed to hamper the management of the university, or at least perceptions of its management?

The need for the University to protect itself from liability and to assist in the management of the University may explain some of the concerns the committee had about my research proposal. At the very least, I would suggest the ethics committee's primary role of protecting the welfare and rights of participants of research is compromised by its need to assist in the management of the University and that this may lead to a form of 'ethics creep'. Was the committee concerned about participant's safety, my safety, or keeping the reputation of the institution safe from headlines such as "University liable after mentally ill researcher kills mentally ill research participant: Research approved by University of Canberra Human Research Ethics Committee". While this is clearly a 'worst-case scenario', it could explain the

committee's concerns about safety, my lack of clinical expertise, the need to screen participants, and my disclosure of a past diagnosis of mental illness.

Reflects a tendency to base decisions on worst-case scenarios and imagined harms

It is important to acknowledge that most academic articles in the area of research ethics and mental illness focus on clinical and biomedical research. There are very few that deal with the ethics of qualitative research with people diagnosed with a mental illness, although there is a growing critique from within the social sciences and humanities of the role of research ethics committees more broadly. van den Hoonaard (2001) considers whether the rise of research ethics review is a case of a 'moral panic' (Cohen, 1987), which he says involves "exaggeration of harm and risk, orchestration of the panic by elites or special interest groups, the construction of imaginary deviants, and reliance on diagnostic instruments" (p. 25). It may be that the prevalence of interest in ethical matters in biomedical research, such as drug trials, works to the disadvantage of non-medical qualitative research, the risks of which are minimal compared to actual physical or psychological harm that can be brought about by biomedical procedures and experimental conditions (Corbin & Morse, 2003; Haggerty, 2004; SSHWC, 2004).

The committee had no reason to be concerned about safety in regard to the research involving any kind of human experimentation, the application of medical procedures, or the giving of drugs because the nature of the proposed research was a conversation. However, its concerns suggest that the research was deemed to entail more than minimal risk. In particular, the concern about the safety of participants and myself can be seen to exemplify the hypothetical 'worst-case scenario' aspect of ethics creep because there is no way of knowing the likelihood of risks to safety occurring. This concern, therefore, is based on imagined harms, not on any empirical evidence about breaches of safety in qualitative research with people diagnosed with a mental illness. Concerns about safety can clearly relate to any number of things, depending on the imagination of the members of the ethics committee, which is a product of prevailing discourses about mental illness in society: biomedical discourse and news media discourse, for example. The committee's concern about the safety of participants and myself reflects unfounded assumptions about the likely risks participants would have posed and the risks associated with non-medical, qualitative research.

The committee's concerns about safety of participants and myself, my lack of clinical expertise, and the need to screen participants to ensure they are well enough to consent may well be underpinned by the dictum of 'better safe than sorry'. These concerns also imply a limited perception of people in the community who have been diagnosed with a mental illness and/or who may have wanted to talk about their knowledge and experience of mental health and illness in general. It is as though the mere label of 'mental illness' raises alarm bells and ensures that tougher constraints will be placed on this kind of research compared to research involving, I would suggest, most other participant groups. In her research with current and former 'psychiatric patients' Morrison (2005) found that this group "raised a red flag with the IRB as a Special Subject Population of mentally disabled persons, who are historically at risk for research abuses and potential harm from participation as research subjects" (p. 30). The irony, she notes, is that while she was required to assure the IRB that research participants and the institution would not be harmed as a result of the research:

The ethical issues they revealed regarding both standard treatment and clinical trials with psychiatric subjects led me to wonder: Why were the relatively low risks of talking with me so carefully monitored, when so many psychiatric patients spoke about harmful experiences, both psychic and physical, that had occurred previously with no apparent protection and no means for redress? (Morrison, 2005, pp. 31-32)

It may be that 'moral panic' governs ethics committees' decisions about all kinds of research with this participant group as a result of the real potential for harm, and the difficult issues of informed consent, associated with biomedical drug trials in psychiatry. While 'moral panic' resonates with some scholars' experiences with ethics committees, I do not view it as providing the best framework within which to situate the ethics committee's concerns about my proposal. These concerns are best understood as reflecting deep-seated cultural assumptions about mental illness and the privileged status of clinical approaches to researching it. Do these assumptions constitute an ethical or fair basis on which to restrict people's citizenship rights and participatory efforts in non-medical qualitative research?

I now want to consider the case against the ethics committee's concerns in relation to the c/s/x movement and postpsychiatry's calls for a more inclusive agenda in mental health research.

Reflects unfair and unfounded assumptions about potential participants

While it is said that ethics committees should not generally be protective or paternalistic by rejecting research that poses risk to people who are competent to decide for themselves

(Edwards, Kirchin & Huxtable, 2004), the spectre of medical paternalism looms large if potential research participants are people who have been diagnosed with a mental illness. In relation to qualitative research with mental health services users, Tee and Lathlean (2004) found that one of the barriers to obtaining ethics approval is that “mental health service users often have to wrestle with the assumptions about vulnerability that others make, including those on ethics committees, based on limited understanding of diagnostic labels” (p. 539). Risk and safety considerations must be balanced against a person’s right to participate and the possible benefits that might ensue from participation in research (Singer & Levine, 2003; SSHWC, 2004). In the interviews I proposed to conduct participants may have spoken about thoughts and experiences that were a source of distress or discomfort, just as may occur in many research projects, in daily life and in doctor-patient interactions. But to determine that this possible distress or discomfort is a greater probability than the possible benefits of the research seems to reflect an overly pessimistic view, and may also undermine the participatory efforts of those it is intended to protect.

Failing to include certain people in research, on the basis of paternalism disguised as benevolence, can compromise research findings and the applicability of research (Wilson & Stanley, 2006). In order to satisfy IRB concerns about her research with current and former ‘psychiatric patients’ Morrison (2005) chose to interview only individuals who were presently working as advocates in the mental health system so “their capacity and competence would not be in question” (p. 31). While this decision may have satisfied the ethics committee, in my own research I did not wish to restrict participation to people who were working as advocates in the mental health system. Morrison says, “As I learned subsequently, the categorical term ‘psychiatric patient’ is constructed, fluid and more contestable than the IRB might have imagined” (p. 31). The terminology of “people with personal or indirect experience/knowledge of mental illness/health” that I used in my application also extends far beyond those people who work as advocates in the mental health system.

There is also a strong ethical argument for including those people in research who may be deemed not “well enough” to consent or “at risk” by a third party, but who themselves wish to participate. This can ensure that research processes and outcomes are relevant to people in similar situations, rather than primarily serving the interests and agenda of professionals, service providers, or the select group of people whose capacity to consent these same professionals do not question (Bracken & Thomas, 2005; Faulkner & Thomas, 2002; Telford

& Faulkner, 2004). Moreover, in a medical or health care context the presumption of incapacity to consent may equally be applied to a person who refuses to give consent, whether to treatment or to participate in research. Over-riding a person's consent, or refusal to consent, is an imposition on their human rights yet, as Morrison (2005) found in her interviews, this practice is common in psychiatry. Thus, it seems that informed consent for people who have been diagnosed with a mental illness is an empty rhetoric that, rather than being an "antidote to counter medical paternalism" (Corrigan, 2003, p. 76), functions to disguise medical paternalism.

There is no power as insidious as that which is exercised in the name of benevolence.

Prominent psychiatric survivor and activist, Judi Chamberlin (1998) writes:

The history of civilisation is, in part, the struggle against paternalism and for self-determination. People in power are always saying that they know what is best for those they rule over, even if those poor unfortunate individuals think they know best what they want. The powerful seldom cast their own motives in anything but benevolent terms. Rulers and slave masters like to think (or to pretend) that their subjects love them and are grateful to them, often having to ignore much evidence to the contrary. The struggle for freedom has always been seen by the powerful as a denial of the obvious truth of the superiority of the rulers. (p. 406)

The psychiatric survivor movement is particularly concerned about the way in which people's rights as citizens by virtue of a diagnosis of mental illness are denied by the presumption that they lack insight into their own experiences (Beresford, 2002a; Chamberlin, 1998). While denying the rights of people who have been diagnosed with a mental illness to participate in non-medical research is not in the same league as other human rights abuses sanctioned by a diagnosis of mental illness, it is certainly informed by and productive of the same discourses upon which these abuses are justified. Members of ethics committees are no different from the rest of us in that they too live in a world in which a diagnosis of mental illness functions to immediately devalue the person who receives it and to pathologise the very aspect of our selves – our minds – upon which so many rights and privileges in our society are based. The assumptions made about people who are diagnosed with a mental illness, including by ethics committees, are the assumptions that legitimate and reproduce these human rights abuses. The ethics committee's requirement that participants need to be screened to ensure they are well enough to consent and participate, while cast in benevolent terms, can be seen as a manifestation of paternalism and a threat to people's citizenship rights, including the right to

participate in non-clinical research; a right that is enjoyed by the supposedly ‘normal’. As David Webb said in response to the ethics committee’s concerns:

...us mad folk are having these conversations (I don’t like the word ‘interview’) all the time – and yes, there is risk in living in this world – but no, it is not OK for ethics committees to deny us this ‘dignity of risk’ that is a part of life that we are all entitled to. (personal communication, November 2, 2006)

Constrains non-clinical research

Each of the ethics committees concerns can be seen to place constraints on non-clinical research with people diagnosed with a mental illness and, therefore, to sustain the dominance of clinical knowledge structures in the field of mental health. The ethics committee’s need to be assured that I had specific training or experience in interviewing people diagnosed with a mental illness, or ‘clinical expertise’, fails to recognise the limitations of the knowledge produced through clinical research and the unequal power relations inherent in clinical encounters. The ethics committee’s framing of this concern implies that my assurances of clinical expertise would have lent credibility to the research proposal and alleviated concerns about participant and researcher safety. However, the distance created by expert positioning could have equally posed a barrier to the display of empathy and the need for rapport that is required for successful qualitative in-depth interviewing. It could also have made participants reluctant to talk for fear that their words would be construed within a diagnostic frame. The concerns of the ethics committee are consistent with the privileged status of evidence-based medicine and clinical knowledge structures in mental health research, one of the potential consequences of which is to unfairly restrict people who have been diagnosed with a mental illness to being the subjects of this kind of research.

Postpsychiatry (see Chapter One) requires thinking outside the medical model in recognition that many people who have been diagnosed with a mental illness reject medical accounts of their experiences as being limited, unhelpful and even harmful. It is argued that service user/survivor-led research and qualitative research with service users and survivors is important for countering the view that so-called evidence-based medicine is the only valuable knowledge in mental health research (Bracken & Thomas, 2005; Faulkner & Thomas, 2002; Laugharne, 2004; Lewis, 2006). Faulkner and Thomas (2002) argue that qualitative research is needed to shed light on some of the questions that are impossible for evidence-based approaches (such as random-controlled drug trials) to answer. Qualitative research is “ideally

suitable to the elaboration and description of personal experience and to establishing the meaning behind people's views and actions" (Faulkner & Thomas, 2002, p. 2) and it accords with the desire of many people to situate their experiences in social, cultural and personal contexts (Tew et al., 2006; Thomas & Bracken, 2004).

The ethics committee's concern about my lack of clinical expertise represents a potential barrier to researchers from humanistic disciplines bringing their insights, theoretical perspectives and methods to bear on mental health and psychiatric research. It is a barrier to cultural studies of psychiatry that would emphasise personal, social and cultural contexts readily glossed over by biomedical discourse (Cohen, 2000; Lewis, 2000). Thus, in order to include the knowledge of service users and survivors in research it may be that the requirement that a researcher has clinical expertise needs to be balanced against the recognition of the limitations of clinical discursive frameworks. This would require ethics committees to reassess the basis on which they make decisions about what kind of qualifications and experience is necessary in explicitly non-clinical research with people who may have been diagnosed with a mental illness. Having a diagnosis of mental illness, past or present, should not restrict people to only being able to participate in medical, psychiatric or psychological research conducted by people with these forms of expertise. Service users and survivors challenge dominant social and cultural assumptions that privilege clinical expertise over their own knowledge and experience. Given the problem of knowledge that mental illness is, are ethics committees justified in privileging 'psy' power/knowledge as the yardstick by which to govern research in this field?

Maintains the illusion of detached research and researchers

The decision of the ethics committee that my disclosure of having been diagnosed and hospitalised with a mental illness as a teenager was "not appropriate" meant that I could not provide an honest and reflexive outline of my research to potential participants. It is difficult to see how my disclosure could have caused harm to participants or myself, or in any other ways jeopardised the ethical conduct of my research. It seems to be purely a product of the objectivist-positivist origins and aspirations of the current ethical review framework governing academic research; a by-product of which is the illusion that academic research should be 'neutral' and 'value free', and that the knowledge gained through academic research should meet the standards of 'objectivity' and 'generalisability'. Current ethics

review standards leave little room for the type of reflexivity that is essential for good qualitative research, and intrinsic to the research I was proposing to conduct.

This is not to suggest that having been diagnosed and hospitalised with a mental illness qualifies me with any clinical expertise or experience with interviewing people diagnosed with a mental illness, but that it should *not* disqualify me from being able to openly undertake academic research in this area. Rose (2003) suggests that being able to use her own experience to review consumer perspectives on electroconvulsive therapy – a treatment she herself has undergone – did not compromise research rigour. From her experience with the Service User Research Enterprise (SURE) in the UK she says, while there may be a danger of being over-involved, “I don’t see this in our team any more than other professionals who are committed to their discipline” (p. 1331). In a similar vein, Telford and Faulkner (2004) argue “research undertaken from the experiential perspective should be at least as valuable and influential as research from the professional perspective” (p. 552). My personal experience would not have compromised the research any more so than research conducted by clinicians is compromised by their values, experience and the discourses through which they view research participants.

The ethics committee’s concern about my disclosure represents an attempt to maintain the illusion that the academic and the personal self are separate and that a scholar’s research interests are not influenced by their personal worlds. This is an illusion that is undermined by feminist, disability and postmodern perspectives and qualitative forms of inquiry, which call for greater self-reflection in research (Rhoads, 2003). This concern represents a barrier to overcoming the split between the academic self and the personal self and, as Bochner (1997) laments, “We pay a steep price for producing texts that sustain the illusion of disinterest and neutrality by keeping the personal voice out” (p. 436). As noted in the previous chapter, qualitative researchers stress the “intimate relationship between the researcher and what is studied” (Denzin & Lincoln, 2000, p. 8). Qualitative researchers, like many service user and survivor researchers, reject traditional research requirements of ‘objectivity’, ‘neutrality’ and ‘distance’, and critique the rational scientific basis of knowledge production (Barnes, 2002; Beresford, 2002).

It is significant that the letter from the ethics committee used the word “appropriate” four times in referring to its concerns, while the word “ethical” was not used once. A possible

explanation for this is that the aspects of my application that provoked concern failed to meet the standard of appropriateness, but did not actually meet the standard of being unethical. In relation to my disclosure, it may be that in taking up the position of a subject of psychiatric discourse, to use K. Phillip's (2006) terms, I violated the "bounds of decorum" (p. 316) that surrounded my prescribed subject position as a postgraduate student affiliated with a university. As K. Phillips says:

The integrity of a given subject position is maintained in large part through notions of appropriateness via decorum – the sense that given one's position one is entitled to speak in certain ways and about certain things, but also limited in these regards. (p. 316)

It could be argued that the use of ethics review to govern and proscribe the subject positions that researchers choose to take in the conduct of their research poses a serious threat to a person's ability to move between subject positions and, thus, challenge the illusionary divide between our academic and personal selves.

In my view, the key difference between appropriate and ethical is that ethical principles as they are inscribed in the National Statement that governs university ethics committees have been agreed to in a community consultation process. They have been shaped by history, and the reason so much weight is given to them is a product of the importance that our society places on ethical conduct, the protections it provides, and the potential forms of misconduct that it guards against. The National Statement pertains to ethical conduct in human research, not appropriate conduct, and using ethics review as a forum for making decisions about appropriateness raises questions about the basis on which these decisions are made.

Not only was my disclosure appropriate, it was also in no way unethical and, paradoxically, holding back this information could have constituted a form of deception and therefore unethical conduct. Did participants not have the right to know this information? Is it not appropriate to their decision to participate? Did the ethics committee view it as a potential conflict of interest, and if so, why did they view it as inappropriate to disclose? One might suggest that what is appropriate can also be seen as ethical and vice versa and what is unethical can also be seen as not appropriate and vice-versa. However, a form of conduct may be appropriate but not ethical. Similarly, a form of conduct may breach standards of appropriateness but not ethical standards and this, I suggest, is the case in regard to my personal disclosure. I would suggest that neither my own or potential participants' interests

would have been served by not disclosing a key motivation for my research. In the context of disciplinary constraints that control the way we write and impose a split between the academic and personal self, Bochner (1997) argues:

This is not so much an issue of standards – that is whether to have standards – but rather a question of which standards to have and whose interests are served by the standards that are accepted and upheld. What is excluded by the rules of conformity that discipline our writing? (p. 435)

One could similarly ask, whose interests are served by current ethics review standards and what do they exclude?

Ethics committees: governing research in the name of risk

Theoretical perspectives on risk, particularly the ‘risk society’ thesis and the governmentality perspective, can inform current debates about research ethics committees. Both of these perspectives alert us to the way in which risks are socially constructed. To say that risk is socially constructed is not to say that hazards and ‘bads’ do not exist but, rather, it is to forefront the way in which our assessments of risk are not objective, value-free and universal. This is in stark contrast to the techno-scientific perspective on risk – a realist position - employed in disciplines such as science, engineering, economics, medicine and epidemiology where risk is treated as a taken-for-granted objective phenomenon (Lupton, 1999). One of the problems with this approach is that it fails to account for lay frameworks of knowledge about risk and the fact that they frequently contest expert understandings and recommendations in accordance with their personal goals and sociocultural assumptions and values (Lupton, 1999; Mythen, 2004; Petersen, 2003; Wynne, 1991, 1996).

As discussed in Chapter One, for some theorists ‘risk’ has become a central organising principle in modern societies. Beck (1992) and Giddens (1994) characterise late modernity as the ‘risk society’ – a society not so much concerned with the distribution of goods (insurance, welfare), but the distribution of ‘bads’ (pollution, food contamination, medication side effects). Citing Beck, Haggerty (2004) suggests “concerns about the ethical quality of research are characteristic of a society where anxieties about the unintended consequences of science and technology are increasingly common” (p. 392). It is perhaps symptomatic of such a society that researchers have turned their attention to the workings of a system and a process that is targeted to risk management and avoidance – that of human research ethics committees. In relation to its concerns about my research proposal I have suggested that they

reflect a tendency for ethics committees to focus on the risks rather than the benefits of research. In accordance with the 'risk society' thesis, it could be argued that ethics committees embody the negative logic of 'bads' avoidance, rather than the positive logic of 'goods' acquisition (Mythen, 2004).

Foucault's concept of governmentality can also inform our understanding of risk and the role of research ethics committees. Foucault documented the emergence of a range of expert knowledges and "apparatuses and institutions built around the construction, reproduction, dissemination and practice of these knowledges" (Lupton, 1999, p. 4). The 'governmentality' perspective on risk focuses on the dominant discourses that "render risk calculable and knowable, bringing it into being" (Lupton, 1999, p. 6). The governmentality perspective does not deny that 'real risks' exist but posits that real/inert objects can only be deemed as hazardous as a result of our evaluations of risk, which Fox (1999) describes as "the likelihood of an adverse result from an incident" (p. 19). Petersen (2003) suggests governmentality studies can play an important role in rendering visible the ethical content of the particular "practices of self associated with contemporary forms of rule" (p. 188). In her work on risk discourse in the public sphere, Lupton (2005) argues that it "serves as an effective Foucauldian agent of surveillance and control that is difficult to challenge because of its manifest benevolent goal of maintaining standards of health" (p. 428). A similar argument could be made about ethics committees as governmental apparatuses that control and constrain our knowledge production endeavours in accordance with a research ethics framework inscribed with values that are inimical to certain ways of knowing. Moreover, ethics committees do so in the name of the benevolent goal of maintaining standards of ethics in research.

Ethics committees are primarily concerned with governing the conduct of research. In discharging this role they make assumptions about the nature of research proposals, potential participants, and the qualifications and expertise of the researcher. At each of these levels decisions are made about the likelihood of risks occurring and the strategies that the committee may advise researchers of in order to avoid such risks. Ethics committees privilege expert knowledges when it comes to assessing people's capacity to consent and researchers' qualifications for controlling risks. This is akin to a techno-scientific approach to risk and research, which assumes that expert knowledges will free us from the inevitable uncertainties of life and, in the case of research ethics committees, the dynamic process that is research that

involves people. To the extent that ethics committees tie themselves to the health/medical model of ethical decision-making, qualitative research approaches can be disadvantaged (Ramcharan & Cutliffe, 2001) and expertise by experience deemed inferior, subjective, anecdotal and value-laden - all the things that it is assumed expert knowledges are free of.

In contrast, Wynne (1991, 1996) argues it is critical to explore how perceptions of risk are constructed by 'situated' knowledge and how decisions about risk are managed at the local level – of the individual, the personal and the intimate. My view of the risks associated with the research clearly differed from that of the ethics committee, as may have the views of potential participants, and this exemplifies the situated nature of risk perception. However, the ethics committee aligns its perception of risk to the expertise of clinical knowledge by implying that this 'expertise' would alleviate its concerns about risk and safety in the research. In turn, its concerns fail to recognise the 'situated' nature of risk perception and decision-making about risks. This approach is also underpinned by an assumption of 'rational' decision-making, whereby those who are deemed to not have such capacity are denied the opportunity to make decisions for themselves; in this case, people who may have been diagnosed with a mental illness. As I have suggested, the ethics committee's concerns about the wellness of participants to consent to participate can equally apply to any research participants on any research topic. This view is confirmed by Ells' (2003) discussion of the problems with current understandings of informed choice in the context of Foucauldian thought: "What Foucault's analysis makes problematic is the very assumption that choices can be voluntary, or more specifically, that influences might not determine the outcome of choice in typical informed choice contexts" (p. 220).

Conclusion

This chapter examined the concerns of a university ethics committee in response to my proposal to interview people who may have been diagnosed with a mental illness, as part of my doctoral research into how they talk about their experiences. It is important to recognise the limitations of the analysis and discussion provided. Firstly, it is limited in that I did not seek clarification or substantiation from the ethics committee about its concerns, particularly my personal disclosure. For all of the other concerns I can accept, albeit reluctantly, that the ethics committee was carrying out what it saw as its duty and responsibility in accordance

with the National Statement. But I continue to struggle to understand the basis for the concern about my disclosure.

My analysis is also based on the concerns of only one ethics committee, in response to one ethics application at one moment in time and, thus, it has not been my aim to generalise these concerns to other ethics committees. I do note, however, that recognition of the different levels of risk involved in medical compared to humanities and social science research is evident in the ethics approval procedures in place at other Australian universities. Some of these include the University of Melbourne, the University of Queensland, the University of New South Wales (UNSW), the University of Tasmania and the Australian National University (ANU), which is based in Canberra. Unlike the University of Canberra, which has one HREC that is responsible for reviewing research proposals from all academic disciplines, these universities have implemented different types of school level review for those applications that involve minimal risk to participants. The small size of the University of Canberra relative to these other institutions may explain why it only has a single tier ethics review system for all research involving humans, even that which may entail minimal risk. I recognise that the opportunity to compare my experience with the ethics committee to other researchers' experiences, particularly in relation to research with people diagnosed with a mental illness, would make my analysis more complete.

The observation that other Australian universities have distinct disciplinary panels confirms that there are different ethical issues raised by medical research and research in the humanities and social sciences, and that imposing the standards of the former on the latter may not be in the best interests of ethics committees, researchers and the ethical conduct of research. Nonetheless, Haggerty's (2004) discussion of ethics creep is based on his experience as a member of a Research Ethics Board specific to the Social Sciences and Humanities, which suggests that even within a disciplinary specific ethics committee ethics creep can be a problem. In an Australian context, Israel (2005) says that the working party set up to review and revise the National Statement included only five people with a social science and humanities background, and he argues that if the National Health and Medical Research Council were serious about creating a general framework for research ethics, it would not use a biomedical base as its starting point.

In response to the epistemological assumptions that explain why qualitative research does not fit the dominant paradigm that governs ethics committee thinking, some researchers have proposed new formats for ethics review (Tolich & Fitzgerald, 2006; van den Hoonaard, 2001). On the basis of the discussion I have provided in this chapter some procedures for ethics committees to consider when reviewing qualitative social research and, particularly, research proposals involving people diagnosed with a mental illness are proposed. These pertain to the need for ethics committees to:

- Recognise the limitations of the biomedical paradigm for reviewing qualitative research proposals from the humanities and social sciences, in which the roles of researcher and research participant are often blurred and in which the unequal relationship between researcher and research 'subject', as found in biomedical research, does not apply.
- Shift the balance of ethics review away from its current focus on potential risks in research and liability to the university, in accordance with a worst-case scenario mentality, toward the likely benefits of research participation and the value of the knowledge obtained through qualitative research.
- Substantiate the ethical basis of their concerns, particularly in regard to potential harm to participants, rather than merely express them as a concern.

These suggestions accord with those that have been made by other researchers. On a general level, van den Hoonaard (2001) suggests that rather than reviewing research proposals from the perspective of 'universal' moral codes, ethics committees should look at them from the perspectives of those being studied. It has also been suggested that the concept of minimal risk should be replaced with that of 'identifiable harm', which would require clarification of which 'harms' in the social sciences and humanities might warrant attention (SSHWC, 2004). This would put the onus on ethics committees to substantiate and justify concerns about risks and harms that are not readily identifiable either by the researcher or people who are willing to participate or to whom participation is open, which would be an improvement on protecting people in two-people talking situations from 'imagined harms' (Gunsalus et al., 2005).

In relation to mental health, Tee and Lathlean (2004) suggest the inclusion of more qualitative researchers on ethics committees might help overcome the biomedical domination of mental health research, which is seen as responsible for a lack of research into what is important to

service users. They also say “there is a strong argument that groups of mental health service users should be routinely involved and consulted during ethics approvals procedures” (p. 542). Likewise, Townend and Braithwaite (2002) say the quality and relevance of student dissertation proposals at the program in Community Mental Health at the University of Birmingham has been improved as a consequence of the Local Area Ethics Committee (LREC) membership comprising fifty percent service users. In the context of my research orientation toward reading psychiatry against the grain I propose that ethics committees must also:

- Recognise that there are alternative perspectives in conducting any research, including with people who have been diagnosed with a mental illness.
- Invite consumers/survivors/ex-patients, c/s/x academics or researchers, advocates and/or carers to provide their point of view in the review of research of this kind. This would increase the credibility of the ethics committee’s decisions.
- Recognise that a psychiatric diagnosis does not automatically mean that research participants require special treatment in the form of ethical provisions, and that this assumption is the antithesis of inclusive, emancipatory and participatory models of research.
- Recognise that people who volunteer to participate in research should not be treated any differently to other research participants purely on the basis of a current or past diagnosis of mental illness, and that questioning their decision-making capacity to volunteer for research is a violation of their human rights.
- Recognise the magnitude of the c/s/x movement locally and internationally and be informed by their human rights agenda in all decisions that they make about people who have been diagnosed with a mental illness.
- Recognise that harmony does not reign both inside and outside the psychiatric and mental health community about the status of mental illness and the most desirable methods for understanding it.

Each of these points of recognition could be accommodated within the existing ethics review framework to counter its epistemological bias and I suggest that doing so would make the process of ethics review itself more ethical. Additionally, ethics committees should be aware of alternative ways of thinking about ethics. Thomas and Bracken (2004) say Foucault’s

conceptualisation of ethics as a sensibility to Otherness, rather than a system of rules or codes to be followed slavishly, is the most important feature of his work for postpsychiatry. This sensibility accepts that the “generation of knowledge is not ethically neutral but at every step involves implications for other people” (p. 369). According to Bracken, Giller and Summerfield (1997), postmodern ethics involves a concern not to impose order on the world but to allow the emergence of other voices and visions even when this involves increasing complexity and ambivalence. A similar orientation is found in Denzin’s (1997) feminist communitarian ethics, a model in which participants have a say in all aspects of the research. Clearly these alternative approaches to ethics cannot be accommodated so long as people’s right to make decisions about their own lives is denied and so long as ethics committees are more concerned with protecting the university than with enabling us as communal beings to engage in dialogue with one another. Changing the way we think about ethics involves more than making tokenistic concessions to qualitative researchers, it involves changing the way ethics committees think about what research is, what it should be, and what it can be.

