MAD SCIENCE:
DISCOURSES OF ‘SCHIZOPHRENIA’
AND ‘THERAPY’ FOR HEARING VOICES

Michael John Wise

School of Psychology

This thesis is presented for the degree of Doctor of Philosophy, Murdoch University.

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

.............................................

Mike Wise
Science must begin with myths, and with the criticism of myths.

Popper (1957) Philosophy of science.
In C. A. Mace (Ed.) *British philosophy in mid-century*

...people aren’t crazy for thinking that other people control their minds. That could not be a source of their craziness. That could only be a matter of wisdom.

Sacks (1992) *Lectures on Conversation*, vol. 1, p. 401
ABSTRACT

People who are diagnosed with ‘severe mental illness’ experience some of the most extreme and pervasive prejudice of all groups in Western society. How can this still be so?

Although the term ‘mental illness’ is typically reserved for the most ‘serious’ of ‘cases’, psychiatry’s medical model is expanding into increasingly everyday realms. Thus, in concert with efforts to reduce social stigma, ‘mental illness’ is becoming ‘normal’. Nevertheless, ‘abnormality’ is a requirement of biopsychiatry and its offshoots; professionals require some ‘thing’ to remedy. How do ‘clinical’ professionals manage these tensions? And what alternatives are there to the pathologizing of such phenomena? Such concerns are considered in relation to my main thesis question: How do professionals represent ‘schizophrenia’ and hearing voices in theoretical texts, and how is that played out in the minutiae of therapy practices?

Drawing on discourse analysis and conversation analysis, I critique professional categorizations of what are typically known as ‘schizophrenia’, ‘mental illness’, ‘patients’, ‘clients’, and ‘therapists’. My case in point is the experience of hearing voices - pathologically known as ‘auditory hallucinations’. ‘Delusional’ beliefs are also considered.

In Part 1, accounts of voices as supernatural or ordinary phenomena, or as a ‘symptom’ of ‘severe mental illness’, are considered. Mainstream psychiatric and psychological texts are analyzed and critical alternatives are summarized.

In Part 2, a selection of studies of interactions involving ‘severe mental illness’ are reviewed and ongoing analytic/methodological debates are discussed. A cognitive-behavioural therapy group for hearing distressing voices then provides data from
‘clinical’ talk-in-interaction for analysis. I focus on negotiations of ‘reality’ (the ordinary versus the psychiatric) and on what I take to be sanist prejudice-in-action.

Part 3 relates findings from Part 2 to the context and findings of Part 1. There is also discussion of the positive implications of a more social and dialogical approach to understanding and otherwise dealing with the phenomena in question; for voice hearers, ‘schizophrenics’, and society at large.
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PREFACE

This thesis is centred on the contemporary depiction of hearing voices and ‘schizophrenia’ in psychiatry. The project began as a quantitative study of a cognitive-behavioural therapy group for people who hear distressing voices. Having recorded rich audio data, the project soon became a discourse analytic study of the ‘therapy’. Before long, the focus widened to representations of hearing voices and then to representations of ‘schizophrenia’, including some consideration of ‘delusions’. What began as the dissertation component of a coursework clinical psychology Masters, became a professional doctorate in psychology, and settled into a PhD with interdisciplinary interests. Hearing voices remains the main focus.

People who are diagnosed with any ‘severe mental illness’, especially ‘schizophrenia’, remain one of the most maligned and powerless groups in Western society. We shall see how representations of ‘mental illness’ and ‘mental wellness’ are mutually constitutive of patient and therapist identities; of certain social power relations. I aim to explore and address some of these issues; to explore the need for dialogue and cross-fertilization between psychologically, socially, and psychiatrically orientated disciplines and between professionals and the people who, arguably, have most expertise with the phenomena in question. I also aim to evidence a few ‘home-truths’ concerning psychiatry and psychology. Criticism from within a discipline can sometimes be more powerful than from without.

But why is this dissertation so critical? As Popper (1957) noted, critical analysis may be defined as the informed examination of what is generally assumed, simply, to be. This is a worthwhile project for any topic. It is doubly worthwhile when examining an area which is so dominated by one point of view: biological psychiatry. Critical
analyses of positive practices of psychiatry and therapy could constitute many more studies besides.

At its broadest, this study concerns what people often refer to as ‘mental illness’, of any type. It is also an example of the blending of certain analytic modes; the critical, membership categorization, and the discourse analytic. First and foremost, however, this study is about analyzing the construction of hearing voices and ‘schizophrenia’. Hearing voices is a reported phenomenon which need not be considered a part of ‘mental illness’, whatever the context of that experience. I take it that, to a large extent, our representations of the ‘symptoms of mental illness’ affect how we otherwise deal with such experiences and how we deal with those who experience them. Language is seen, here, as the most pervasive form of social inter-action. All words, such as ‘mental illness’, perform social actions; they do not simply represent objects or communicate thoughts between people (Potter, 1996). How we represent ‘mental illness’, like everything else, is not a given, not an absolute.

I would have liked this research to have been ‘schizophrenia-free’ (Boyle, 1990). Unfortunately, despite being scientifically untenable - in current, biologically skewed forms, at least - ‘mental illness’, ‘schizophrenia’, and their progeny continue to function for their protagonists. Therefore, I have chosen to study ‘schizophrenia’ and the ‘symptoms of psychosis’ as a major, institutionalized context for people who hear distressing voices. Furthermore, although I tend to privilege first-hand accounts of these perplexing phenomena, I focus on critiquing professional accounts as a way of highlighting current practices and promoting positive social change.
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An earlier version of a portion of Chapter 6 was co-presented with Mark Rapley as *Hearing voices: Institutional and ordinary talk in the negotiation of ‘reality’*, at Orders of Ordinary Action, the International Institute of Ethnomethodology and Conversation Analysis conference, Manchester Metropolitan University, UK, July 2001. The present chapter were co-written with Mark Rapley.

An earlier version of a portion of Chapter 7 was presented as *The production of prejudice: Voice-hearers, therapists, and the mad*, at Talking Race and Prejudice, the Murdoch Symposium on Talk-in-Interaction, Murdoch University, December 2001.
PART 1. A CONCEPTUAL LANDSCAPE


CHAPTER 1.  PROLEGOMENON

In concluding their devastating analysis of the medical model of ‘schizophrenia’, Sarbin and Mancuso suggest - and of necessity I quote at length - that the strength of the ‘concept’ lies in its *mythic* nature:

> When people (scientists or laymen) encounter events for which they have no ready-made linguistic form ...they make use of a metaphor from another universe of discourse. They select a term that captures similarity but at the same time contains the connotation of difference. Under specifiable conditions (Chun & Sarbin, 1970) a metaphor may be literalized. Such reification may expand to become a myth. Phlogiston, animal magnetism, and ether were once lively metaphors.

...the unicorn is a mythical beast. Defined in this way, the unicorn is an apt metaphor for schizophrenia. Both schizophrenia and the unicorn share membership in the class *mythic entities*. The reader is urged to dwell on this conclusion while reading Rilke’s (1949) sonnet on the unicorn.

> This is the creature that has never been.  
> They never knew it, and yet, nonetheless,  
> they loved the way it moved, its suppleness,  
> its neck, its very gaze, mild and serene.  
> Not there, because they loved it, it behaved  
> as though it were. They always left some space.  
> And in the clear unpeopled space they saved  
> it lightly reared its head, with scarce a trace  
> of not being there. They fed it, not with corn,  
> but only with the possibility  
> of being. And that was able to confer  
> such strength, its brow put forth a horn. One horn.  
> Whitely it stole up to a maid, to *be*  
> within the silver mirror and in her [p.95].

(Sarbin & Mancuso, 1980: 222-223; original emphasis)

‘Schizophrenia’, then, has gone from disease metaphor to acceptance as a biopsychiatric entity, despite a lack of evidence. That is, ‘schizophrenia’ is an unexposed myth. Sarbin and Mancuso take Salzinger’s (1973) comparisons between ‘schizophrenia’ and the
unicorn at face value and, in doing so, point to the irrationality of believing in either. It is, therefore, in keeping with researchers such as Sarbin, of great concern to note that ‘schizophrenia’ is more than a storybook ‘unicorn’. ‘Schizophrenia’ is like the ability of mediums to speak with the dead; an ability in which some people report earnest belief, despite a lack of empirical evidence. But ‘schizophrenia’ is more than that. ‘Schizophrenia’ is like UFOs; mythical to some but deemed tangible by others. Yet ‘schizophrenia’ is also more than all of these. ‘Schizophrenia’ is widely considered to be, principally, a physical manifestation in the lives of many; largely devoid of social context. All of these ‘things’ belie the fact that ‘schizophrenia’ and ‘mental illness’, demonstrably, are morally based, mechanistic, social constructions of ‘deviant’ behaviour (for ‘schizophrenia’, see also Boyle, 2002a & b). The psychiatric industry rests on ‘schizophrenia’ and ‘mental illness’. Unwanted conduct is medically managed via this morally based, reductionist construct.

Quoting once more from Sarbin and Mancuso:

...To demonstrate the mythic character of a concept is not to make light of the events presumably illuminated by that concept. The woman who reports that her husband forces her to enact the role of prostitute is not a myth.

Because they have utility, myths must be taken seriously. The student of myths is enjoined to ask detailed questions about their utility. The prime question is: Whose interests are served by the individual or collective actions guided by a particular myth?

(1980: 221)

I take it that such an approach poses two important and related questions, neither of which deny people’s reported experiences (distressing or otherwise): ‘How is the myth of ‘schizophrenia’ perpetuated?’ and ‘What are the costs and benefits of this scientific delusion and for whom?’. This thesis represents a partial attempt to address these issues via a close examination of both the professional literature’s consolidation of the
‘concept’, and the policing of normality under the guise of the provision of therapy for victims of the ‘disease’.

SECTION 1. ANALYTIC CHOICE

This dissertation is based on analyses of talk and written texts. In keeping with the allusion to ‘mad scientists’ in the main title, I critically examine discursive representations of ‘mental illness’ which involve professions which are based, purportedly, on science. I use the terms ‘representation’ and ‘categorization’ more or less interchangeably. Both have an epistemological and an action orientation (Potter, 1996: chap. 4). That is, both terms involve social action. This is a departure from standard social and clinical psychology.

Within these bounds, the example to which I keep returning is accounts of hearing voices, within and without the problematic ‘concept’ of ‘schizophrenia’. I am seeking an answer to the question of how people represent hearing voices and ‘schizophrenia’ - and, therefore, the accountable and massively occurring issues of reality and sanity - in certain psychiatric texts and in group therapy talk about hearing distressing voices. How

1 It is no simple matter to choose between terms such as ‘schizophrenia’, ‘symptom’, ‘mental health’, ‘mental illness’, ‘mental wellbeing’, ‘psychiatric diagnosis’, hearing voices, ‘delusions’, etc. Each category has its own varying functions in the examined texts and in my own. I tend to place terms such as ‘schizophrenia’ and ‘symptoms’ in inverted commas, to indicate that they are in some way problematic and/or to draw attention to them as constructions. In contrast to ‘schizophrenia’, I typically do not place the term ‘patient’ in inverted commas because the people in question are so often treated like patients, rather than, say, ‘clients’ or ‘ordinary people’. Nor do I generally place the term ‘hearing voices’ in inverted commas, since this term is generally not so problematic.
is the dominant psychiatric ‘point of view’ constructed?\(^2\) How are other ‘points of view’ about hearing voices and ‘schizophrenia’ constructed? And how do these perspectives relate to each other and interact? That is, my focus is on the participants’ concerns (ie, the action-evidenced concerns of those who are locally present) of the reality/truth of professional knowledge and ‘psychotic’ experience(s). Either directly or by implication, this thesis is concerned with the sanity status of those involved; it is concerned with privilege and prejudice, in so far as they are embodied in talk and text. These are not concerns which I have simply made up; I aim to show that they are issues which are present within the various texts under scrutiny.

It may be worthwhile providing a brief introduction to methods at this stage. My analyses utilize or are inspired by the data-driven qualitative methods of discourse analysis (DA: Potter & Wetherell, 1987; Wetherell & Potter, 1992; Potter, 1996; ie, the Loughborough school of discourse analysis/discursive psychology), conversation analysis (CA: Sacks, 1992; ten Have, 1999), and membership categorization analysis (MCA: Sacks, 1992; Antaki & Widdicombe, 1998).

The above qualitative approaches may all be seen as having grown from ethnomethodology. Ethnomethodology has been described by Garfinkel, its pioneer, as the systematic study of practical action (2001). A breakdown of the term ‘ethnomethodology’ confirms this definition as the study of (ology) people’s (ethno) actions (method[s]). Thus, EM is a set of overarching interests and principles rather than a specific methodology. This general approach has been adopted, merged, and developed within a number of academic disciplines. The abbreviation ‘EM/CA’ is

\(^2\) I acknowledge that what I call the ‘professional’, in this case ‘psychiatric’ or ‘medical’, ‘point of view’ might also be meaningfully considered as an amalgam which is (co-)constructed from a number of complimentary and disparate expressed ‘points of view’ or ‘frames of reference’. However, for convenience, I refer to this as simply the psychiatric ‘point of view’.
sometimes used (with or without a slash), reflecting the close relationship between EM and CA.

In so far as much of the data presented in this dissertation involves psychological issues, many of my analyses operate within the scope and methodological framework of discursive psychology (DP: Edwards & Potter, 1992; Edwards, 1997; Edwards & Potter, 2001; and especially Edwards & Potter, 2004). DP is the application of discourse analysis to issues which are either explicitly identified as psychological or which are psychological by implication. DP analyzes the form and function of professional and lay accounts of people’s actions (ie, of behaviours within a social context), without the analysis itself making use of mentalistic explanations.

Although they are rhetorically useful, mentalistic accounts are seen in discursive psychology as circular (ie, not provable and therefore not a good basis for an empirical endeavour). For example, a psychologist might describe a person’s behaviour in terms of ‘cognitions’, yet they can only ‘examine’ their subject’s ‘mind’ via the person’s behavioural responses to stimuli (including verbal or written questions; even if the person is, say, under hypnosis). That is, ‘cognition’ does not exist independently of the term’s use. In that representational, get-at-able sense, presumed internal events are not in any way real before, beyond, or without social action.³

The same circularity conundrum is present in typically unvoiced objectivist assumptions about the description/representation of so-called external objects. As Potter puts it:

³ When I use the term ‘representation’, here and elsewhere, I do not mean to imply an objective representation of Reality. Rather, I mean a re-presentation of a version of reality. This assumes that any representation can only ever be a social presentation/construction, and that, far more often than not, such a ‘thing’ is more of a re-presentation than an ‘original’. 
To judge whether a description was mirroring or constructing reality requires the description to be compared to the reality. Yet reality (or ‘reality’) cannot enter this debate except as another description, which would beg the question of whether this new description is itself descriptive or constructive.

(1996: 98)

This metaphorical mirror (ie, language) is murky and pitted enough in relation to ‘reflecting’ external objects, without the added problem for internal subjects/objects of them being supposedly initially located in our opaque heads/minds. It is a problem cubed when professionals and academics present themselves as being able to measure and categorize mental states without such circularity just as they purport to do for external objects. As Edwards (1997: 107) describes, there is an underlying assumption of some kind of direct transmission between minds.

Discursive psychology side-steps these issues, preferring to launch from a theoretically firmer foundation. DP holds that social construction is an integral part of all representation. Its scope, therefore, need be no narrower than any other empirical approach. Indeed, empirical texts themselves can, reflexively, become a topic of analysis.

Discursive psychology includes the study of the form and function of psychological accounts, wherever they occur; eg, within the discipline of psychology and within everyday talk and texts. It includes both accounts in which psychological issues are topicalized and accounts in which such issues are not the topic of conversation but where psychological constructs are invoked. The approach does not hold that accounts involving mental constructs should be considered over and above other discursive actions. Rather, it holds that psychological accounts are of analytic interest because they
are commonly evidenced Members’ concerns. This is the case in everyday talk and is particularly so in the discipline of psychology.

The conceptual analytic approach (critical analysis) which I use most in early chapters on texts about ‘schizophrenia’, I owe to Boyle (2002 a & b), who relentlessly unpicks many hidden assumptions and representational practices which have gone into building the historical and modern construct of ‘schizophrenia’. Indeed, Boyle argues that ‘schizophrenia’ does not even satisfy the basic requirements of being a scientific concept.

The dialogical (and not pathological) approach to hearing voices which underlies much of this dissertation, I owe to Leudar, Thomas, and colleagues (see Leudar & Thomas, 2000). This approach considers the dialogical bases of hearing voices and dealing with voices: how the self may be organized dialogically, how voices and voice hearers dialogue, and how voice hearers and others dialogue. That is, following Leudar and Thomas, I ask (a) what voices can do with words, and (b) is it likely to be helpful for a distressed voice hearer to talk about disturbing voices experiences with another person and under what circumstances? The pragmatic aspects (ie, functions) of voice-related talk are very much at issue here. (To a lesser extent, from a conversation analytic perspective, the form of talk is also considered).

In my use of these approaches, I take a social constructionist and relativist stance in which there is no one, objective, Reality (Edwards, Ashmore, and Potter, 1995; Potter, 1996). There are no simply out-there distinctions between any given fact or fiction. Rather, there are versions of reality/truth/facts which cannot be brought into being without social action. Descriptions are taken as being constructive of a version of the

4 In the tradition of conversation analysis, I tend to capitalize the ‘M’ of ‘Member’ to distinguish a Member of the conversation-having community/culture from, say, family members or members of a therapy group for hearing distressing voices (who are, nevertheless, also Members).
world as ‘real’ and not as being simply, unproblematically, descriptive of the world which is real.

Many people find such positions ludicrous, challenging, or ‘fine at the time, on a certain academic level’. Pollner’s (1987) ethnomethodological work on mundane reason bears on this:

The assumption of an ‘out there’, ‘public’ or ‘objective’ world is a central feature of a network of beliefs about reality, self and others which comprise what I shall call mundane reason. For most contemporary Western adults, the assumption of an objective reality is virtually self-evident (and thus truly mundane). Yet a tradition of philosophical scepticism, Eastern epistemology, phenomenological investigations, certain ‘pathological’ experience and what some purport to be the cutting edge of physics (O’Flaherty, 1984) suggest that the epistemology and ontology implicit in every and scientific discourse is historical, contingent...

(x; original emphasis)

Pollner’s book is concerned with examples of how people systematically work to maintain a shared sense of the world being objective and orderly. Although I shall not present examples in this introduction, there is much work to be done in producing a matter-of-fact, bottom-line, incontestable reality, and to pull it off as if no such work needs doing:

When mundane inquiry reaches out for the ‘real’, it is confronted by a paradox: the real is precisely that which is independent of its ‘grasp’, and yet it is available only through some sort of grasping. The ‘facts’ of the ‘case’ for a judge, for example, are features of the world and are thus independent of the manner in which they are made observable. Yet, the facts are only available through a situated course of talking, pointing, representing, perceiving or thinking. Mundane inquiry, in its concern for the real, attempts to transcend the particularity and situatedness of its concern, and yet it is always situated, always particular.
Under this analysis, what is assumed to be the objective, somehow ‘becomes’ immediately the subjective, whenever people are in any way involved (experiencing, representing, and the like). Of course, one does not have to identify oneself as a relativist (and I am not clear to what extent Pollner, or his “judge”, does) in order to find this dissertation of interest (as I hope Pollner would).

As this introduction to DP suggests, the approach takes a specific stance towards the ‘mind’ and its relation to reality and language. There may be three distinctive stances on this relationship. First, there is a realist position in which one may aim for an increasingly accurate and objective understanding of things in the external, real world. Similarly, one may aim for an objective understanding of how such things are represented ‘mentally’ and then re-presented in some form of external text. Here, one assumes that there is a passage between the external world and an individual’s inner world, and between that inner world and the inner world of others, which can be, at least potentially, unaffected by social factors. This is what Edwards (1997: 107) describes as some kind of transmission between minds, or ‘telementation’ (Taylor & Cameron, 1987).

A second stance, is where “mind is ‘socially constructed’ ontologically” (Edwards, 1997: 47). Here, mind is real and it is built through the internalization of actions in the social, real world (as it was for the developmental psychologist, Piaget). Much of cultural psychology and some branches of discourse analysis have such realist, cognitivist underpinnings.

A third stance on the relationship between language, cognition, and reality is what Edwards describes as “epistemic constructionism” (1997: 48). This is the principal position of discursive psychology, and one which I adopt throughout my dissertation. Discursive psychology is about how psychological issues are constructed as and through
descriptive social action. It is not about how such social action influences the mind (and in that way construct it), as in the second stance. Nor is it about how the mind influences social action, as befits the first stance.

I have positioned the Loughborough school of discourse analysis and discursive psychology as being relativistic. Yet, such a position does not require relativistic fence-sitting. All arguments can be judged according to their merits; according to whether or not they are convincing. Relativism does not require an ‘anything goes’ approach; it does not require political or moral inaction. Indeed, it is a powerful lever against realist positions that something, anything, “has to be taken as merely, obviously, objectively, unconstructedly, true” (Edwards, Ashmore, & Potter, 1995: 39). As such, it can very much be a tool for positive change. That is, relativist, social constructionist criticism can be constructive as well as de-constructive. Thus, the following questions are pertinent to this dissertation. How do the various accounts relate to voice hearers and to people diagnosed with ‘schizophrenia’? What social action is achieved via these accounts at micro (local) and macro (societal) levels? How might things be done differently? And, when judging between such factual versions, what versions of ‘reality’ do you uphold and under what circumstances?

Discourse analysis, in particular, is concerned with how and what questions, such as, ‘How is discourse constructed to perform what social action?’. That is, the ‘structure and function’ of any given piece of discourse is the topic of analysis. DA holds that all talk and text is systematically action-orientated, within a range of normative, culturally available options (ie, mutually held, understandable, analyzable, but more like guidelines than rules which must be followed). (And, in the case of hearing voices, the discourse may, perhaps optimally, be dialogical; between the voice and the voice hearer and between the voice hearer and other people). Thus, all talk and text is discourse; between participants, actual or potential. Words do not neutrally reflect Reality. A
neutral, objective Reality does not exist. Versions of ‘reality’ are constructed from words (and other forms of representation) which are selected from a range of culturally available options. Words perform certain tasks - just as the words on this page are presented to argue my position from a rational ‘point of view’ and as this confession potentially adds to an air of fairness, rigour, and reflexivity. Some may consider all this to be ‘mere rhetoric’ and trickery. I argue, instead, that all representations are rhetorical (Potter, 1996); that Reality is an often missed sleight of hand (Edwards et al., 1995; Boyle, 2002a); and that, amongst other things, three-part lists can be an effective rhetorical device in dissertations as well as political speeches (Atkinson, 1984: 151).

In discourse analysis, questions of why someone said what they said are not answered in terms of mental and/or biological processes. Indeed, such why questions are only answered indirectly, in terms of the above kinds of how and what questions. This is a departure from most explanations provided by psychologists, lay people, and psychiatrists (ie, most people, in most contexts), which tend to assume an unproblematic two-way road between what occurs in external Reality and how it is represented in our heads. For example, people’s descriptions tend to be taken as representing an external, objective, and common ‘reality’, ignoring the social action which is inherent in all forms of representation (Potter, 1996). Thus, scientific ‘findings’ can be passed off as a neutral reflection of Reality rather than a version of ‘reality’ which is presented as Fact. Similarly, people tend to invoke representations of internal, subjectivity-forming, and individual mental states and structures, without accounting for the unavoidable social action which is involved in the representation with language of what is inferred to go on in someone’s mind. Thus, psychological questionnaires may be designed to ‘measure’ beliefs and attitudes, and responses may be taken to reflect the respondent’s ‘state of mind’. The same goes for any account, given by any person, in any form. The social
action involved in, for example, the design of questions and responses is usually treated as negligible, unproblematic, and uninteresting.

The main focus of this dissertation is to investigate how professionals represent ‘schizophrenia’ and hearing voices in theoretical texts, and how that is played out in therapy practices. As a critique of the dominant professional approach, my discussions are evaluative. The question, thus, might become: ‘What is a ‘good’ way or the ‘best’ way to represent ‘mental illness’ and hearing voices?’ However, from my findings I conclude that, given the variety of valid views on the phenomena in question, no single answer or approach should hold sway. Rather, I advocate the use of (more) dialogue. I call for dialogue between co-equals, without prejudice (especially that which is against those with less social power) and without presumptive privilege (especially that which in favour of those with more social power). Dialogue between all combinations of ‘patients’ and ‘professionals’; as people who show respect, listen to, and at times challenge, other ‘points of view’. This is mutual, rather than didactic, learning.

And if any one view or set of views should hold any sway over others (besides the view of advocating dialogue), it would, from my point of view, best be the person who is most directly experienced with the bizarre experiences and behaviours which they or others report.5 6 More typically, however, the a priori domination of one or more

5 See Crowe (2000b) for a mental health nursing perspective on turning to service users to learn how best to help.

6 When I say ‘bizarre’, it is to mean ‘bizarre but (at least potentially) not incomprehensible’. This locates reported behaviours and experiences which are often considered to be associated with madness and ‘schizophrenia’ outside of moral or medical frameworks. This is in keeping with Boyle’s (2002b) use of ‘bizarre’, to mean “behaviour or experiences which disturb observers and are incomprehensible to them” (248; my emphasis). That is, the more we learn about the social contexts of reported behaviours and experiences, then the more understandable they will become; outside of considering them to be ‘symptoms’ of a biological disorder. It is precisely because understandability emerges as a function of
professional frames of reference brings with it the price of disrespect and the loss of potentially valuable information; not least, the experience of not being heard and not having one’s needs met by those who are there to ‘help’.

SECTION 2. VOICES IN A BOX

Socrates’ sign was perhaps no vision, but rather the perception of a voice or else the mental apprehension of language that reached him in some strange way. So in sleep, where no sound is uttered, we fancy, as we receive the impression or notion of certain statements, that we hear people speaking.

(Plutarch, 1959: 451)

Divinities, voices, hallucinations

As Leudar and Thomas (2000: 14 ff.) observe, ‘the voice’ of Socrates has been well documented at different points in history. It has been variously described, including as a ‘voice’, a ‘divine sign’, and a ‘daemon’. Socrates himself left no written record of his work. However, Plato, Socrates’ pupil and the teacher of Aristotle, pays close attention to describing the phenomenon in several of his Socratic dialogues, including The Republic. The contemporary military general and historian, Xenophon, also describes the divinity (in the dialogue, Conversations with Socrates) and the ancient Greek shared culture and as a function of the scope of one’s consideration of context that it is unacceptable as a criterion for diagnosis. It is most ironic that the diagnosis of schizophrenia officially requires that ‘symptoms’ cannot be rendered comprehensible in terms of a person’s sociocultural context (Boyle, 2002b: 296 and see 312-315), so that, in a sense, the deficit is in the diagnostician not grasping the patient’s ‘reality’ and not vice versa.
biographer, Plutarch, devotes a monograph to the subject (the dialogue, *On the sign of Socrates*).

Although the degree to which Socrates’ daemon is like contemporary accounts of hearing voices seems a little ambiguous in the words of the various historical authors, their characters, and translators, Leudar and Thomas (2000: 15) convincingly argue that Socrates probably had the sort of experience which modern psychiatry would call an ‘auditory hallucination’: (a) the divine sign is often described as being an auditory experience,7 (b) it is often described as involving meanings which came in discernable words (and can therefore be called a *verbal* ‘auditory hallucination’ or ‘verbal hallucination’), (c) it was a private experience, and (d) the daemon was experienced in the absence of people speaking. This argument holds, without notably conflicting with Socrates’ recorded experience, besides the aspect of his believing that the voice was of supernatural origin. Modern professional conceptualizations of ‘auditory hallucinations’ give little or no credence to the supernatural.

Socrates is on record as always following what the voice had to say. It acted as a guide, giving him warnings and helping him make decisions, ever since he was a child (Plutarch, 1959: 405; Ehrenberg, 1969: 369). He chose to make at least some of what he heard publicly available. He and his followers considered the daemon to be supernatural and divine, after all. Unlike some voice hearers, Socrates was fortunate in considering himself blessed, not distressed. Nevertheless, it may be surprising to learn that Socrates - esteemed Greek philosopher and intellectual leader - experienced what would today be categorized typically as ‘auditory hallucinations’ or ‘hearing voices’.

7 Elsewhere, Leudar and Thomas (2000: 55) discuss the experiences of the eminent German judge, Daniel Paul Schreber, some of which were not auditory. Schreber reported that some of his voices were in “nerve language” which was rather like “silent prayer”. Like auditory voices, this “nerve language” was verbal and experienced as not originating from the self.
In his own time (around 470-399 B.C.), Socrates distinguished himself in several military campaigns before focusing on intellectual enquiry and attracting numerous followers (Cook, 1990: B56). As already noted, the daemon played a valued - though sometimes highly mundane - advisory role in his life and, through Socrates, in the lives of his close followers (eg, see Plutarch, 1959: 405 ff.). Indeed, the voice and its divine message was described by Plutarch’s characterization of Simmias as being discernable only through the sort of sublime qualities with which Socrates was believed to have been endowed:

But whereas some men actually have this sort of apprehension in dreams, hearing better asleep, when the body is quiet and undisturbed, while when they are awake their soul can hear the higher powers but faintly, and moreover, as they are overwhelmed by the tumult of their passions and the distractions of their wants, they cannot listen or attend to the message; Socrates, on the other hand, had an understanding which, being pure and free from passion, and commingling with the body but little, for necessary ends, was so sensitive and delicate as to respond at once to what reached him.

(Plutarch, 1959: 451)

However, Socrates was an eccentric and influential man of artisan descent who stood against moral compromise and whose daemon was not recognized as a god in Athenian society. Thus, he was considered a threat by the authorities. He was eventually arrested, tried, and condemned to death. The two charges levelled against him were corrupting the youth - principally of the ruling classes - and not believing in the official gods and introducing his own divinity. Socrates is said to have gracefully accepted his sentence, and drank from a cup of hemlock (Ehrenberg, 1969: 367 ff.).

Leudar and Thomas inform us that Socrates’ case fared little better in the nineteenth century. The eminent philosopher was retrospectively diagnosed as insane by a number of medical practitioners (Lelut, 1836; Maury, 1855; Brunet, 1863; see James, 1995; all cited by Leudar and Thomas, 2000). Socrates was placed in the good company of
Pythagoras, Mohammed, Merlin, Joan of Arc, Luther, Loyola, and Pascal, who all fell from greatness at a stroke of the diagnostic pen. It was in the nineteenth century, not before, when ‘visionaries’ became ‘hallucinators’ and ‘hallucinations’ began to be formally associated with madness. Thus, voices - as ‘auditory hallucinations’ - became associated with the emergent psychiatric labels ‘schizophrenia’ and ‘psychosis’.

**Psychiatric classification**

*The symptoms of ‘psychosis’*

If one word encapsulates how the experience of hearing voices is generally framed in contemporary Western society then that word is ‘schizophrenia’. Hearing voices, considered as ‘auditory hallucinations’, is a key ‘symptom’ of ‘psychosis’ and ‘schizophrenia’. The term ‘psychotic’ is generally used to refer to a state of mind and behaviour in which a person is said to ‘lose touch with reality’, to become - in lay terms - mad, for a time at least. Here I offer a summary and critical analysis of the formal diagnostic classifications of ‘psychosis’ and ‘schizophrenia’.

In psychiatry, the term ‘psychotic’ has had various meanings:

The narrowest definition of *psychotic* is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A slightly less restrictive definition would also include prominent hallucinations that the individual realizes are hallucinatory experiences. Broader still is a definition that also includes other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behavior).

(American Psychiatric Association, 2000: 297; original emphasis)

Instead of focusing directly on what are taken to be symptoms, other recent definitions have centred on the presence of a severe degree of impairment which grossly interferes
with the capacity to meet ordinary demands in life, a loss of ego boundaries, or a gross impairment in reality testing (APA, 2000: 297). However, the above extract makes clear the degree to which psychiatry currently considers hearing voices to be an important feature of psychosis. The quotation also goes some way towards illustrating how ‘schizophrenia’ is considered to be the quintessential psychosis - principally through the existence of what are deemed to be delusions and prominent hallucinations.

Yet, there is an apparent tension within these considerations of ‘schizophrenia’ and psychotic symptoms. The two most characteristic features of psychosis, delusional beliefs and hearing voices, are part of numerous diagnoses - other than ‘schizophrenia’ - which must or may include psychotic features. However, psychiatrists point out that...

...it should be understood that psychotic symptoms are not necessarily considered to be core or fundamental features of these disorders, nor do the disorders in this section necessarily have a common etiology. In fact, a number of studies suggest closer etiological associations between Schizophrenia and other disorders that, by definition, do not present with psychotic symptoms (e.g., Schizotypal Personality Disorder).

(APA, 2000: 297)

The above extract covers disorders which are classified as being fully psychotic, rather than merely those cases which may present with associated psychotic features.

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8 Despite being critical of psychiatry, here, I shall drop most of my problematizing inverted commas, in the interests of narrative flow.

9 The diagnoses ‘delusional disorder’ and ‘shared psychotic disorder’ are considered to be psychoses in the absence of any voices.

10 Psychotic disorders which must include psychotic symptoms include ‘schizoaffective disorder’, ‘schizophreniform disorder’, ‘brief psychotic disorder’, and psychotic disorders due to a general medical condition or due to substance use. Disorders which are categorized as sometimes presenting with psychotic symptoms include ‘dementia of the Alzheimer’s type’, ‘substance-induced delirium’, ‘major depressive disorder’, and ‘bipolar disorder (type I)’.
Somehow, the following positions are said to co-exist: (a) delusions and prominent hallucinations are *defining features* of psychosis; (b) delusions and prominent hallucinations are *the most characteristic features* of ‘schizophrenia’; (c) delusions and prominent hallucinations are *almost as characteristic* of other psychoses and of the psychotic features which may be associated with other mental disorders; and yet (d) psychotic symptoms are *not necessarily core or underlying* features of any disorder, even ‘schizophrenia’.

Such a consideration of psychosis and ‘schizophrenia’ reveals a diagnostic tension between the clinical presentation and the supposed aetiology of symptoms. Indeed, to this day, individual acts of diagnosis still rely on observations by clinicians rather than tests for underlying physical causes. Diagnostic purposes, not laboratory findings, dictate the way in which ‘schizophrenia’ is grouped with other disorders on the basis of psychotic symptoms (APA, 2000: 297). That is, any given diagnosis (and treatment) of ‘schizophrenia’ is based on a combination of theoretical conceptualizations of illness (of what constitutes an individual symptom and what constitutes a relevant cluster of signs and symptoms of illness) and clinical judgement. (See below for more on signs and symptoms). It is important to note, however, that theoretical conceptualizations and clinical judgements can be *more or less* informed by empirical evidence.

In summary, from the above introduction, it should be apparent that psychiatry does not consider hearing voices to be associated with schizophrenia alone. However, it should also be apparent that modern psychiatry (the dominant variety at least) - unlike at some other times in European and world history - most definitely considers hearing voices to be a symptom of ‘mental illness’. For psychiatry, the notion that someone can hear voices but not have a ‘severe mental illness’ is an oxymoron.

As ‘schizophrenia’ is widely considered to be *the* quintessential psychosis/mental illness and because the majority of people in our hearing voices therapy group had
current diagnoses of ‘schizophrenia’, my discussion will not focus on any of the other diagnoses which are typically associated with hearing voices. Nor will I focus, as much as it would merit, on the more common experience of hearing voices outside of psychiatric diagnosis.

Indeed, there is a small but steadily increasing number of studies of hearing voices which resist a diagnosis of ‘mental illness’ and/or the foci of orthodox psychiatry. For example, Skirrow, Jones, Griffiths, and Kaney (2002) investigated the ‘auditory hallucinations’ of patients in an intensive care unit. The researchers found that current stories in the media (such as stories about the then war in Kosovo) affected the contents of hallucinations. This supports the investigation of hallucinatory contents and the consideration of contextual (ie, social, cultural, personal, and/or individual) influences upon contents. Such practices are atypical in psychiatry but are to some extent performed in cognitive interventions for psychosis. ‘Schizophrenia’, as a disease concept, however, currently prevails.

In the light of recent progress, being categorized as ‘having’ ‘schizophrenia’ should not entirely be met with pessimism (British Psychological Society, 2000: 14; WHO, 2001: 33). However, a large proportion of people who receive this illness label remain designated as ‘ill’ and associated with ‘mental health’ systems for many years (Coleman, 1999; Thomas, 1997). Within mainstream psychiatry, recovery from ‘schizophrenia’ to ‘normal’ functioning - with or without medication - is considered unlikely at best.

Consider the issue of how many people, once diagnosed with ‘schizophrenia’, receive a follow-up diagnosis of “single episode in full remission” (APA, 2000: 312). I do not have statistical answers to this specific question, but the optimistically entitled World Health Report 2001, Mental Health: New Understanding, New Hope, states that there is “complete symptomatic and social recovery in about one-third of cases” (WHO,
2001: 33). This part of the account presumably includes people who no longer take medication but it is not clear whether it pertains solely to that group. Also, ‘cases’ can be taken as those who come to the attention of psychiatrists and who, at least initially, take medication. The report goes on to say that “with modern advances in drug therapy and psychosocial care, almost half the individuals initially developing schizophrenia can expect a full and lasting recovery” (WHO, 2001: 33), which presumably includes, and may exclusively refer to, people who are taking ongoing medication. It is pertinent here to note the lack of a classification for people who might be diagnosed as having something like continuous or multiple ‘episodes of schizophrenia’ but who are now in full ‘remission’ (APA, 2000: 312). Classifications for people who have been diagnosed with ‘schizophrenia’ over the long term but have subsequently recovered (with or without ongoing medication) are notably absent from the DSM.

Further evidence of a diagnosis of schizophrenia’s ability to stick can be gleaned from the way it has been constructed to flex in relation to the patient’s progress (or lack thereof) and medication. For example, the diagnostic criteria allow for the diagnosis to be given the benefit of the doubt, as it were, and still be applied if the symptoms last for less than one month and if the success is attributed to treatment (ie, medical management and medication) (APA, 2000: 312). Thus, the symptoms - which are somehow also supposedly characteristic of the ‘illness’ - may be short-lived and no longer present but still the diagnosis can be applied to the period in question. Furthermore, the classification of ‘in full remission’, may be applied - for any so-called mental disorder - when the patient is receiving ‘prophylactic treatment’ (APA, 2000: 2) and not exhibiting any symptoms. Thus, the diagnosis can remain and medication may be taken for life on the basis of that continuing diagnosis. The classification system places medication in the privileged position of being attributed success in relieving symptoms, over any non-medical developments which might occur for the person. In
this sense, the *DSM-IV* classification system favours the ongoing use of medical intervention over its briefer use or the use of alternative approaches. Medical management (including medication) may also be less likely to receive blame for not curing patients because a full, official, classification for a person who is recovered and not taking medication (although they may have in the past) is not available as an option in the diagnostic criteria, even for the purpose of being a closing point in a psychiatric case-file. It may be argued that the general course specifier ‘prior history’, in the diagnostic criteria (APA, 2000: 2), could be used to note a full recovery of schizophrenia. However, ‘prior history’ is designed for occasional use when the ongoing noting of a prior history of having met the criteria for a disorder and recovered is deemed important. Such a specifier does not appear to be designed for use in closing a file. ‘Prior history’ is also absent from the longitudinal course specifiers which are specifically listed for use with the diagnosis of ‘schizophrenia’. In sum, once applied, the diagnostic criteria of ‘schizophrenia’ are constructed so as to remain applicable, regardless of the presence or absence of what are taken to be symptoms.

Voice hearers, in the context of being diagnosed as ‘having’ a ‘mental illness’, typically lose much control of their lives to others. It is the psychiatric professionals (of various disciplines) who have the institutionally vested power to sanction, enforce, and restrict treatments and many other resources. It is the professionals who formally bestow and revise a patient’s diagnosis. One is left wondering how Socrates could have functioned as a great intellectual for so many years without the help of modern professional practice, afflicted as he ‘must have been’ with the ravages of a ‘severe mental illness’.

23
A diagnostic classification system for ‘schizophrenia’

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (and its text revision) is the foremost system for classifying mental disorders in the world (APA, 1994, *DSM-IV*; APA, 2000, *DSM-IV-TR*). The manual is widely held to be an authoritative text; a distillation of expert knowledge from the science of psychiatry. *DSM-IV* thus contains the de-facto official definition of ‘schizophrenia’ (Berrios, 2000: 567). I will come to some of my own critical analysis of DSM criteria later.

The DSM has been revised a number of times and a fifth edition is scheduled for publication in 2006. However, the diagnostic criteria for schizophrenia which appear in the current edition are much the same as in *DSM-III*:

...*DSM-III* was the landmark edition of the DSM, the first to include correspondence rules (diagnostic criteria) for its concepts. Subsequent editions have not made fundamental changes to the actual criteria for inferring ‘schizophrenia’, although the justifications given for producing particular criteria have changed.

(Boyle, 2002b: 100)

Thus, the general arguments presented here in connection to *DSM-IV* are likely to apply to subsequent editions.

The manual’s section on schizophrenia comprises diagnostic criteria (what to look for when assigning a diagnosis) and supplementary information including definitions of

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11 I shall henceforth use the term ‘DSM-IV’ to refer to *DSM-IV* and *DSM-IV-TR*, as the issues raised here apply equally to both. Also, in terms of my arguments, the diagnostic criteria in the other prominent classification system for mental disorders, the *ICD-10 Classification of mental and behavioural disorders* (WHO, 1992), are very similar to those in *DSM-IV*. Jablensky (2000a: 587) notes that *DSM-IV* and *ICD-10* have been shown, presumably in clinical research, to agree well on the core cases of schizophrenia, although they agree less well on atypical or milder cases.
terms and justifications for the criteria used. There also are sections covering generic issues to do with the diagnosis of ‘mental disorders’, plus a general glossary of terms.

The symptoms of ‘schizophrenia’

The criteria for inferring ‘schizophrenia’ place particular diagnostic importance on ‘bizarre’ delusions and certain types of auditory hallucinations. I will consider delusions before moving on to voices. A delusion is defined as:

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof to the contrary.

(APA, 2000: 821)

Examples of delusions include false beliefs that the person is being persecuted; that messages from television, newspapers, or strangers, etc., are specifically directed at them; that the person is directly involved in religious events; and that they are someone of great renown (APA, 2000: 299). DSM-IV acknowledges that the “distinction between a delusion and a strongly held belief is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence” (APA, 2000: 299).

If erroneousness is the quality which is taken to mark a belief as delusional (ie, psychotic), then bizarreness is the quality which gives a belief its specifically schizophrenic hallmark. As with falsity, DSM-IV acknowledges that bizarreness is not always clear-cut:

...“bizarreness” may be difficult to judge, especially across different cultures. Delusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences.

(APA, 2000: 299; my emphases)
The diagnostic manual goes on to describe how delusions which (supposedly) involve a loss of control over mind or body are generally considered bizarre. Examples include the person believing that their thoughts have been taken away by some outside force (thought withdrawal), that alien thoughts have been put into their mind (thought insertion), or that their body is being manipulated by some outside force (delusions of control). It is perhaps not surprising that, with such personal- or other-reported perceptions and experiences being categorized as delusional (alien thoughts, etc), that cognitive therapy approaches typically consider hearing voices in relation to what they are supposed to have in common with delusions, namely cognitive errors.

*DSM-IV* cautions that clinicians should take cultural differences into account when “assessing the symptoms of Schizophrenia in socioeconomic or cultural situations that are different from their own” (APA, 2000: 306). For example, “ideas that may appear delusional in one culture (e.g., sorcery or witchcraft) may be commonly held in another” (APA, 2000: 306). However, it is clear from the previous extracts that this gesture of considering the person’s (potential) ‘points of view’, and what they may be attempting to achieve or express, does not extend to erroneousness or bizarreness.

Also defined as a symptom which is both within and without the diagnosis of ‘schizophrenia’, *DSM-IV* describes an hallucination as a sensory perception which may occur in any modality and which

...has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from *illusions*, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognize that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality.

(APA, 2000: 823; original emphasis)
Such an illusion-hallucination distinction, however, is less certain than it appears in the above extract. For example, consider three different versions of the ‘same’ events. First, there is a hearer’s account in which they report having heard the voice of a neighbour criticizing them by name. According to the above illusion-hallucination distinction, this reported experience may be formally taken to be a *hallucination*, if there is a professionally deemed absence of an external stimulus, regardless of whether or not the hearer claims that the voice was ‘real’. But who is the best judge of whether or not an external stimulus was present? In a different version of events, the experience might be described by the hearer as having been the sound of the neighbour’s actual voice, shouting insults through an adjoining wall. In this second version, having been reported differently from the first, the experience which before was taken to be a hallucination may now professionally be deemed to be a *normal auditory experience*. However, this conclusion is, arguably, unlikely if the hearer’s grip on reality has previously been deemed by the psychiatric professional to be doubtful. A third version of events might be when a professional considers that, after evaluating the hearer’s account, the neighbour had actually been shouting but that that they were referring to a person other than the hearer in question. That is, the hearer in question had misconstrued what they heard as applying to them. Strictly speaking, this version may be officially deemed to be an *illusion*. However, if the person reporting the experience is considered *a priori* to be a ‘mentally ill’ voice hearer, then it seems likely that this third version of the event would also be professionally deemed to be an auditory hallucination. Thus, orthodox psychiatry overlooks the fact that these are all *accounts*: they are locally produced and situated in inter-action, and, with a subtle difference in accounting or in the enacted construal of an account, a reported experience may be rendered either ‘normal’ or ‘abnormal’. Instead, psychiatry assumes that it is professionals who are the rightful judges of what is Real concerning the hearer’s reported experiences.
Auditory hallucinations are described officially as being the most common type of hallucination (APA, 2000: 300). It is considered possible for “transient hallucinatory experiences to occur in people without a mental disorder” such as when going to sleep or waking (p. 823). Auditory hallucinations, however, are “usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts” (p. 300). Isolated experiences such as hearing one’s name called or experiences which lack the quality of being from an external stimulus, such as a humming in one’s head are not considered symptomatic of psychosis. And yet the diagnostic manual also states that, unlike some researchers and clinicians, it makes no distinction “as to whether the source of the voices is perceived as being inside or outside of the head” (APA, 2000: 823).

Just as with delusions, DSM-IV advises of the need for cultural awareness when assessing hallucinations: “In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God’s voice)” (APA, 2000: 306). However, cultural awareness is only discussed in the context of religion. There is also no consideration given to how the voices may fit into the life-context of the person who experiences them nor to their personal meaning. Even a broad personal evaluation of the voices (eg, whether they are deemed positive or negative) is given very little diagnostic weight.

The diagnostic criteria for ‘schizophrenia’ contain six categories, each of which must be met: characteristic symptoms, social/occupational dysfunction, duration, plus three criteria for excluding cases which are deemed to correspond better with other diagnoses (APA, 2000: 312). In the production of a diagnosis, these criteria are assessed by psychiatrists and other professionals via methods which are held to be based on largely objective, scientific knowledge.
I shall restrict my focus to certain aspects related to the top of this *DSM-IV* list, “Characteristic symptoms”. For a diagnosis of ‘schizophrenia’ to be made, two or more of the following types of symptoms must be present in the characteristic symptom category: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour (ie, a variety of marked motor abnormalities), and negative symptoms (ie, affective/emotional flattening, poverty of speech, and an inability to initiate and persist in goal-directed activities). However, only one characteristic symptom is required “if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behaviour or thoughts, or two or more voices conversing with each other” (APA, 2000: 312). Thus, delusions and auditory hallucinations are singled out as being symptoms of particular diagnostic significance. Furthermore, “if delusions are bizarre or hallucinations involve ‘voices commenting’ or ‘voices conversing,’ then... The presence of this relatively severe constellation of signs and symptoms is referred to as the ‘active phase’” (APA, 2000: 301). The reported hearing of such voices - speaking in the second and third person - is thus taken to be a clear indication of what may be more mundanely described as ‘raving madness’. However, as we saw earlier in the definition of psychosis, the diagnostic classification system is able to accommodate these supposed symptoms being particularly characteristic of ‘schizophrenia’ both in the presence and absence of insight concerning their ‘departure from reality’. These ‘things’ all depend on the judgement of clinicians.

The terms ‘psychotic’ and ‘schizophrenic’ - presumably with particular reference to the person in question currently being in an active/acute phase of the ‘illness’ - seem to have replaced many instances of the terms ‘insane’ and ‘mad’ in clinical and everyday settings. However, matters of questionable rationality/groundedness in reality are at the heart of all psychiatric diagnoses and can be very much at issue in therapy, as I will
demonstrate in Part 2 of this dissertation. That ‘schizophrenia’ is, to a greater or lesser degree, officially constructed as inseparable from being ‘out of touch with reality’ stands in contrast to the data in Part 2 in which the patients construct themselves as being patently ‘not mad’.

The subtypes of ‘schizophrenia’

In addition to providing overall diagnostic criteria for schizophrenia, *DSM-IV* also includes descriptions and diagnostic criteria for categorizing a diagnosis of schizophrenia into a number of subtypes:

The subtypes of Schizophrenia are defined by the predominant symptomatology at the time of evaluation. Although the prognostic and treatment implications of the subtypes are *variable*, the Paranoid and Disorganized Types tend to be the least and most severe, respectively. The diagnosis of a particular subtype is based on the clinical picture that occasioned the most recent evaluation or admission to clinical care and may therefore change over time. Not infrequently, the presentation may include symptoms that are characteristic of more than one subtype.

(APA, 2000: 313; my emphasis)

So why make such categories available for use if the behaviours they summarize are so “variable”? Before we consider this question, I shall briefly relate certain aspects of each subtype, with quotes from *DSM-IV*. The essential feature of the “Paranoid type of schizophrenia” is

...the presence of prominent delusions or auditory hallucinations in the context of a relative preservation of cognitive functioning and affect... Delusions are typically persecutory or grandiose, or both, but delusions with other themes (e.g. jealousy, religiosity, or somatization) may also occur.

(APA, 2000: 313)
According to *DSM-IV*, the essential features of the “Disorganized type of schizophrenia” are

...disorganized speech, disorganized behaviour, and flat or inappropriate affect...

[Behavioural disorganization] may lead to severe disruption in the ability to perform activities of daily living... Historically, and in other classification systems, this type is termed *hebephrenic*.

(APA, 2000: 314; original emphasis)

The “Catatonic type of schizophrenia” is characterized by

...a marked psychomotor disturbance that may involve motoric immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia, or echopraxia... The excessive motor activity is *apparently purposeless* and is *not influenced by external stimuli*. There may be *extreme negativism* that is manifested by the maintenance of rigid posture against attempts to be moved or resistance to all instructions... Echolalia is the pathological, parrotlike, and *apparently senseless* repetition of a word or phrase just spoken by another person. Echopraxia is the repetitive imitation of the movements of another person.

(APA, 2000: 315; my emphases)

It is worth noting that, even for the above symptoms, or several of them at least, the categorization of being a ‘symptom’ very much appears to be made from the vantage point of a professional or lay observer who finds the person’s behaviour to be “apparently purposeless” and, quite literally, without reason. The term “extreme negativism” may also be taken as being morally evaluative, over and above its apparent descriptive accuracy. These considerations are in line with what I have already mentioned in connection to the observer’s ‘points of view’ which is taken with regards to ‘delusions’ and ‘auditory hallucinations’.

Additional subtypes include the “Undifferentiated type”, where prominent active-phase symptoms are present but the criteria for the above subtypes are not met, and the
“Residual type”, where there has been at least one episode of schizophrenia but there is currently only disturbance from negative symptoms or two or more mild positive symptoms.

It should be clear by now that I take issue with the categorization of behaviours/actions/expressed experiences at the symptom level, the subtype level, and the disorder level. Even the writers of DSM-IV admit that its subtypes of ‘schizophrenia’ are more than a little flawed. Indeed, “[b]ecause of the limited value of the schizophrenia subtypes in clinical and research settings (eg, prediction of course, treatment response, correlates of illness), alternative subtyping schemes are being actively investigated” (APA, 2000: 313). Yet it appears that history and the preferences of psychiatrists have triumphed over science on the matter, at least for the time being. It is as if no-one wants to throw anything out, regardless of the evidence. Much the same can be said of ‘schizophrenia’ itself, as I will discuss in the next chapter.

Two alternative (but, in many ways, still conceptually flawed) subtyping schemes are discussed in the DSM-IV commentary but not included in any of the diagnostic criteria. The first to be discussed is the positive-negative symptom dichotomy. The so-called characteristic symptoms of schizophrenia “may be conceptualized as falling into two broad categories: positive and negative” (APA, 2000: 299):

...positive symptoms (Criteria A1-A4) include distortions in thought content (delusions), perception (hallucinations), language and thought processes (disorganized speech), and self-monitoring of behaviour (grossly disorganized or catatonic behaviour)... [N]egative symptoms (Criterion A5) include restrictions in the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behaviour (avolition).

(APA, 2000: 299)
In the second alternative set of subtypes, the positive symptoms “may comprise two distinct dimensions, which may in turn be related to different underlying neural mechanisms and clinical correlates” (APA, 2000: 299). These are known as the “psychotic dimension” and the “disorganization dimension”. The resultant three dimensions (psychotic, disorganized, and negative) “may come together in different ways among individuals with Schizophrenia” (APA, 2000: 313).

**Normality and disease: The dichotomy-continua cocktail**

The diagnostic manual pathologizes the ‘symptoms’ of ‘schizophrenia’ - including hearing voices. For example, “associated laboratory findings” from neuroimaging, neuropsychological, and neurophysiological studies are reported, along with their “pathophysiological implications” (APA, 2000: 305; my emphasis).

However, *DSM-IV also* presents the ‘symptoms’ of ‘schizophrenia’ as being on a continuum with ‘normal functioning’. For example, “[t]he positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminution or loss of normal functions” (APA, 2000: 299). Yet the term “distortion” in this extract suggests a qualitative difference between the dysfunction which is said to underlie ‘psychotic symptoms’ and ‘normal functioning’, rather than a quantitative or categorical difference.

Further to this, the following passage explicitly invokes a normality continuum concerning ‘negative symptoms’:

> Although common in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a *continuum with normality*, are relatively nonspecific, and may be due to a variety of other factors (including positive symptoms, medication side-effects, depression, environmental understimulation, or demoralization).

(APA, 2000: 301; my emphasis)
Here, negative symptoms are held as being difficult to evaluate mostly because of their relatively close relationship with ‘normality/commonality’. For example, they are “relatively nonspecific” and they may be due to a variety of other factors, which, besides “positive symptoms”, may be taken as being relatively ‘normal/common’. But relative to what? The DSM-IV discussion, from which the above extract is taken, speaks first of ‘positive symptoms’ (not shown) before moving on to ‘negative symptoms’. The above extract, then, is part of a comparison between ‘negative’ and ‘positive symptoms’. But why should ‘negative symptoms’ be harder to evaluate, given that both types of ‘symptom’ are said to be on a continuum with ‘normal’? Are they simply closer to ‘normal’ in a quantitative sense? This extract may be taken as implicitly referring to a dichotomy between ‘positive’ and ‘negative symptoms’ in terms of a dichotomy between ‘positive symptoms’ and ‘normality’; perhaps the sort of qualitative dichotomy with ‘normality’ which was suggested earlier by the term “distortion”. ‘Negative symptoms’ are more ‘normal’ than ‘positive symptoms’; they are harder to distinguish from ‘normality’ and therefore harder to evaluate as to whether or not they are to do with ‘schizophrenia’. This is supposedly because ‘positive symptoms’ are a “distortion of normal functions” and therefore they are not just further from ‘normality’ in distance (ie, quantitative difference) compared to a “diminution or loss of normal functions” but they are also less like ‘normality’ in kind (ie, a qualitative difference).

Let us consider these issues concerning dichotomies and continua a little further. Why might it be relatively easy to distinguish, for example, between bizarre and more ‘normal’ delusions or between auditory hallucinations and socially acceptable ‘voices’ (as reportedly heard by commercial psychics, for example), if none of these are pathological? Assuming that positive and negative symptoms are afforded separate continua, is it that negative symptoms are closer to ‘normal’ on their continuum, compared to positive symptoms? Or it is that bizarre delusions and certain types of
voices - compared to less severe positive symptoms and negative symptoms - are so ‘out of touch with reality’ that it is difficult to conceive of them as being anywhere on a continuum with ‘normal’?

What of the normal-diseased distinction? Well, comparing ‘normal’ (ie, not diseased) with ‘diseased’ is bit like comparing apples with oranges. This idiomatic expression is generally used to denote futility or impossibility. Why might such a comparison of fruit be so problematic? All apples and oranges are made up of a number of recognizably different properties/qualities. The terms ‘apple’ and ‘orange’ are categorical. Each category is characterized by its own combination of one or more different qualities (eg, ‘size’ and ‘sweetness’). Each property can be measured quantitatively and represented as an amount in the form of a number, which in turn can be represented as a linear spatial comparison between two or more different items within the same category. It makes sense to compare ‘apples’ in terms of their ‘size’, since that is comparing members of a particular category in terms of a measurement of a particular property. Apple size comparisons are meaningful because each apple fits well enough into the category ‘apples’ (a composite of different properties which apples are said to share) and can thus occupy different points on a ‘size’ continuum without the category ‘apples’ being confounded by the other differences they may have (such as the variety of apple or the number of blemishes).12

A continuum may thus be defined as a linear spatial construct, where members deemed to be in the same category can each be represented according to a measurement

12 Physical ‘size’ combines the qualities/properties of length, height, width, depth, volume, etc. Although each property of any given category of items is defined as having its own unique linear dimension, these particular properties are sufficiently related to be meaningfully referred to as ‘size’. ‘Size’ can be taken to mean either one of these properties or several of them in combination.
It does not make sense to place apples and oranges on the same continua in terms of their ‘appleness’ or ‘orangeness’. Apples do not have the property of ‘orangeness’, and vice versa. One would surely infer either confusion or irony from such a comparison. Either way, it would not, logically, be taken as a representation of an objectively testable comparison. Of course, apples and oranges can occupy the same continua because they share a number of other properties. Thus, they can be grouped into the same category such as ‘object’ or ‘fruit’ and then compared in terms of their size. That is, although it would not make sense to compare apples and oranges in terms of their ‘fruitiness’, since both are classes of ‘fruit’, they can occupy the same continua in terms of some other measurable property such as size.

That said, how can ‘not diseased’ and ‘diseased’ meaningfully occupy the same continuum in terms of ‘normality’, in order to describe a ‘symptom’? In this context, normality-abnormality refers to the property which is, purportedly, measurable and measured. Leaving aside the not inconsiderable problem of whether a particular ‘abnormal’ item can be measured as having a magnitude of zero without it disappearing

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13 In this strictly linear definition, the terms ‘continuum’ and ‘dimension’ may be used synonymously. However, in order to sufficiently describe a continuum, one must specify the overall category (‘fruit’), any pertinent subcategories of the items represented (‘apples’, ‘oranges’), and the quality which is being represented (‘size’). In addition, the magnitude of the measurement for each item can be described (‘large fruit/apple’). On occasions, the property alone may be referred to as a ‘dimension’.

14 Apart from the diagnostic manual (APA, 2000: 301), Boyle’s (2002b: 91) discussion of categories and dimensions was the inspiration for my discussion of continua in psychiatry. I am not yet aware of others who have taken this critical approach to ‘pure’ and quasi-linear continua.
from the continuum altogether, how is ‘normality-abnormality’ to be measured and represented?

One way of representing ‘normality’ is in terms of the statistical properties of a population of items (ie, members). Any population which exhibits a normal distribution can be represented on a graph as a bell-shaped curve (with the magnitude of the property being measured plotted along the horizontal axis and frequency of occurrence along the vertical axis).

In linear terms - when a single property of the category of items is measured and represented on a continuum (ie, without the vertical axis) - such ‘normality’ could be shown as a single number, a particular point on that continuum. The ‘normality’ point is a particular magnitude of the property being shown, not the property per se. Such statistical normality could be represented as the average magnitude of any given property or meaningful composite of properties in a given population - for any of the continua being represented. That is, this version of statistical normality is at the centre of all continua (representing the centre of the bell-shaped curve).

It does not make sense to consider that any one item is better for being more or less ‘normal’ than any other since such normality is a property of only a single central point on every given continuum. An item simply is normal or it is not. Being average is not something which is good or bad, from a statistical point of view. One item may be closer to statistical normality than another item but to say that one item is better than another on that basis is a moral evaluation and not a mathematical one. It does not make

15 Picture someone attempting to measure the height of an apple which has zero height. An apple with zero height cannot be.

16 Even this kind of normality, the statistical kind, is an idealized representation of a naturally occurring population, however large. Nevertheless, sufficiently large naturally occurring populations exhibit such central tendencies, by definition.
sense to conceive of one number being better than another, since all positions on the continuum in question represent potential or actual items which all meet the entrance criteria for being members of the category being measured.

In discourse, however, the normality (e.g., averageness, moderateness, or ordinariness) of a person and their reported mental states may be constructed as being morally ‘good’ or ‘bad’ - or various other senses of ‘rightness’ or ‘wrongness’ - depending on the task at hand. For example, Sacks (1992, vol. 2: 215-221) has discussed the way that people do ‘being ordinary’; which I interpret as ‘the done thing’ and, thus, in many ways it is implicitly ‘positive’. Wetherell and Potter (1992: 151, 164, & 166) have considered how ‘moderate’ political views and actions can be constructed as positive, in contrast to other views and actions which can be constructed as ‘extreme’, despite, or because of, having their own claims to legitimacy. Wooffitt (1991) has studied how the tellers of paranormal stories construct themselves as being grounded and reliable (and in that sense ‘normal’) witnesses of extraordinary events. Consider also how ‘being average’ (‘boring’, ‘ordinary’, ‘monotonous’, and so on) is often constructed as a negative quality in everyday conversation and television advertisements.

Returning to continua, it does not make sense to conceive of one end of a continuum as being ‘bad/not good’ and the other end as being ‘good/better’. For one thing, most items in a large enough population category would, more or less, all occupy the middle region rather than the ‘good’ end. Also, more importantly, ‘goodness’ cannot be reduced to a single objectively measurable property and, if it could, then ‘not good’ would not be able to occupy a place in a ‘goodness’ continuum. Normality-abnormality continua, are confused to say the least.

Even in the sciences, any kind of ‘normality’, other than statistical normality, must boil down to a moral, or other, value judgement. If a category is not designated on the
basis of statistical measurement of some ‘intrinsic’ property, and if a category does not have some truly arbitrary basis (as it cannot have, because, in a constructionist world, nothing can), then it is an morally evaluative category. Such moral evaluations may be represented numerically. However, the moral ‘quality’ of ‘rightness’ is not a single, objectively measurable property. Nor is ‘goodness’ or ‘utility’ a ‘naturally occurring’ property, it is a human value judgement. A moral ‘quality’ is composed of a number of otherwise unrelated properties, many of which cannot be objectively measured, even in isolation. So then, comparisons like those in the DSM extracts above, in which disease-free functioning and disease-related symptoms are said or implied to be on a continuum in terms of ‘normality’, cannot be objectively tested because they are based on moral evaluations. In terms of objective scientific methods, it is therefore nonsense to make such comparisons.

What of the category ‘not diseased’? I have already begun to consider why representing ‘not diseased’ on one end of a continuum with ‘normal/diseased’ at the opposite end is problematic. For one thing, such a continuum cannot exist and be empirically testable because its ‘normal’ is morally evaluative - rather than statistical. Thus, such so-called continua are beyond ‘true’ scientific methods.

There is a second reason why this so-called continuum is less than convincing. Even if such a morally evaluative kind of ‘normal’ had a statistically legitimate reason for being on the continuum (which it cannot have), then it cannot occupy the end of the continuum - as would be suggested by claims of a ‘not diseased’ to ‘diseased’ continuum. That is because continua, well, continue. Put simply, a size zero apple = not an apple = not fruit = cannot be on a continuum of fruit in terms of size. Similarly, ‘not diseased’ cannot be on a continuum of symptoms in terms of disease. Thus, ‘not diseased’ - which is typically inferred by the term ‘normal’ in the context of ‘mental
illness’ - would not be able to occupy a continuum which also contained the ‘symptoms’ of ‘mental illness’.

Taking the above points together, it is nonsense to say that ‘not diseased’ is on a continuum with ‘diseased’ in terms of ‘normality’. The DSM appears to be making moral judgements which cannot be reduced to a single quality for objective measurement. One conceptually possible alternative would be to distinguish between behaviours/actions/reported experiences in terms of ‘diseasedness’, where each item would be more or less diseased. There would be no items which are free from disease. Every item on such a continuum would be a ‘symptom’. There would be a statistically normal (but ‘diseased’) item at the centre, with ever ‘less diseased’ items at one end and increasingly ‘more diseased’ at the other end. However, this continuum would only be scientifically testable, in the present, if an objective measure of ‘diseasedness’ (such as a neurobiological sign of the illness) were already available and found to be valid predictor of the main behavioural category which is being represented on the continuum.

If no such sign exists then it is not a testable medical disease concept which is being considered - with or without a mixture of ‘biopsychosocial’ influences. If a disease process cannot be objectively measured, then any supposed continuum involving biological influences on behaviour/actions/reported experiences may be hypothesized but not scientifically tested. Any such hypotheses are based on acts of faith rather than empirical data. It is one thing for a scientist to create a testable hypothesis (based on evidence or an unsubstantiated belief), to go about testing it for a period of time, to establish the hypothesis as ‘fact’ or ‘unproven’ on the basis of those results, and to maintain the ‘fact’ or discard the hypothesis accordingly. However, it is quite another thing for a scientist to create an untestable hypothesis, present it to others as if it were testable, and continue performing actions - founded on that hypothesis as ‘proven’ - ad
infinitum. Psychiatry appears to be engaged in the latter enterprise, for ‘schizophrenia’ and all other ‘mental illnesses’. Psychiatry, more or less, presents all ‘mental illnesses’ as being at one end of a ‘normality’ continuum with ‘normal’ at the other end. This, like all other representations, entails rhetoric; it is the construction of a particular version of reality. In this case, however, despite its prevalence, persistence, and power, it is a remarkably unconvincing version.

As I hope to have shown already, it is clearly difficult to reconcile the incompatibilities in ‘schizophrenia’ and other ‘mental illness’ models which seem to overlay notions of qualitative comparisons between ‘not diseased’ and ‘diseased’, on the one hand, and notions of quantitative comparisons between ‘more bizarre behaviour’ and ‘less bizarre behaviour’, on the other hand. A quantitative comparison which includes such qualitative differences would require a quasi-linear continuum (an oxymoron, just as non-linear continuum would be) - where one or more of the items being compared do not fit well enough into the main category such that different continua are needed to be overlaid or laid alongside each other in order to meaningfully represent more than one main category. Such problems arise in addition to the basic scientific criterion of each continuum being objectively testable.

The term ‘pathology’ denotes the presence of disease/illness. In psychiatry, ‘mental illness’ is generally taken to imply that there are one or more underlying biological disease processes which cause problem behaviour (but see Chapter 4, on Coulter, 1979, and Bentall & Pilgrim, 1993). Such meanings, which include both the biological and the psychological, have at least two important consequences. First, ‘not diseased’ and ‘diseased’ cannot occupy the same continuum (although ‘diseased’ and ‘less diseased’ could conceivably do so) because the difference between them is qualitative and not quantitative (categorical and not linear). Second, if the external environment were found to play a sufficiently causal role in the problem behaviour - presumably along with the
In contrast, a comparison which is based on quantitative differences can be represented on what I call a ‘true’ or linear continuum (a tautology which appears necessary in the present discussion). The DSM problematically seems to include both linear and quasi-linear continua, sometimes overlapping them to describe the same behaviour or ‘mental process’. Also, remember that the DSM’s continua are not yet testable in terms of the authors’ own professed scientific standards. I shall henceforth refer to such continua as ‘normality-abnormality quasi-continua’, ‘nonsensical continua’, ‘mixed continua’, or simply ‘normality-abnormality continua’ (but without inverted commas), depending on my argument.

If the psychiatric disease model were discarded in favour of a less skewed ‘biopsychosocial’ model (not one which merely looks more balanced on the surface) then a number of hypotheses could be developed, perhaps involving testable continua to represent behaviours/actions/reported experiences in terms of measurable biological signs, psychometric properties, or some kind of observable and quantifiable social ‘property’. If such an enterprise were possible, then the balance between the ‘bio’, ‘psycho’, and ‘social’ elements could begin to be settled on empirical grounds (initially for each individual continuum), as is the purported way of science. At least then, a more equal dialogue might be possible between component points of view. If comparisons of a particular feature are to be made across instances or cases, then such comparisons, in empirical disciplines, should avoid relying on vague ‘concepts’ such as ‘abnormal’ and specify the particular measurable property which is being compared. In line with less presumptive privileging of medical perspectives, it might also become more widely accepted that adherence to any kind of medical model of ‘mental illness’ is
incompatible with a ‘fuller’ conceptual integration of social factors into our knowledge of perplexing reported beliefs and experiences.

The incompatibility to which I refer is the fact that the social understandability of ‘symptoms’ is an oxymoron, from a medical perspective. This is because the diagnostic criteria for psychosis require that the phenomena in question are only ‘symptoms’ if they are not understandable within the person’s culture.

Categories, quantities, and the professional ‘point of view’

Having championed the use of quantitative measurements for the preceding few pages, I am not however, suggesting that everything should be reducible to categories and quantities, even if that were possible. Categorization and quantification are two of the foundations of science as we know it. However, they do not encapsulate all empirically valid methodologies. One of the uses of qualitative empirical analyses (such as conversation analysis and the closely related form of discourse analysis) may be to explicate social aspects of diagnosis (and the perhaps related practice of ‘therapy’) which are liable to be lost through quantification. From this, it may also be possible to empirically inform the creating and discarding of ‘biopsychosocial’ kinds of hypotheses, to take more notice of how micro- and macro-social variables can, on a given occasion, operate when people deal with ‘mental’ distress.

Psychological models of what are otherwise known as psychiatric ‘symptoms’ are often presented as including continua which look more like ‘true’ continua. For example, measurements of ‘biased’ decision-making, as evidenced by responses to a questionnaire, may be represented on a continuum with ‘less biased’ at one end and ‘more biased’ at the other. Such models are said to inform psychological approaches to psychiatric diagnoses and psychological ‘therapeutic’ practice. However, it should not be overlooked that what I described above as a ‘true’ continuum is not without its
pitfalls, particularly in the context of ‘schizophrenia’. Thus, we have ‘abnormal’ psychology and its evidence of psychological ‘dysfunction’, which is often placed on a continuum with ‘normal’ psychological ‘functioning’. (Consider the very the title of the textbook, *Abnormal Psychology: An integrative approach*, by Barlow & Durand, 2002, in contrast with normal psychological processes). All that has happened, compared to the dominant mental illness model, is that ‘dysfunction’ has been stood-in for ‘disease’. An evaluative ‘normal’ (‘functional’/ ‘not dysfunctional’) still tends to occupy the other end of the continuum. Indeed, there is even the increasing invocation of evidence of biological dysfunction/disease as if it were a proven sign in relation to psychological ‘dysfunction’. Such an implied normality-to-pathology continuum, with or without a valid biological sign or psychological stand-in, as a property to be measured, is, as before, scientifically nonsensical. These difficulties are seldom if ever explicitly stated in the canonical professional accounts of psychiatry and psychology.

How, then, can one behavioural form or function (or thought, for that matter) be sufficiently isolated from others so that ‘true’ quantitative differences are measured, without the confounds of qualitative differences/other behaviours? The categorical and evaluative practice of diagnosis (and therapy) claims to do just that. These problems are not ‘merely’ logical/philosophical; they may well have some very practical implications for the parties involved in diagnosis and therapy. An alternative to these kinds of processes may be one in which there is less early and broad categorizing and more dialogue.

In conclusion, let us return to the previous DSM extract, but consider it in the more general context of how categorizations are made:

Although common in Schizophrenia, negative symptoms are difficult to evaluate because they occur on a *continuum with normality*, are relatively nonspecific, and may
be due to a variety of other factors (including positive symptoms, medication side-effects, depression, environmental understimulation, or demoralization).

(APA, 2000: 301; my emphasis)

At least a degree of influence on negative symptoms is attributed to “environmental understimulation and demoralization” and to the (presumably understandable) reaction of having a low mood in response to potentially traumatic and perplexing experiences such as ‘delusions’ and voices (referred to as “positive symptoms” and rendered as understandable to the observer by their inclusion in the list of influences on ‘negative symptoms’). So why are external (and internal?) environmental influences and the understandability of ‘symptoms’ to the observer - from the person’s (potential) ‘points of view’ - barely if ever raised in connection to ‘positive symptoms’? In short, if ‘negative symptoms’ can be recognized as responses to the environment (external and internal; socially-related or otherwise) then why can’t ‘positive symptoms’?

Moral or arbitrary professional choices are made - implicitly and for want of empirical evidence - on the basis of the characteristics, duration, and timing of potential influences on behaviour and supposed mental states. Indeed, more generally, why is personal meaning and social interaction not taken explicitly into account during diagnosis (and therapy)? Diagnosticians (and therapists) ignore an alarming number of potential influences on behaviour. Recall that “[d]elusions are deemed bizarre if they are clearly implausible and not understandable and do not derive from ordinary life experiences” (APA, 2000: 299; my emphases). How can a professional judge such matters of understandability without any reference to the influences on and actions done by the person who is doing the experiencing?

Recall also that a diagnosis of schizophrenia is currently made by a professional observing the person in question, listening to them, and/or being told by others of what the person does or reports of their experiences. Such a diagnosis cannot be performed
without various social (inter)actions (including the representation of observations). How then can the judging of another person’s actions to infer how their brain functions - with both parties supposedly isolated from social and personal context - ever be a scientifically valid activity? And how can the process and outcome of any diagnostic or therapeutic activity be sufficiently ‘meaningful’ if professional points of view are privileged over those of the (initial) ‘owner’ of the experiences?¹⁷

SECTION 3. OUTLINE OF CHAPTERS

The main body of this dissertation is in three parts. Part 1, “A conceptual landscape”, comprises four chapters, including this introduction. Chapter 2 is concerned with analytic methodology. Chapter 3 analyzes data from a canonical psychiatric textbook for professionals (ie, the psychiatric orthodoxy on ‘schizophrenia’) and from cognitive-behavioural therapy manuals for ‘psychotic symptoms’ (ie, potentially, a psychological challenge to biopsychiatric dogma). In contrast, Chapter 4 contains a selective review of alternative, mostly professional approaches to ‘schizophrenia’, ‘symptoms’, and ‘mental illness’.

Part 2, “The production of insanity: Studies of psychotic talk”, comprises three chapters. Chapter 5 is a selective review of discursive studies of ‘severe mental illness’.

¹⁷ I am not necessarily saying that psychiatrists taking social interaction into account will result in ‘better’ diagnoses, although that may well be the case. Rather, I have attempted to point out some of the important logical shortcomings in current psychiatric definitional and diagnostic procedures. It is my view that adequate attempts to address such problems are likely to be of overall benefit to people who would otherwise be diagnosed within the present type of system or within any future diagnostic systems which include biological signs of ‘illness’. Similar advances in what would otherwise be done as ‘therapy’ may also be beneficial.
But none of these studies involve the talk-in-interaction of people diagnosed as ‘psychotic’ in actual clinical encounters. To address this shortfall, my final two data chapters present original analyses of transcripts from a cognitive-behavioural therapy group for psychiatric patients who hear distressing voices. Chapter 6 concerns negotiations of ‘reality’ between professional and patient views; of ‘what really happened’ and ‘what really helped’. Chapter 7 focuses on various aspects of professional privilege and patient prejudice-in-action, as it occurs in the therapy sessions.

Part 3, “Picking up the threads”, brings a discussion of conclusions from our examination of ‘schizophrenia’ and hearing voices representations, in the literature and in the hearing voices group. This includes relating findings from the data in Part 2 to findings and observations from the materials in Part 1. Finally, we come to a fuller acknowledgement of how little is known about the phenomena in question and an acknowledgement of the need to enhance dialogue; between ‘patients’ and clinical professionals and between various professions. Suggestions are made for putting this into action. Only when such interactions become more widespread will we begin to see how personal and interpersonal understandings might more beneficially fit with or challenge current, biomedical and psychological views.

SECTION 4. PRELIMINARY CONCLUSIONS

The thesis topic has now been mapped. I have argued that present understandings of the hearing voices experience are historically and culturally contingent. They could always have been otherwise and it is possible to re-imagine them. However, dominant contemporary understandings have important ramifications. With a diagnosis of ‘schizophrenia’, people are pathologized and treated medically (along with cognitive
behavioural therapy, on some occasions). They are treated by virtue of those biopsychiatric understandings. In Part 2 of this dissertation we shall see how this state of affairs squares with the talk of actual patients. In this dissertation, the combined methodologies of critical analysis and discursive psychology are used to unpack some of the issues around written texts and talk-in-interaction. These methods are considered further in our next chapter.
CHAPTER 2. METHODOLOGY

Here, I consider analytic methodology in more detail. Section 1 comprises an introduction to discursive methodologies. Section 2 adds a discussion on the application of cultural knowledge and criticism.

SECTION 1. DISCURSIVE ANALYSES

Introduction

The ‘Loughborough school’ of discourse analysis draws on ethnomethodology and conversation analysis (CA), amongst other approaches, to study social action in written texts as well as in ‘conversational’ and ‘institutional’ talk. Membership categorization analysis (MCA) is yet another ‘method’. MCA is often included under the heading of conversation analysis. It is, however, both related to and distinct from CA.

On occasions, I use terms such as ‘discursive approaches’ or ‘discourse analysis’ to include all of the varying CA-inspired DA and MCA approaches in which I engage. That is, terms such as ‘discourse analysis’ can be used as both an umbrella term to include approaches such as conversation analysis and as a distinction from conversation analysis. Discourse analysis, itself, is also practiced in many different forms, some of which can be identified as belonging to a particular school of DA. I do not survey those schools here. Rather, we shall focus on CA, the Loughborough school of DA, and MCA.

Discourse analysis and conversation analysis have both grown out of ethnomethodology (EM). Briefly, EM is the study of the practical action of ‘Member’s
methods’, as described by its pioneer, Harold Garfinkel; conversation analysis focuses on the fine-grained study of turn-by-turn interaction in and through talk (Sacks, 1992; ten Have, 1999; Silverman, 1998; Hutchby & Wooffitt, 1998); and discourse analysis draws on EM, CA, and more to analyze the form and function of social action in discourse (including across accounts; Potter & Wetherell, 1987; Wetherell & Potter, 1992; Potter, 1996; Leudar & Nekvapil, 1998). CA focuses on normative, sequential aspects of talk-in-interaction and DA focuses on rhetoric and discursive manoeuvres in talk and text.

However, it is perhaps easier to demonstrate than define these approaches. Just as EM is an overarching set of principles and interests rather than a specific methodology, so too are CA and DA. Perhaps, though, this is true of CA and DA to a lesser extent than EM, as the analytic methods, their data sources, and their canonical analyses become somewhat established and institutionalized themselves (see Hester & Frances, 2001, on ‘applied’ vs ‘pure’ CA; see also ten Have, 2001).

Membership categorization analysis (MCA) is the systematic study of categories in talk and text, as performed by ethnomethodologists and conversation analysts (Sacks, 1992; Antaki & Widdicombe, 1998; Silverman, 1998; Hester & Eglin, 1997a; Jayyusi, 1984). Typically, there is a focus on what mainstream social psychologists might describe as ‘social identity’, but from an interactional perspective.

Discursive psychology (DP) may be defined as the application of discourse analysis to accounts of, and accounts which implicate, psychological phenomena (Edwards & Potter, 1992; Edwards, 1997; Edwards & Potter, 2001; and especially Edwards & Potter, 2004). Edwards and Potter (2001) summarize DP, as applied to institutional settings, and counselling in particular:

[Descriptions and formulations] formulate the world and the identities of the participants in a range of different ways, and they have a range of practical upshots. Our
general point has been to show the value of treating discourse as *occasioned* (in this sequence, in counselling talk), as *action-oriented* (addressing a range of practical counselling tasks), and as both *constructed* (from particular terms and devices) and *constructing* (of the clients’ problems in ways that prepare them for counselling work).

(p. 24; original emphasis)

Rather than add further to the somewhat abstract discussions of Chapter 1, this chapter focuses on a more practical ‘how to’ approach to discourse analytic methods. That is, I will attempt to explicate ‘what was done’ in the analyses which are contained in this dissertation. Indeed, like ethnomethodology and conversation analysis, DA is more of an approach than a method, per se. As McHoul and Rapley (2001b: xii) put it, these methods are not to be followed slavishly, but, like Wittgenstein’s ladder, they are to be kicked away once they have performed their function.

**Discourse analysis**

Having attempted to introduce certain aspects of what discourse analysis involves (ie, what it *is*), I shall change tack and consider what it *is not*. To achieve this, I turn to Antaki, Billig, Edwards, and Potter (2003). Essentially, this is a ‘how not to’ guide for DA. But, rather than being merely negative, it can help decide whether particular instances of analytic practice are sufficiently rigorous, thus serving as a ‘how to’ guide by contrast. Thus, it is not the case that ‘anything goes’, a criticism which is often levelled at qualitative methods by those who work with quantitative methods. Antaki et al. also take great pains to maintain a generality in their paper so as not to grossly favour one form of DA over another; hence the lack of examples of what they deem to be analysis proper.¹

¹ See Burman’s (forthcoming) commentary on this paper, in which she adds three further shortcomings and argues for the inclusion of “a wider spectrum of discursive approaches”.

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The authors describe six forms of non-analysis: under-analysis through summary, under-analysis through taking sides, under-analysis through over-quotation or through isolated quotation, the circular identification of discourses and mental constructs, false survey, and analysis which consists in simply spotting features. Antaki et al. describe and offer limited examples of these non-analyses by referring to a single piece of data, an interview on the nature of marriage.

One of the first points which is made concerning ‘Under-analysis through summary’ is that transcription is not theory-neutral. Decisions of what to include in a transcript and how to include it should not be taken lightly. (I add to this, the matter of deciding which parts of a transcript to include as extracts). In connection to this, the authors warn against the presentation of transcript alone, in place of analysis proper. The transcripts (and any audio or video that is supplied) are the data in the paper, not the analysis. Just as quantitative analysts perform statistical tests on their data, rather than merely present raw data or graphs of data, so too must discourse analysts analyze their data. The mere presentation of summaries of discursive data is akin to the presentation of graphs without noticing anything, without drawing any conclusions. A summary loses information without adding anything. The authors illustrate this by condensing their 3 pages of transcript into 3 lines of summary: “the Respondent is expressing a belief in the desirability of marriage and the necessity to work hard to maintain marriage relationships; he stresses that in this view the demonstration of commitment is important and that divorce has become too easy” (Antaki et al., 2003). Such a summary does not, for example, identify a ‘discursive theme’ or an ‘interpretative repertoire’ (more on these later). Indeed, it misses out on the fine grained detail which is contained in the transcript, such as the presence of an apparent switch of position on marriage. Nor does the summary analyze possible effects of the switch and the detail of how it is presented and in what context. Summaries may prepare for analysis but that is the most
they can do. At worst, summaries can distort what speakers say and pre-frame data within externally imposed categories/theories, thus markedly colouring any subsequent analysis proper before it has even begun.

Although summaries are not analyses because they do not add anything to data, it does not follow that all additions are analysis. The section entitled ‘Under-analysis through taking sides’ speaks to this issue. The authors note that position-taking by analysts is a matter of much debate and there is not even complete agreement amongst the authors themselves. However, an analyst’s alignment or critical disalignment with positions which are taken by those whose words are being studied is not analysis in itself, whatever the subject matter, whoever the participant(s). Using Antaki et al.’s examples concerning the marriage interview data, an analyst might say that the respondent “‘takes seriously’ the idea of marital commitment and ‘sees the problems’ of divorce”. These mentalistic ascriptions are an example of what the authors call “pointed references”.

It is pointed references which are probably most relevant to this dissertation. These also do not constitute analysis in themselves. An example provided by Antaki et al. is that a radical feminist “might summarise the respondent’s comments and add that the respondent ‘fails to understand the patriarchal nature of marriage’”. Given that this is a description of a failure by the hypothetical feminist analyst (ie, the respondent does too little), the authors add that an analysis proper could emerge from this avenue if, for example, there is a highly detailed examination of the respondent’s discursive strategies to counter such themes of gender inequality, and all this in the situated, interactional context of questions and other contributions from the interviewer. These are my goals.

Some of this analytic rigour, then, is a product of data being interactional. Although interactional data does not feature in Part 1 of this dissertation, it does in Part 2. In Part 1, I criticize the authors of what I describe as psychiatric orthodox discourse for doing
too little (eg, the prejudice-in-action of too little listening to other points of view) but I recognize that the absence of something can be harder to prove than the presence of something. I also endeavour to show how orthodox psychiatric discourse is replete with the privileging of orthodox professional points of view; the other side of the same coin. Nevertheless, as Antaki et al. put it:

> Thus, one can say that under-analysis can occur when the analyst substitutes sympathy or scolding for detailed examination of what the speakers are saying. A particular danger is that the desire to sympathise or censure, when not allied to careful analysis, can lead to the sort of simplification that is the antithesis of analysis.

(2003)

The next category of non-analysis which is described by Antaki et al. is ‘Under-analysis through over-quotation or isolated quotation’. The first part, over-quotation, might be seen as the antidote to under-analysis through summary. However, over-quotation adds precious little to the text by way of analysis. Typically, a quick sighting of a low ratio of analysis to quoted data is enough to warn of this. Antaki et al. add that another common sign is when text by the ‘analyst’ tends to refer to the quotations rather than analyzing them. Presumably this is criticizing the referencing of large pieces of quotation as opposed to referring to (and analyzing) smaller phrases or words from the quotation. However, I suggest that analysis which involves what are called ‘interpretive repertoires’ (see below) may be considered a special category of analysis proper in the way that it tends to refer to relatively large pieces of quotation. Either way, what is being targeted here is the removal of talk and text from its discursive context. I suppose that one reason why the consideration of interpretive repertoires may not be considered (by some) to suffer greatly from this criticism is because, rather than isolating quotations from their context, the invocation of interpretive repertoires attempts to link pieces data to a wider discourse than is apparent within the close-up context of the data.
This, however, has its trade-offs in tending to sacrifice some of the local context. What appear to be aspects of this position are considered by Antaki et al. in their later section on the circular discovery of discourses (see below).

Isolated quotation is also identified by Antaki et al. as under-analysis. An example of this is when a single quotation is left to ‘speak for itself’, as if its contents were so obvious as to require no analysis. I have made use of isolated quotations in previous chapters (especially at the end of a section, for dramatic effect). Antaki et al. (2003) write that “[a]t best, this may be a rhetorically powerful embellishment of an analysis done elsewhere; but Under-Analysis through Isolated Quotation is not itself analysis”. I have nothing more to add.

We now move on to two related kinds of analytic errors which are at the heart of the conceptual framework of Loughborough discourse analysis: ‘The circular discovery of (a) discourses and (b) mental constructs. The circular discovery of discourses is an under-analysis error which is most likely to occur in the context of the analyst compiling quotations into a profile. This may be done when an analyst studies how certain discursive devices are used in certain contexts, or when they study purportedly shared patterns of understanding/interpreting the world. Such patterns are sometimes known as ‘interpretive repertoires’, ‘ideologies’, or ‘discourses’. Some analysts consider it important to link selected texts together on this basis, to show how they were ‘drawn’ from socially shared discourses.

This is certainly adding (a sense-making) to the data. However, notice that, in isolation, this practice is more about explicating themes (ie, content) than actions. Antaki et al. discuss how identifying discourses can lack substance if the quotations are simply left to speak for themselves. Without backing up claims of a discourse with a detailed analysis of its form and (ideally) its situated functions, socially shared phenomena lack substance. This ethereal quality comes to the fore when analysts
engage in circularity by using certain discourses as an ‘analytic explanation’ of the data, whilst using the same data to ‘substantiate’ the ‘presence’ of certain discourses. For example, with the marriage interview, an analyst might ‘amass’ a number of quotes from the respondent which are said to include the theme of ‘marital commitment’. Other respondents might also be included in this, if their responses fit the theme. The analyst may then claim to have ‘discovered’ the discourse of ‘marital commitment’ and then rely on that discourse in their explanations of the data.

The problem, here, is that this endeavour does not constitute analysis if discourses are merely a handy way of referring to specific pieces of data which share a common thematic content. All this actually does is act as a summary of data, and it does so arbitrarily, so far as the social action of talk and text goes. To take an extreme example, one could identify content on the basis of a certain word occurring, such as ‘kettle’, and argue that all data which include the word ‘kettle’ is ‘kettle discourse’. One problem is deciding on the size of these extracts of ‘kettle discourse’. What should the unit of analysis be? The word? The entire transcript? And what is ‘kettle discourse’? Does it concern a particular kind of household appliance perhaps, offering someone a drink, or some kind of social action in the context of a relationship break-up? Does it make sense to consider these all to be, primarily, ‘kettle discourse’? Such questions highlight a property of words and utterances which discursive analysts call *indexicality*. Briefly, ‘indexicality’ describes the way in which “the meaning of a word or utterance is dependent on its context of use” (Potter, 1996: 43). One sentence may refer to, or index, one particular kettle but a different sentence may index a different kettle or the same kettle in a different context. Thus, understanding the meaning of a word or phrase requires consideration of the context in which, and for which, it was deployed.

Applying such matters to Antaki et al.’s marriage interview data, circularity ensues “if the analyst, having quoted extracts to claim the existence of a ‘marital commitment
repertoire/ideology/discourse’, then goes on to imply that *the speakers made those particular utterances because they shared this discourse, repertoire or ideology*” (Antaki et al., 2003; my emphasis), as context. Thus, the social constructs in this argument (ie, shared knowledge in and through shared discourse) are pasted into a circular argument which approaches mentalism, as context. This position is just one step away from directly invoking a ‘discourse’ as a motivator which is in the heads of participants and not just in the transcript.

If the latter step is fully taken then it involves what Antaki et al. call ‘The circular discovery of mental constructs’. Such circular arguments assume a mirror model of communication (see Chapter 1 of this dissertation). At their most obvious, they involve taking participants’ psychological phrases such as ‘I think’ and ‘I feel’ and working with them under the assumption that they are exactly the same as the thoughts and feelings which are supposedly in participants’ heads. Rather than being subject to analysis, psychological states, dispositions, etc, are taken at face value. Thus, in a circular fashion, mental ‘entities’ may be used in the explanation of discursive ‘entities’, and vice versa. They are taken as having equivalent explanatory currency.

A discursive psychologist would, instead, analyse what phrases such as ‘I think’ and ‘I feel’ achieve, as social action. For example, one possibility in the marriage interview is that the respondent might use phrases such ‘I think’ and ‘I feel’ in order to appear respectful of others’ views whilst describing views of their own. A detailed analysis would need to develop around this discursive practice, if it is to be substantiated as such:

...to see how the speaker manages the dilemmas of presenting opinions forcefully but without seeming to be dogmatic. One would note how the speaker backtracks, going from strong statements about marital commitment to giving reasons for divorce if either ‘party are really unhappy’ (an analyst might ask precisely what the ‘really’ is accomplishing here); how he gives justifications; how he qualifies his utterances and so
on. One would examine what the addition of ‘I believe’, ‘I think’, or ‘that’s my view’ perform in the interaction. One would consult the relevant previous research on all these conversational moves and apply the accumulated insights to the present data. Or we could collect a corpus of examples of when and how people use such expressions as ‘I believe’, and ‘I think’, and examine what kinds of work such expressions perform, what kinds of contingencies they handle, what kinds of contrasts they occur in, and so on.

(Antaki et al.: 2003)

Although I make extensive use of the shorthand of ‘orthodox psychiatric discourse’ in this dissertation, I have tried to avoid arguing that, for example, ‘professionals or patients wrote or said such-and-such because they were using a particular discourse’. Rather, I have tried to locate my use of ‘discourse’ within an explication of social action, just as Antaki et al. advise:

...analyses must provide some extra elements. The analyst might, for example, want to show how particular repertoires, ideologies or discourses are drawn upon to deal with specific features of the conversational interaction, such as particular moves from the interlocutor; or that when speakers use this repertoire in a general way, they will tend to qualify it by introducing counter-themes... Such an analysis would draw attention back to the details of the talk, as the analyst seeks to relate specific use of themes to specific conversational junctures. Much more will be required than quotation and assertions of commonality to sustain such an analysis. The analyst would need to demonstrate the commonalities in detail.

(2003)

Besides advocating a firm grounding in the data-at-hand, the authors make an allowance for the optional value of including a consideration of claimed ‘discourse(s)’ which is beyond the transcript. Stating something about the wider occurrence and nature of the ‘discourses’ can help to substantiate claims of their existence. For example, the
historical development of the discourses in question could be researched and discussed. However, any such consideration would need to refer back to discursive actions within the data-at-hand (including the demonstration and invocation of shared knowledge).² To these ends, in my consideration of representations of ‘mental illness’, I have invoked both history and a wider contemporary social context than is immediately apparent within the presented data. That is, so far, I have aimed for the weight of evidence to stem from a relative broadness of coverage, more than a fine grained density of analysis.

The error of ‘False survey’ is when a researcher over-generalizes from their analytic findings to ‘the same kinds’ of text or participants which are beyond the data. I suggest that this is an obvious danger in the study of data from applied settings, where ways of (inter)acting can be so easily assumed to be a product of institutions (other than conversation, that is). Assuming that specific data represents a class of data is an easy trap to fall into with applied data because settings are typically assumed to be institutions on the basis of institutional buildings, uniforms, and the like. In this sense, institutions can be assumed into being, rather than constituted in interaction. It is then tempting to simply compare data from one instance of the institution to the next. It is an easy mistake for an analyst to give the misleading impression of reporting survey data. A working compromise must be drawn clearly between generalization and specificity. However, in DA and CA, the locally situated nature of data should remain paramount.

Finally, we come to Antaki et al.’s remaining category, ‘Under-analysis through spotting’. The authors begin with recognizing the developed literature on numerous conversational and rhetorical features. The recognition of a menagerie of discursive devices can be useful in training but it obscures detailed, focused analysis. Just as analyzing the history and functions of railways is not achieved by a pile of train-spotting reports, analytic research should not consist primarily of feature-spotting. The

² It is the latter, bracketed point to which I perhaps pay insufficient heed in my analyses.
authors describe how their example marriage interview is laden with noticeable features but explain how the mere spotting of such features would not count as original research. Novel analytic research needs to be grounded in the inter-actional business at hand, to show how discursive features are formed in such-and-such a way, in a particular context, to (potentially) produce a particular outcome. Here, the authors note that proper analysis “moves convincingly back and forth between the general and the specific” (Antaki et al., 2003).

**Conversation analysis**

My ‘how to’ for CA focuses on Baker, Emmison, and Firth’s (2001) study of telephone call openings on a computer software helpline. This concerns a kind of institutional help giving and receiving, as do psychiatric services in general and therapy in particular. As such, it is an apt example of applied CA.

The authors describe how they drew from approximately 50 calls in their transcribed data corpus to systematically elucidate a “general sequential framework” which applies to most of their calls (p. 42). It can therefore be described as involving the study of a collection of cases, as opposed to being a single case study (Hutchby & Wooffitt, 1998, chap. 4 & 5). Baker et al. helpfully describe the sequential process which they themselves went through in doing their analysis. This includes (1) observing scene-setting ethnographic information about the workplace setting being studied; (2) focusing on call openings, rather than other parts of calls; (3) noticing regularities in the call openings; (4) elaborating and refining the analysis of such regularities to identify the components of a general sequential framework which applies to most calls; and (5) tracking the calls which are made to technicians to see how the calls fit with serially related complex work practices, including tracing backwards to the organization’s pre-technician ‘gatekeeping’ stage and forwards to their specialized technician stage.
The authors begin “The call openings” description of their study (step 2, above\(^3\)) with an account of their having gained a number of transcribed phone calls, of varying duration, and deciding to ‘start at the beginning’. Baker et al.’s first extract is included below. CT is the call taker and C is the caller:

Extract 2.1 (from Baker et al., 2001: 43)

1. CT welcome to Microsoft technical support, this is Leena,  
2. can I start with your customer number please  
3. C yes that’s three five oh (.) six four four  
4. (1.8)  
5. CT it’s Benny is it?  
6. C yeah that’s right  
7. CT how can I help you?  
8. C I’ve recently installed Microsoft office pro:  
9. (0.4)  
10. CT yeah  
11. C and in the access part of the thing I’ve- I wanna use  
12. the membership (.) but I’ve got those Americanized  
13. dates an’ phone numbers an’ erm there’s some form of  
14. ma:sking on them?  
15. CT yes there’s an input mask on them?  
16. C yeah I wanna- how do I get that bin to an Australian  
17. standard?  
18. CT you need to edit the ma:sk

Baker et al. describe how, after looking closely at only 2 or 3 calls, they began to notice some regularities in the call openings. For example, there was an initial sequence of turns during which the call taker ascertains caller name and number. This phase tends to take a certain form and can contain detail which is important in the problem-talk proper.

The structure of regularities search continues, with further data, in the authors’ next section, “First finding a structure of regularities”. For example, they noticed the ‘open’ aspect of the CTs turn ‘how can I help you?’. This is said rather than ‘can/may I help you?’, as heard often in shops and offices. This is an example of CA’s interest in its own question of ‘why this now?’, ‘why was such and such said/done, rather than available alternatives?’. A feature of ‘how can I help you?’ is that it cuts straight to

\(^3\) The authors themselves do not use the term ‘step’ and caution should be taken so that Baker, Emmison, and Firth’s (2001) account (or any account of such ‘method’) is, at most, a guide and not a rulebook.
problem-description. The typical answer to the question is the caller describing their problem, not saying ‘you can help me by doing such-and-such’. Thus, Baker et al. point out that this moving straight into problem-description is jointly accomplished by both speakers.

Another CA staple is what is known as the next turn proof procedure. This is where an utterance, which may be hearable to the analyst in a certain way, for example, as a question, is taken by the analyst to be a question only if both participants treat it as such; locally, interactionally. For example, a question is usually followed by an answer in the next turn (and an answer is usually preceded by a question). Other examples include greetings and return greetings, and offers and acceptances/refusals (Hutchby & Wooffitt, 1998: 39 ff.). These ‘paired action sequences’ are known as adjacency pairs since, a first pair part is typically followed by the second pair part in the next turn. Indeed, there are even typical ways of responding to certain first pair parts. For example, a particular question may call for agreement as the preferred response (see, Pomerantz, 1984). Disagreement is typically dispreferred. Note that it is not the participants’ personal preferences which are being considered, here, by the analyst. And, when the preferred response is absent, then certain inferences about the potential respondent are made relevant: Why did they not respond so? However, questions and answers can take many forms and analyses have shown that participants have many ways available to them for seeking or providing information whilst reducing the likelihood of being seen to be doing just that. When, for example, a dispreferred response is given, a speaker tends to use what are known as dispreference markers, such as ‘well’ and ‘uhm’. (In terms which are rather more DA than CA, this can be seen as a way of minimizing confrontation, and so on).

These are all shared resources, which are available to Members (ie, interactants) for bringing off a conversation. A fundamental aim of Sacks was to show how everyday
talk has ‘order at all points’; it is fundamentally systematic, even down to what might, without systematic study, seem to be the most trivial and incidental of features. Talk (be it the institution of ordinary conversation or institutional talk which is, more or less, based on ordinary conversation) is normative. This is not in the statistical sense (although that may, on occasions, be the case), but in the sense of participants operating within, or otherwise orientating to, a usually unspoken and unwritten set of guidelines, available to all Members. These are not rules which must be rigidly adhered to, but a set of mutually available resources for achieving the sequential process of conversation (and, in rather more DA terms, (inter)action). Thus, CA is concerned with shared methods and shared understandings; embodied in sequences of talk.

Returning to Baker et al., another example of a feature which was noticed in many callers’ problem-descriptions was the presence of brief pauses, place-holders such as ‘um’, and phrases which end in ‘interrogative’ intonation. It is pointed out that these features variously combine to make the talk hearable as: (a) composed on the spot (even though some callers had been kept waiting for a long time), (b) CTs not being sure quite how to describe the problem, (c) leaving places for CTs to add listening tokens (such as ‘mm hmm’), and/or (d) leaving places for CTs to begin talking. Thus, this talk is from a lay person to an expert.

The authors also discuss how CTs mostly leave callers to continue with their description, aiding CTs in the formulation of a solution for callers (ie, recipient design; Schegloff and Sacks, 1973; cited by Baker et al., 2001: 46). It was noticed that callers used recipient design in the way that they used a two- or three-step procedure for locating the problem as being in a particular part of a particular software product. Also, a ‘turning point’ was identified in calls, when speakers moved from C’s description to CT’s first major offering (‘next things’). I turn to quotation to capture the authors’ nuanced descriptions of this part of their analysis:
We found ‘next things’ working not just in one call, but in several. As we found a phenomenon in one call, we then looked for its equivalent in others, thus bringing in more and more examples as we proceeded. We did the analytic work together, re-listening to the tapes while reading (and revising and refining) the transcripts, making observations on what we saw to be happening in the talk, challenging each other with counter-examples, investigating the counter-examples, and building a cumulative sketch, on paper, of the shape of the calls and their components. All of this was done in constant reference to our knowledge of the CA research literature. These activities produced a stronger sense of confidence in our analyses and also generated some small epiphanies when the detective work on tiny details of counter-examples resulted in confirmations of our initial observations. There were equally significant moments when we conceded that some initially exciting idea was not going anywhere.

(Baker et al., 2001: 46)

This extract beautifully illustrates the analytic process of unmotivated looking and deviant case analysis. Unmotivated looking is the practice/aim of allowing phenomena to emerge from the data rather than being searched for on the basis of presumptive theorizing (see ten Have, 1999: 102-103). Later, as ten Have puts it, “there is no escape from a careful and sensitive case-by-case analysis” (1999: 152). The analysis of deviant cases (“counter-examples”, in the above extract) allow for further testing of the regularities which an analyst has seen (ten Have, 1999: 136-137). If an analyst has, on the basis of initial observations, noticed that such-and-such tends to occur in certain conditions then what happens on the occasions when it does not occur in those conditions? Does the analyst need to refine their understanding of the ‘rules’ in operation and/or do participants in some way orientate their speech towards the ‘rule’ whilst, at the same time, deviating from it? In such ways, the analysis can become more finely honed or rewritten, “elaborating and refining” (Baker et al., 2001: 42) our understanding of what occurs in the data in various local contexts.
In their section, entitled ‘Refining the analysis: Components of the openings’, Baker et al. present further data to confirm and refine their description of the structure of call openings. Then, in ‘Components of the call’, ten sequential components are identified as being general across cases of call openings (using terms such as ‘often’ and ‘typically’, p. 49; see ten Have, 1999: 134-137, on generalization). General examples are given for each component. I shall limit myself to a list of the subheadings: (1) The ‘open’ opening by the call taker, (2) The prelude to first talk by the caller, (3) The narrative beginning of initial caller descriptions, (4) The two- to three-step procedure within the narrative, (5) Callers give a narrative account of the reason for the call, (6) (x) and (y) and/or (z), 4 (7) Turn-constructional units and pauses in the caller’s description, (8) Minimal uptake, (9) Talk in relation to minimal uptake (note: including sometimes a diagnosis of the problem, an elaboration of the problem, &/or further evidence of the caller’s detective work), and (10) First substantive insertion (note: by the CT).

In their penultimate section, Baker et al. present ‘A schematic summary of the organization of call openings’. I shall not reproduce it here. The authors note that not every call fits neatly into the sequential structure. However, and in keeping with my above description of CA staples:

These calls are surprisingly regular in their structure. This is all the more remarkable because some of the callers might be calling the helpline for the first time. We therefore witness in these openings to calls the participants’ patterned deployment and competent use of conventional resources in order to get a particular task done. CA is concerned

4 In my summary, the algebra-like notation of step (6) requires a little more explanation. The x and y parts are scene setting in the caller’s narrative description. That is, they concern what the caller has been doing or trying to do with the software (x) or a specific part of the software (y). This is followed by a description of what is happening or not happening (z), which is usually in terms of the computer. (See Baker et al., 2001: 51).
with the discovery of conversational phenomena and their situated and locally designed use in the production of sequences - in this case, a problem-elicitation and description sequence done over the phone...

(Baker et al., 2001: 54)

The authors’ final section, ‘Tracking back’, locates the calls (including certain aspects of their form and content) further within the structure of the organization. An example is the tracing back of calls which are made to technicians to see how the calls fit with serially related complex work practices, including tracing backwards to the organization’s pre-technician ‘gate keeping’ stage and forwards to their specialized technician stage. Although Baker et al. do not state it, in a sense this is using cultural knowledge (or, perhaps more precisely, subcultural knowledge) to supplement analysis of the data-at-hand. How else would the analyst know that there was something to trace back to, without such knowledge? This is a hotly debated subject in CA and DA circles (Wetherell, 1998), as it is in this dissertation; as is the issue of ‘applied’ versus ‘pure’ in CA (Hester & Francis, 2001).

In sum, and borrowing from McHoul and Rapley’s editorial (p. 41), Baker et al. provide an elegant and useful sequential description of their conversation analytic ‘discovery’ of the orderly, sequential openings of software helpline calls. These openings are co-produced by the expert interactants (call takers) and non-expert interactants (callers); each party demonstrating their competence in computers and software helpline conversations.

**Membership categorization analysis**

MCA is the strand of ethnomethodology which focuses on the categorical rather than sequential aspects of conversation (Hester & Eglin, 1997b: 2). A key focus in many MCA studies is what may be described in mainstream psychology as ‘social identity’. 

66
That is, MCA studies are concerned with the ways in which categorizations are performed, especially in relation to the identities of people. The ‘principles’ of MCA were pioneered by Harvey Sacks, alongside his introduction and development of conversation analysis (Sacks, 1992; Silverman, 1998: chap. 5). MCA has since been further developed and applied (Jayyusi, 1984; Hester & Eglin, 1997a; Antaki & Widdicombe, 1998; Silverman, 1998: chap. 7), including studies of how discursive social identity is involved in, and constitutive of, social action. In this section, I shall very briefly summarize some of Sacks’ foundational work on MCA before turning to a brief example of its more recent application.

**Sacks on MCA**

Sacks’ work on MCA can be found in his doctoral dissertation (1966), some of his lectures (1992), and in some of his articles (eg, 1972a, 1972b, 1979). Overviews can be found in Jayyusi (1984: appendix 1), Silverman (1998: chap. 5), and Hester (1998). I turn mostly to these overviews.

The idea of *membership category* and *membership categorization devices* (MCDs) was introduced as follows:

My attention shall be exclusively limited to those categories in the language in terms of which persons may be classified. For example, the categories: ‘male’, ‘teacher’, ‘first base-man’, ‘professional’, ‘Negro’, etc., are the sort I shall be dealing with. Frequently, such ‘membership categories’ are organized, by persons of the society using them, into what I shall call ‘collections of membership categories’. These collections constitute the *natural groupings of categories*, categories that members of society feel ‘go together’. They are not constructed merely as aids to my analysis; whether or not a particular category is a member of a particular collection is, in each and every case, a matter to be decided empirically.

(Sacks, 1966: 15-16; original emphases; cited by Jayyusi, 1984: 212)
Points of note, here, are that this enterprise is to do with: (a) language (but especially talk-in-interaction); (b) social identity categories (i.e., the identity of persons, not objects per se, as understood in terms of social classification); and (c) the analysts’ concern is with the participants’ concerns, as embodied in language (rather than researchers’ categories being imposed upon the data). The natural groupings of membership categories which are referred to in the extract are known as membership categorization devices. Thus, ‘father’, ‘mother’, ‘son’, ‘grandmother’ form the MCD ‘Family’, and ‘teacher’, ‘doctor’, and ‘lawyers’ belong to the device, ‘Occupation’ (Jayyusi, 1984: 212).

Sacks’ work focuses on systematically explicating how Members make sense of the world by their use of membership categories and MCDs. As with conversation analysis, this work is fine-grained and technical. With both conversation and categorization, the behind the scenes machinery is remarkable, making social interaction appear so simple; so easy to take for granted. However, the selection of a membership category, from the many which may be relevant for a person on any particular occasion, is not simply a matter of correctness. It depends on such interactional and analytically complex matters as appropriateness, recipient design, implicativeness, and orientation to categories already present in the discourse (Jayyusi, 1984: 212). There is so much to explicate within what is otherwise simply taken as ‘common sense’.

Sacks’ term ‘implicativeness’ refers to how the invocation of some categories, or notable lack of aspects of their invocation, can come with certain normative implications, depending on the type of category and the local context of the interaction. That is, on this basis, certain inferences about the person being categorized (or the person doing the categorizing) may ‘naturally’ be drawn by observers.

However, despite this complexity, Sacks was able to identity the essence of membership categorization as working with a few elegantly simple (but still technical)
constructs and rules. For example, there is the notion of *category-bound activities* (CBAs). These are characteristics of membership categories; they are particular activities which are linked to particular identities. Along with the direct naming of a category, CBAs are one way in which a particular category may be assigned to a particular person or persons. Any CBA is, thus, normatively attached to one or more categories. Such norms are available to Members as an interactional resource for making sense of others and making sense to others. In this regard, Sacks describes a *viewer’s maxim* for CBAs:

> If a Member sees a category-bound activity being done, then, if one sees it being done by a member of a category to which the activity is bound, see it that way.


Subsequent researchers have gone on to study different kinds of category-bound characteristics (different *category predicates*), besides activities. These include rights, entitlements, obligations, knowledge, attributes, and competences (Hester, 1998: 135).

To understand this and other related notions further, let us turn, as is the custom, to a quintessential example from Sacks’ child’s story opening, ‘The baby cried. The mommy picked it up’ (1992, vol. 1: 236). To illustrate a point about this example, Silverman begins with the sentences, stripped of nouns: ‘The X cried. The Y picked it up’ (1998: 78; citing Sacks, 1992, vol. 1: 248-249). Why are observers likely to hear X as being a baby, rather than a teacher? And why is Y probably taken to be an adult, and specifically the baby’s mother?

The activities of crying and being picked up are taken to be the kind of things which babies do, just as mothers are taken to be the sort of people who pick up crying babies. That is, in this X and Y example, CBAs invoke the identities of X and Y. Thus, according to Sacks, with ‘The baby cried. The mommy picked it up’, we infer that the categories ‘baby’ and ‘mommy’ go together as incumbents of a collection of categories.
known as ‘Family’ (1992, vol. 1: 238) (an MCD). Furthermore, once a category has been applied then the failure of the categorized Member to perform a particular CBA in a situation which warrants the performance of that CBA may entitle an observer to infer that a different category now applies (Jayyusi, 1984: 217).

Sacks, however, holds that MCDs are more than just collections of categories which are normatively inferred from nouns and/or CBAs: A device is ‘a collection plus rules of application’ (1972b: 332; cited by Silverman, 1998: 79). A few of these rules are summarized below.

Silverman describes the economy rule, by continuing with the child’s story (p. 79). ‘Baby’ and ‘mommy’ are single category descriptions, in that other descriptions of the mother and baby (such as age) are not included and that is not a problem in making sense of the categories. The application of a single category to each Member (‘baby’ to one, and ‘mommy’ to the other) is sufficient to settle their identity.

A second, related, application rule of MCDs is known as the consistency rule. This holds that if a category from a given collection has been applied to someone for whom it is relevant (a population member) then that category or other categories may be applied to other people. That is, the application of a particular category to a particular person makes relevant the application of that category and certain other categories to other people.

However, as it stands, potential ambiguity remains. There are many different, perfectly accurate, ways to describe someone. That is, a category can belong to more than one collection. For example, the child’s story extract could be described as ‘The male shed tears and the female picked him up’. But the categories in this contrived

5 It is worth noting that the word ‘may’ highlights the normative quality of these rules: they are guides to Members rather than hard and fast rules.

6 Recall my mention of indexicality and its significance to the discursive approach.
example are not co-selective of, and co-selected by, the respective CBAs; not in the way which occurs with the naturally occurring baby and mother example (Hester, 1998: 135). Similarly, ‘baby’ can be part of a collection other than ‘Family’, such as ‘Stage of life’ (along with ‘child’, ‘teenager’, ‘adult’, etc).

Sacks resolves this apparent ambiguity (just as he claims Members do) with a ‘hearing rule’ which he dubs the consistency rule corollary (1992, vol. 1: 239 & 248, respectively; cited by Silverman, 1998: 80): when two members of a population are described which may belong to the same MCD then hear them that way.

It is now clear why we hear the ‘mommy’ and ‘baby’ to be part of a ‘Family’ collection (as opposed to, say, ‘mommy’ being an ironic description of someone who is treating you like a child and ‘baby’ being a term of endearment to a romantic partner). However, it is not clear why ‘mommy’ and ‘baby’ are taken to be in the same family. To account for this, Sacks explains that ‘Family’ is a kind of collection in which the members belong together, like a team. He calls this property duplicative organization (1972b: 334; 1992, vol. 1: 225, 240, 247-248; cited by Silverman, 1998: 81). Thus, ‘mommy’ and ‘baby’ are hearable as being in the same ‘unit’.

Yet, I suppose (logically, if not interactionally), it may still be that ‘mommy’ and ‘baby’ are in the same family but that the described mother is not the mother of the described baby (eg, they could be a grandmother and a grandchild, an aunt who has children and her niece or nephew, or even sisters). Application rules would therefore also need to account for the mother and baby description preferring the collection ‘Nuclear family’, rather than, say, ‘Extended family’. Sacks’ hearer’s maxim for duplicative organization makes sense of such hypothetical matters:

If some population has been categorized by use of categories from some device whose collection has the “duplicative organization” property, and a Member is presented with
a categorized population which can be heard as co-incumbents of a case of that device’s unit, then hear it that way.


Thus, if the people described were an aunt who has children and her niece then it would be odd for them to be categorized as a ‘mommy’ attending to a crying ‘baby’, unless there was further sense-making information. Here, then, the smaller applicable unit applies: mother and baby are heard as belonging together, as the ‘mommy’ of this ‘baby’.

Sacks makes a distinction between two types of collections which are relevant to mothers and babies. Mothers and their babies are not just part of a team, they have standardized rights and obligations towards each other; they are heard to occupy what Sacks calls collection R.

Collection R comprises what are known as standardized relational pairs:

Any pair of categories is a member of collection R if that pair is a ‘standardized’ relational pair that constitutes a locus for a set of rights and obligations concerning the activity of giving help.

(Sacks, 1972a: 37; cited by Jayyusi, 1984: 214)

Other examples mentioned by Jayyusi are ‘husband / wife’, ‘parent / child’, ‘neighbour / neighbour’, ‘boyfriend / girlfriend’, ‘cousin / cousin’, ‘stranger / stranger’. Such groupings are characterized by mutual helping; mutual (but not the same) rights and obligations between members of the same pair. Thus, a baby has a right to be fed by its

7 Note, however, that this need not preclude asymmetrical power relations-in-action. By this I not only mean those asymmetries that are notorious in, for example, parent-child relations but also those which might be (co-)constructed during interactions between members within any of the standardized relational pairs that occupy collection R. Neighbours, for example, are not always symmetrically ‘neighbourly’ in
mother and, perhaps, an obligation to not cry all the time. Similarly, I suppose that a mother has a right to the joys of parenthood and an obligation to feed her baby.

A second kind of collection described by Sacks is known as collection $K$. This collection involves an asymmetrical helping relationship in which members either occupy the class (professionals) or the class (laymen) (i.e., laypeople) but not both, on any particular occasion:

Collection $K$ is composed of two classes (professionals, laymen)...

All those occupational categories for which it is correct to say that Members of the named occupations have special or exclusive rights for dealing with some trouble(s) are occasional occupants of $K$’s class (professionals).

(Sacks, 1972a: 39-40; cited by Jayyusi, 1984: 215)

A therapist and their client (or patient, as identified in discourse) would be generally taken to constitute an instance of collection $K$, depending on the occasion of interaction. As Silverman notes, certain activities are generally taken to be proper for professionals and clients, by way of their membership in collection $K$ (1998: 82). The same is true of certain activities which are generally taken to be improper.

Returning for a final look at our child’s story, ‘baby’ also occupies a class known as positioned categories:

...in one sense of the term ‘baby,’ it’s part of a set of what I’ll call ‘positioned categories:’ ‘baby’ ... ‘adolescent’ ... ‘adult.’ The dots mean that there are other categories in there, in various places. By ‘positioned’ I mean such a matter as, that ‘B’ could be said to be higher than ‘A’, and if ‘B’ is lower than ‘C’ then ‘A’ is lower than ‘C’, etc. And I’m not specifically intending that by ‘higher’ or ‘lower’ what we’ll be their interactions. Similarly, different class members of collection $K$ can enact a mutuality, as I show in this dissertation with therapists and patients.
talking about is anything like the mere fact that there’s an age progression. That is not what is key to a positioned category collection.

(Sacks, 1992, vol. 1: 585; orig. emphasis & subsequent ellipses; see also Silverman, 1998: 84)

Sacks goes on to elaborate how, on the basis of an incumbent’s position in comparison to other positions in the progression, they can be praised, warned, or challenged for performing or not performing position-relevant CBAs.

The status of Sacks’ MCA work in relation to conversation analysis, and the degree of MCAs reliance on cultural knowledge (see my continuing discussion, below) rather than the data-at-hand has been called into question, notably by Schegloff (see Silverman, 1998: chap. 7). In Schegloff’s introduction to Sacks’ Lectures on Conversation (Schegloff, 1992, vol. 1), Schegloff describes the “quasi-generativist themes in the Fall 1965 lectures, and in the 1964-5 lectures” (xxxviii): Sacks had become interested in culture-in-interaction, along with his work on sequential organization. On this topic, Schegloff later notes that “[i]f the Spring 1966 lectures were especially ‘anthropological’ in orientation, then the Fall 1967 lectures are especially oriented to linguistics” (lv), with the latter referring to the challenge of what became sequential analysis vs established linguistics. Although at various points in the introduction Schegloff clearly favours Sacks’ sequential interests over Sack’s interest in culture, the introduction provides a valuable account of the differences between and the interplay between the emerging fields of conversation analysis and discourse analysis, respectively. Consider, for example, Schegloff’s account of Sacks “testing the claim that the categorization device ‘therapist/client’ is ‘omni-relevant’” (xlii; re the next turn proof procedure; see xliii):

Sacks sometimes asserts a claimed category-bound activity without carrying through a test or deriving a further finding (e.g., lecture 4, p. 302), but there can be little doubt that the principle is basic - commonsense knowledge cannot properly be invoked as itself providing an account, rather than providing the elements of something to be
accounted for. [I omit Schegloff’s endnote, here] In my view, Sacks abandoned the use of ‘category-bound activities’ because of an incipient ‘promiscuous’ use of them, i.e., an unelaborated invocation of some vernacularly based assertion (i.e., that some activity was bound to some category) as an element of an account on the investigator’s authority, without deriving from it any analytic pay-off other than the claimed account for the data which motivated its introduction in the first place.

(Schegloff, 1992, vol. 1: xlii; my emphases)

My emphases mark what I take to be Schegloff’s use of internalizing devices to disparage the practice (and, by extension, the person) of any analyst who uses cultural knowledge in the course of an analysis. I take the unifying notion between these two positions to be our shared interest in considering “a culture - and language as one component of culture - to be organized on the basis of ‘order at all points’” (xlvii). In this way, “a culture is not then to be found only by aggregating all of its venues; it is substantially present in each of its venues” (Schegloff, 1992, vol. 1: xlvi). (See also Rapley, 2004, especially chap. 2).

Criticisms such as Schegloff’s are likely to be stronger against non-interactional data (such as in Chapter 3 of this dissertation), however they can also be firmly levelled against interactional data. Despite or because of this unsettled debate, in Chapter 7 especially, I still intend to explicate Members’ (co-)constructions of sanity-related identities and their hierarchical positioning. Thus, I claim to principally explicate social power relations-in-action, within the normative bounds of social interaction, rather than in relation to some cultural theory or the like.

**MCA example**

For our example of MCA in practice, we take a selective look at a study by Hester (1998) on the identity of the ‘deviant’ child in school. In particular, these are teachers’
categorizations of pupils, as suitable referrals for help from an educational psychology service. Rather than treat talk as an analysts’ resource - for example, to aid in the abstraction of a classificatory system of ‘deviance’ - and rather than theorize about ‘deviance’, Hester seeks to study the identity as a topic in its own right. Thus, he analyzes ‘deviance’ as situated practical accomplishment.

Hester begins with an initial consideration of category contrasts. For example:


HT: He’s he’s such a ahm you know so many children if they are telling you lies you [it sta]nnds out a [mile] the lying but with=
EP: [Mn ] [Mn ]
HT: =Robin.
EP: He’s good.
HT: ((sotto voce)) He’s very good.
EP: He’s quite I can’t re[member the the exact assessment].
HT: [He’s very good and so inno]nt looking.
EP: Yeah I seem to remember he’s at least average intelligence isn’t he?

Hester notes that, here, there are two parts being contrasted: the observability of ‘telling lies’ of the referred child, Robin, versus “so many children”. In this instance, Robin is rendered as ‘abnormal’ for being too able, compared to ‘normal’, apparently detectable lying. (Thus, being able to lie well in such circumstances is presented as problematic, ‘bad’). Hester also notes how the category contrast is collaboratively produced, in that the headteacher’s (HT) first utterance is completed by the educational psychologist (EP), with the candidate categorization “He’s good”, and then upgraded by HT, with “He’s very good”.

The next topic of analysis is the ‘stage of life’ membership categorization device. We saw earlier that this kind of MCD is what Sacks called a positioned category device. For example, there are ‘age terms’ such as ‘one year old’ ... ‘six year old’ ... ‘forty year old’.

These are categories which can, of course, be used contrastively. Hester cites Watson and Weinberg (1982) in pointing out that there are numerous devices within educationists’ discourse which are ‘mapped onto’ the stage of life device. For example
there is ‘stage of education’, ‘stage of emotional development’, ‘stage of language development’, and ‘stage of sexual development’; each with categories which are mapped onto corresponding stage of life categories. Thus, a child of a particular age is expected to have attained the corresponding ‘normal’ level of speech, reading, motor control, etc, and to have certain features, abilities, and interests. A child who displays attributes or performs activities which correspond to children from a lower stage of development does not measure up to the standard. These children may be ‘marked out’ as being ‘deviant’ and/or as having ‘special needs’:

Extract 2.3 (from Hester, 1998: 139-140, Code AN/1)

HT: ...but it wasn’t very long before we realized that it was more than just a poor speaker, he—he can’t speak very much at all, he—
he doesn’t know the language, he [doesn’t know]=
EP:                                [Mm hm       ]
HT: =the names of common objects, no response to various simple instructions such as ‘stand up’, ‘sit down’, he’s really functioning like an=
EP: =Mm hm=
HT: =eighteen month or two year old baby.
EP:  Mm hm

By listing the child’s linguistic deficiencies and going on to state that he is functioning like an eighteen month or two year old, the headteacher implicitly (my word) contrasts the child’s functioning with those of his ‘normal’ peers. That is, it is hearable that the child’s level of competence belongs to the category ‘two years old’ rather than ‘four years old’. This is hearable as a problem. Thus, the child is identified as ‘deviant’, as below the ‘norm’.

Hester moves on to explicate two kinds of category contrast which both describe changes in the seriousness of pupil ‘deviance’ over time. These are retrospective category contrasts, which distinguish between the present and the past by describing the present as worse, and prospective category contrasts, which distinguish between the present and the future by describing the future as worse, unless (by implication) an intervention takes place. Below, is an example of a retrospective category contrast:

MT: ...up till: (0.5) ergh Easter (0.6) though-I-his attitude to: teaching he=er to me particularly (we have gathered from what-is- is) attitude to teaching (.) is one of (.) non-cooperation and contempt.

SW: Mhmm.

MT: And (0.5) but (0.9) this was only in the manner of you know he wasn’t prepared to work (0.5) he-e-wasn’t as far as I was concerned up till this term.

SW: [Mhmm.]

MT: [Um   ] (0.5) actively non-cooperative you know (.)=

SW: [mmhmm    ]

MT: =positively disruptive (0.5) and in the last few weeks he has turned to being positively disruptive.

Thus, the individual’s behaviour (and ‘attitude’) has changed from “non-cooperation and contempt” to “positively disruptive”.

Here is an example of a prospective category contrast:

Extract 2.5 (from Hester, 1998: 143, Code MP/53)

EP: What’s the worst that’s happened to him here has he been temporarily suspended [or] anything like this?

MT: [No]

MT: Time he had

EP: Mhmm.

MT: Right anytime (.): now (.): cos I: y’know unless something happens pretty quick that’s what’s gonna have to happen

This predicts a worsening of the ‘problem’ in the future, “unless something happens” (ie, unless there is an educational psychology intervention). In Chapter 8 of this dissertation, I consider uses of time-related constructs in what I call ‘therapeutic change devices’.

Hester also discusses (citing Pomerantz, 1986) how extreme case formulations can be used to render the ‘problem’ as being worse than the kind of problems which schools face on a day-to-day basis.

There are also category contrasts which focus on the teacher rather than the pupil. In the extract, below, the category of ‘inexperienced teacher’ is first invoked, followed by ‘experienced teacher’, and ‘inexperienced teacher’ once more:
First, we have teachers who are “younger” and “less experienced”, who do not want to admit that they are unable to handle the ‘problem’ child, Peter Willis. Then, there is the contrastive category of ‘experienced teacher’, who is invoked through the category bound activity of having “handled lots of stroppy lads” (in addition to the notion of this being a repeated experience over time, which is invoked through the phrase ‘in my time’). That is, even such an experienced teacher is having difficulties with the pupil in question. Finally, the category of ‘inexperienced teacher’ is cemented with the predicate of “going through the agonies” in trying to deal with such pupils. Thus, through both contrastive categories (‘inexperienced teacher’ and ‘experienced teacher’), the seriousness of the ‘problem’ child, for all kinds of teachers, is made clear.

In relation to studying some uses of descriptions of children as ‘deviant’, Hester also considers ways in which descriptions incorporate recipient design. This is defined as follows:

As Sacks (1992; cf. Speier, 1971) has pointed out, categorizations are selections from alternatives; there are always alternative choices available to describers of persons. Attention is therefore directed to the procedural or methodological character of category selection and, specifically, to how categories are selected with a view to their interactional implicativeness and the categorical identities of their recipients.

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8 Note that Hester uses separate extracts to illustrate each category.
Hester suggests that participants in his data actively characterize referral ‘deviance’ as being more serious and warranting educational psychology intervention than day-to-day pupil ‘deviance’. He also notes, however, that there are very few explicit requests for such intervention. Thus, it perhaps falls to recipient design, including the so-designed category contrasts which were discussed earlier, to implicitly lead participants towards the appropriateness of such referrals and intervention. One possibility, in line with this suggestion, is that the ‘problems’ are described so as to fit with the activities of educational psychologists; they are education-related ‘problems’ and the sort of thing with which educational psychologists tend to intervene. Another related possibility is that expert professional action is warranted by the seriousness of the ‘problem’. A final explanation of why explicit requests for educational psychology services are not typically heard in these referral meetings is that one of the category predicates of teachers is to be able to accurately refer appropriate cases. That is, a teacher’s act of referral may be, in itself, enough to justify the professional help required to deal with the pupil’s ‘deviance’.

Similarly, Hester points out that there is a noticeable absence of explicit formulations of what the ‘problem’ definitely is, in relation to educational psychology. Teachers tended to describe certain identifying details of the ‘problem’ but not supposed underlying issues. Indeed, educational psychologists are then all the more required, to provide the diagnostic formulations, in keeping with their profession. With this absence, teachers “display an orientation to a central asymmetrical dimension of the teacher/educational psychologist relational pair” (Hester, 1998: 149). For example, some of the predicates of the category ‘teacher’ are to refer ‘deviant’ pupils when
necessary and to characterize such pupils in terms of there being serious ‘problems’ in educationally and psychologically relevant areas. These actions can be seen as being tailored towards the predicates of the category ‘educational psychologist’ which involve receiving referrals, diagnosing serious problems, and instigating appropriate psychological interventions. In this sense, the teachers’ referral talk is ‘sequentially implicative’ (Hester, 1998: 150).

In both Hester’s school arena and the psychiatric arena the ‘deviant’ person can be seen as occupying the bottom of each respective hierarchy of identities. In terms which are presented by participants within the data and embodied within the data, the person in question is identified as being ‘deviant’; they are evaluated as having lesser abilities, rights, and so forth. Also, the ‘deviant’ person is often not the principal seeker of help in either the schools or psychiatric clinics. And, in the case of the psychiatric patients considered in Part 2 of this dissertation - given the privileging and prejudice which is demonstrably in operation - it would follow that if and when ‘deviant’ people do themselves seek help, for themselves, then they are still likely to occupy a lowly location on any identities hierarchy which includes ‘normal’ people. Part 2 of this dissertation aims to show how such hierarchical identities can be played out during group therapy sessions, in actual talk-in-interaction.

9 Interestingly, in connection to my use in this dissertation of the phrase ‘the person in question’, Hester implies that pupils who are referred for help, who are identified as ‘having some type of problem, ‘special need’, and/or as ‘deviant’’ (1998: 139), “have their competence, progress and development called into question” (p. 139; my emphasis). Note that I use the word ‘implies’ because, in the structure of Hester’s account, he does not quite make the direct statement that readers are likely to conclude from my reverse-order and proximal presentation of these two quotations. Hester, however, does all but actually make such a direct statement.
Discursive analyses as methods of choice

Discursive analyses emphasise a contrast between what was said and alternatives to what was said. But on what basis do analysts purport to ‘know’ such ‘things’?

First, there is the emphasis on data and analyses which are presented by the analyst, for all to see. Thus, discursive analysis is an empirical, data-driven enterprise. Second, these approaches involve a weaving analytic walk between established aspects of talk/text (what is simply taken to be) and constitutive aspects of talk/text (what is constructed and constructive). In a sense, discursive analysts manage this tension with perpetually adaptive looking, compared to the less flexible, established coding of many other qualitative methods and of quantitative methods. That is, the analyst’s knowledge and skills as a Member of ‘the interactional culture’ come into play, in addition to their knowledge and skills as a member of analytic subcultures. These are the sources of ‘method’, of how analysts purport to ‘know’ such ‘things’. Both sources involve the established and the changing. In addition to the data, readers also have, more or less, free confirmatory or disconfirmatory access to the methods used.

Using a discursive approach, I seek to look at the ‘how’, ‘what’, and ‘when’ of the social action which arises in text data of Part 1 and the talk data of Part 2. I do not seek to consider a mentalistic explanation of ‘why’ it happened. Uniting the issues of social constructionism, non-mentalism, and the building of accounts as facts, my interest is not in whether an account is measured by some criteria to be right or wrong (whether an object or internal state is real or not); although sometimes such matters do figure in my analysis. Instead, I am interested in how people use particular aspects of talk to achieve particular actions. At the same time, however, I point to how participants’ (and analysts’) actions may contribute to wider social consequences, such as the social power asymmetries which come with privilege- and prejudice-in-action.
Rather than relying on external categories and systems for interpretation of what was said, I aim to anchor the analyses to what was said/written. For example, in Part 2, rather than grossly categorizing an exchange as ‘therapy’ and even as a particular kind of ‘therapy’, I will investigate relatively fine-grained and interrelated structures of such talk. Even apparently innocuous analytic categorizations - such as describing a sequence of talk as being a question followed by answer - may cloud the way that ‘questions’ and ‘answers’ can achieve so much more than the categories suggest (Schegloff, 1984, cited by McKinlay & Dunnett, 1998).

Given my emphasis on talk-in-interaction as an occasioned accomplishment, it may not be surprising that claims about the relevance of this research to other studies of instances of therapy or accounts about hearing voices will be highly qualified. Nevertheless, just as selections from the growing body of ‘findings’ within the discursive literature will be used in this dissertation, in review and as resources when they are found to be relevant to a particular instance of talk, so might findings from this study be demonstrated as informative for the analyses in other (past or future) studies of instances of ‘therapy’. One or a thousand studies of ‘mental illness’ representations, voices, and therapy; these ‘things’ will never be ‘done’.

**The stuff of institutions**

Given its relevance to the analyses in Part 2 of this dissertation, it is worth a recap on the relationship between conversation and (other) institutions. This issue also prepares the way for a later discussion on cultural knowledge.

Discursive analyses have shown how informal (conversational) interactions and formal (institutional) interactions are Members’ systematic, collaborative achievements (Drew & Heritage, 1992; Arminem, 1998: 209). However, it is easy to begin generalizing findings, analysts ‘expectations’, and analytic ‘expectancies’, from one
instance of ‘institutional talk’ to another instance of the ‘same type’ of ‘institutional talk’.

For example, in a CA study of mutual help in Alcoholics Anonymous meetings, Arminem states that “[i]n AA the formality of interaction is an achieved formality, which serves the purposes of mutual help” (1998: 210). Not only is there a generalization, here, across AA meetings, but Arminem considers, here, only one type of ‘purpose’ (ie, mutual help). Apart from considering the ‘representation of mental illness’, my analyses of a hearing voices therapy group aim to explicate something of the organization, fluidity, and movement between many ‘purposes’, voiced positions, and degrees of formality and informality. Such multiplicity occurs within and between speakers and even within turns. This is a challenging task for the discursive approach and for a budding practitioner.

Hester and Francis (2001) draw attention to the need for researchers to not reify institutions but rather to assess institutionality as it is locally brought into being through interaction. That is, institutionality is largely built from situated interaction, not from external features of people and places and not from the all-or-nothing operation of a ‘particular type’ of institutional talk.

SECTION 2. CULTURE AND CRITICISM

Discursive researchers emphasise the explication of phenomena, as opposed to explanation. When working to confine analyses and discussions to an explication of local events in largely locally constituted terms, comparisons with exogenous matters are minimized. The line where an explication-explanation distinction is claimed to be drawn is a controversial one, however. For example, some researchers (eg, Schegloff, 1997; Antaki, 1998) maintain that an analysis ought to use only the commonly shared
knowledge and skills of Members as directly exhibited in the data being analyzed (ie, a textual analysis). That is, an analysis which in any way uses external (extra-textual, exogenous) cultural knowledge to make sense of the interaction is flawed by being less driven by the data-at-hand.

However, this seems to be rather like trying to draw a hard and fast line between general dictionaries (cultures) and specialized dictionaries (subcultures). For example, a general English dictionary can be said to hold only information which is recognizable (see Hester & Francis, 2001) to all Members of ‘the English speaking community’. At the same time, the other ‘type’ of dictionary (eg, a dictionary of stamp collecting words) holds information which is most recognizable to ‘members of the subculture concerned’ within ‘the English speaking community’. However, the specificity of the various the’s in the preceding sentences is itself constructed, convenient, and even somewhat arbitrary. Some stamp collectors may not know all the words or ways of making sense of the words, generally, in the specialized dictionary. Likewise, not all Members of the English speaking community will know all words in an English dictionary but they may know some words and some of general ways of making sense of the words in a stamp collecting dictionary. A demonstration of the abilities of people ‘from’ the culture and subculture concerned to make sense of words from each type of dictionary is not likely to result in a rule which ‘accurately’ categorizes people as completely stamp collectors or entirely not stamp collectors either. Such abilities, which supposedly stem from separate pools of general knowledge and specific knowledge, are not as clear-cut as their categories present them to be. Not only are the two ‘types’ of sense-making skills not fully separate, neither are the two ‘types’ of data sources. However, the data-at-hand
at least has the empirical advantage of being graspable, and is thus demonstrably of a
different ‘type’.\textsuperscript{10}

Consider another example, that of differences between analysts in their presented
findings. An analysis, like a transcript, is a constructed version of ‘events’. Rhetoric
cannot be separated from analysis. Thus, there may be many different readings and
presentations of the same data within the community/culture of discursive researchers,
despite all analyses being rigorously and locally applied. This may be likened to
variations between different publications of the English dictionary or between different
specialist dictionaries on the ‘same subject’. Perhaps an even better metaphor is to liken
different analyses of the same materials to different presented readings/findings, despite
using the same dictionary. Different discourse analytic readings can occur between
different analysts and/or between different analytic occasions with the same analyst.
Analysts and their analyses are not beyond construction and the influences thereon.

As I have argued above, variations between discursive analyses and the use of
cultural knowledge at some level (and with it, the ability to recognize parts of
interactions as they are presented) are an unavoidable, and occasionally vital, part of
analysis. Thus, Antaki (1998) may be taken as being not fully convincing in his attempt
to make sense of a reference to “fa:gin” (or Fagin: the scruffy, thieving, fictional
character) without recourse to ‘cultural knowledge’. I acknowledge the risk, here, of
over-summarizing Antaki’s argument and data. Nevertheless, I shall proceed. Antaki

\textsuperscript{10} Does this propose a continuum between external cultural knowledge and abilities and Members’
(endogenous) knowledge and abilities? (For the latter, see Schegloff, 1997, specifically regarding data).
In a sense, it does: a continuity between the data-at-hand (and the cultural context therein) and the wider
cultural context in which the data was performed. However, I do not propose that such a continuum
represents a single measurable property, which is one reason for the unsettle-able debate between
Schegloff and Wetherell.
(1998) looks at the jocular identity ascription of ‘Fagin’ by a mother (Lyn) to her teenage daughter (Zoe). Briefly, Zoe has entered the room (where a video camera has been installed to record their everyday interactions), asked her mother where the cigarettes are, and been given a reply. There is then an exchange in which Zoe comments about the camera being switched on and questions what it has been recording. During this, Lyn mostly laughs. The data continues:

Extract 2.7 (from Antaki, 1998: 73)

30 Zoe: (off camera and out of sight of Lyn) oh go::d (.) look what I’m wear↓ing=
31 Lyn: =((explosive laugh)) >eh eh [hehh hehh hehh<
32 Zoe: [hehh hehh
33 → Lyn: ↓you ↑look ↓like ↑Fa:↓gin=
34 Zoe: =Thahh ha (ha
35 Lyn: (ha hahh (↑↑huh ((very high pitched at end))
36 Zoe: [↑↑hhhh ↓maybe I ↑am
37 Lyn: (1 sec) [in which Lyn starts to mimic pulling gloves on / off]
38 → we ↑just ↓need the ↑little ↓gloves with the ↑fingers ↓out
39 Zoe: °↑very funny°

The jocular identity in question is that of Fagin (line 33). Antaki argues that it is enough to analyze this extract (and the surrounding transcript) without “digging and decoding”; with “neither psychological speculation nor cultural interpretation” (p. 71). However, whilst I readily accept that there is no need for mentalism in making sense of this interaction, I do not concede that there is no place for cultural knowledge as an addition to a textual analysis.

Antaki shows how Zoe’s utterance, “oh go::d (.) look what I’m wear↓ing” (line 30), in the context of the camera being present and in the context of Lyn’s response, may be taken as a complaint (about the camera) and/or a self-deprecation. However, he goes on to suggest that “‘you look like Fa:gin’ is, whatever else it is, the ascription of an identity, and (to argue) why neither of the participants in the interaction, nor we observers, need special cultural decoding or mental speculation to make that clear” (1998: 76; my emphasis). Citing Sacks (1992), Antaki argues for the sufficiency of a sequential analysis to grasp the local meaning of occasioned talk. Thus, all that is
important about Fagin, in terms of understanding *this* identity in *this* interaction, is *in* the text and can only ever be *in* the text.

Note, however, that I briefly touched on this controversy in relation to Sacks, MCA, and CA. Furthermore, how do we know that we are even dealing with the identity of a person here? Antaki provides several interactionally substantiated ‘reasons for why’ (my words) participants and observers alike take ‘Fagin’ to be a “known name”, a “named person”, without (apparently) any need for familiarity with the Fagin character. For example, in concert with my above quotation from page 76:

Thus, Lyn’s offering of ‘Fagin’ is unmarked, implying an easy reference, therefore a reference to *a known name*, or to someone her audience could treat as being a known name. Zoe gives a signal (her echoing overlapped laughter) that she appreciates what Lyn said, and that she is aware (or willing to be taken to be aware that Lyn is referring to *a named person*, and the aptness of that naming in relation to the matter in hand.

(Antaki, 1998: 77; my emphases)

Yet, embedded within this fragment of Antaki’s analysis, there are several features which, ironically, invoke or go towards invoking the *culturally known* Fagin (“‘Fagin’”, rather then fa:gin; “a known name”; “a named person”), let alone the descriptions of the character Fagin which appear in Antaki’s preceding paragraph (“his thievery, his band of child pickpockets...and his image of being hook-nosed, stooped, and dressed in layers of rags”). That is, on top of his elegant and most pertinent empirical analysis of the sequential aspects of the interaction, Antaki implicitly trades in, and benefits from the sense-making of, a culturally informed understanding of Fagin. For all we know, “fa:gin” could be referring to some kind of family in-joke about, say, sea anemones (the gloved fingers/fingerless gloves being, say, the family’s way of pretending to have a sea anemone’s tentacles in role-plays when Zoe was a child). My point is that, in line with Antaki’s stated argument, we do not *know* and can never know *exactly what* was in the
interaction (the content). But we can all benefit from a little informed, and shared
surmising. Lyn appears led to interpret (notwithstanding my speculation about a
possible idiosyncratic family history of marine role-plays), and we observers are left to
interpret, the most commonsensical version of events; that Zoe is most likely referring
to Dickens’ character, Fagin. Such speculative information, when invoked with
sufficient caution, adds value to our understanding.

Thus, McHoul and Rapley (2001a) and Rapley (2004), after Sacks (1992, vol. 1:
420), referred to ‘cultural rules’ about insults and the (ironic) misidentification of
kinship terms to understand the sense in which one participant called another participant
(who was not his mother), ‘Mommy’. An attempt to make sense of such
misidentification with an English dictionary alone might have settled on ‘delusional’
rather than ‘return insult’ or ‘ironic’. In attempted isolation from ‘exogenous’ cultural
knowledge and skills, the application of a ‘rulebook of sequences’ might have fared
little better.

The data extract in question, quoted by McHoul and Rapley (2001a) and Rapley
(2004), comes from Sacks’ recording of teenage boys in a ‘group therapy session’ cum
‘automobile discussion’:

Extract 2.8 (from Sacks, 1992, vol. 1: 420)
Roger: Ken, face it. You’re a poor little rich kid.
Ken: Yes Mommy. // Thank you.
Roger: Face the music.

It may be argued that the only information and skills necessary to analyze this data
come from the application of “the rules of conversation sequencing”. That is, a
sequential, conversation analytic kind of analysis may be said to exclusively comprise
the application of Members’ rules to data. For example, in this case, there is the rule that
‘first insults’ (Roger’s first turn, directed at Ken) are properly followed by ‘second
insults’ (counter-insults from the person or position that was first insulted). Thus, Ken’s turn is a counter-insult, involving the (ironic) misidentification of kinship.

But, what can we say of the culture at work here? Does not varying cultural knowledge and skills play an important part in the application of ‘the rules of conversation’? Does not “You’re a poor little rich kid” involve an oxymoron which observers are likely to take, through the application of cultural knowledge about class struggles, etc, as insulting rather than empathic? Similarly, being identified as ‘little’ and a ‘kid’ is culturally hearable as an insult to anyone above a certain age, especially amongst teenagers; an age group characterized by a struggle with ‘coming of age’.

Although it makes sense to go on, in CA-fashion, to empirically consider both turns, in combination, as a ‘first insult’-plus-‘second insult’ pair, this does not negate the use of, or recognition of, cultural knowledge in arriving at such a conclusion. How else can Hester state that talk in his 1998 paper on ‘deviance’ in schools recognizably relates to educational psychology, without externally derived knowledge that it is part of a referral process to an educational psychology service (see above). To extrapolate, the ‘methods’ of discursive analysts rely on exogenous cultural knowledge, although they are ‘methods’ which are also empirically grounded in the data-at-hand.

And, returning to our consideration of insults, surely oxymorons, irony, sarcasm, and the like, do not always hit their hearable mark? These kinds of ‘insults’ are not always taken by their recipients as insults. Irony is lost on some people. Would such ‘uninitiated’ people be categorically not part of the insulter’s culture? And would the absence of a retaliatory ‘second insult’ render what would have been (and arguably still is, hearably) a ‘first insult’ as entirely uninsulting, according to third party observers and analysts? Surely the empirical rigour of the discursive approach derives just as much from continued, unsettle-able debate as it does from so-far-apparent data and rules? Should the next turn proof procedure be so much the-be-all-and-end-all of all
this? Is the empirical basis of the approach so delicate as to be swamped by a little extra sense-making information? (I end on ironic, iterative questioning).

How does all of this bear on my consideration of the DSM and my forthcoming analyses of ‘therapy’? I have argued that a tension arises for analysts when topics of talk seem to beg the use of expert knowledge (ie, cultural knowledge; knowledge which might also be described as ‘institutional’ - see below). Do initial analysts (the analysts) and subsequent analysts (the readers) require expert knowledge of therapy to understand what occurs in a ‘therapeutic’ interaction? In keeping with what I have said so far, I suggest that some reliance on knowledge of therapy will inevitably come to bear on every stage of the analysis. The issue is whether it can be harnessed as a help or whether it becomes a hindrance. The analytic reins should remain with the talk-in-interaction.

The use of exogenous information is a cornerstone of critical analyses of psychiatric approaches to social problems. This includes the work of critical discourse analysts and the work of Boyle and Sarbin, who variously tend to critically examine social action in psychiatry at a wider discursive and/or conceptual level. For example, Sarbin’s (1997) conceptual analysis of the DSMs targets the “increasing medicalization of distress” and the lack of person as agent. Instead, he proposes a “contextualist approach to understanding unwanted conduct” (more on this approach later). Crowe (2000a) uses critical discourse analysis to examine certain problematic assumptions in how DSM-IV constructs ‘mental illness’ and ‘normality’. Crowe shows how the DSM maintains an authoritative individualistic stance on ‘normality’ on the basis of productivity, unity, moderation, and rationality. This “effectively excludes the social and cultural context in which experiences occur and ignores the role of discourse in shaping subjectivity and social relations” and thus “pathologises experiences that could be regarded as responses to life events” (Crowe, 2000a: 69). Whatever their differences, these critical approaches
clearly use cultural information in their judgement of the desirability or otherwise of social action.

To achieve the benefits of anchoring analyses in data-at-hand whilst also achieving the social relevance and actions of a critical approach, Wetherell (1998) and Rapley (2004) argue for a blended, eclectic, critically- and historically-informed discourse analysis (and in particular, a critical discursive social psychology) which incorporates conversation analysis and post-structuralism; work which may broadly be described as drawing on the post-structuralist writings of Foucault (eg, 1979, 1991) on ‘governmentality’ and Rose (eg, 1996, 1999) on the ‘psy complex’. This justifies the consideration of wider social contexts along with more local interactional aspects of discourse. The use of exogenous information is something which Schegloff (1997, 1998) ardently opposes. My analyses in this dissertation involve the management of this tension, between empirical groundedness on the one hand, and social relevance and social action on the other.

SECTION 3. CHAPTER SUMMARY

We have now considered some of the key features of the analytic methodologies used in this dissertation. We have seen ways in which various approaches to the analysis of talk and/or written text are similar and ways in which they differ. In the next chapter I conduct a careful and critical reading of canonical texts in psychiatry and psychology to pick up further on one of the other major strands from Chapter 1; the current professional view of hearing voices as a part of ‘schizophrenia’.
CHAPTER 3. THE CURRENT PROFESSIONAL VIEW

SECTION 1. PSYCHIATRIC DOGMA: A PROFESSIONAL TEXTBOOK

The dominant view of hearing voices is that the experience is an integral part of ‘schizophrenia’, a ‘severe mental illness’ which typically requires long-term psychiatric treatment. I shall selectively summarize and critically analyze the main chapter on ‘schizophrenia’ from a current text which is primarily aimed at qualified psychiatrists, the *New Oxford Textbook of Psychiatry* (Gelder, López-Ibor, & Andreason, 2000); a volume which is not only authoritative as a textbook for professionals but is published by a highly credible academic publisher, the Oxford University Press. This is a text which represents the canonical Truth in orthodox psychiatry and I suggest that many of my criticisms also apply to those areas of orthodox ‘schizophrenia’ research which I do not directly cover. My analytic methods are in accordance with the general approach taken by Boyle (2002a & b) combined with aspects of discourse analysis. That is to say, what I do here is to take, as a perspicuous instance, a single text which claims a particular authority for itself as a definitive statement of knowledge in the field. As such, I follow Szasz (eg, 1976), Sarbin and Mancuso (1980), and Boyle (eg, 2002a & b) who have argued that if the ‘concept’ of ‘schizophrenia’ can be shown to be invalid, the psychiatric house of cards collapses. Thus, I critically examine a canonical text with, hopefully, the same consequences. In essence, then, the *New Oxford Textbook of Psychiatry* stands for the totality of the psychiatric literature, for if ever a literature demonstrated the truth of Sacks’ observation that cultural phenomena display order at all points it is the literature of psychiatry.
The textbook’s chapter on ‘schizophrenia’ is divided into sections on the history, clinical features, neuropsychology, diagnosis, epidemiology, aetiology, neurobiology, course and outcome, and treatment of the disorder. The presented order of these sections, with the more controversial or fruitless areas of psychiatric research being book-ended by clinical features and treatment, suggests that, when all is said and done, the current psychiatric way of dealing with these matters is the best way. Each section is written by one or more experts in their field.¹

With major realignments away from the construct of ‘schizophrenia’ and away from the dominant use of biomedicine in psychiatry being highly unlikely in the near future, I suggest that my general observations concerning the DSMs and this edition of the psychiatry textbook are likely to remain pertinent for many years to come. Furthermore, given the fundamental flaws in the conceptual foundations of ‘schizophrenia’ - with Boyle (2002b) persuasively arguing that ‘schizophrenia’ does not even have the basic underpinnings of a scientific concept (see Chapter 4 of this dissertation) - my criticisms will remain relevant, regardless of the next big biomedical ‘discovery’.

The *New Oxford Textbook of Psychiatry* is prefaced with the acknowledgement of three themes which “can be discerned in contemporary psychiatry: the growing unity of the subject, the pace of scientific advance, and the growth of practice in the community” (Gelder et al., 2000: preface). These themes are presented as a testament to the progress which has been made in psychiatry and will continue to be made in the third millennium. One aspect of this increasing consensus is described as follows:

１At the end of the chapter, which is entitled “Schizophrenia and acute transient psychotic disorders”, there is a section on “schizoaffective and schizotypal disorders” and one on “acute and transient psychotic disorders”. I shall not address these additional sections. Within what I call the ‘chapter on schizophrenia’, some of the authors describe as ‘chapters’ what I describe as ‘sections’.
The growing unity in psychiatry is evident in several ways. Biological and psychosocial approaches have been largely reconciled with a general recognition that genetic and environmental factors interact, and that psychological processes are based in and can influence neurobiological mechanisms.

(Gelder et al., 2000: preface; my emphasis)

It is worth noting that this introduction not only presents something of a unity within the profession of psychiatry, it also holds that there is a growing unity between psychology and neurobiology; the professions and the objects of their work. However, since it is stated/assumed that psychological processes are ‘based in’ the biological, this does not appear to be taken as being a unity amongst co-equals. Similarly, genetic factors are taken to have primary and principal control over the aetiology of mental illness, compared to the environment. That is, in orthodox psychiatry, biology comes first. Furthermore, with regard to mental illness, the term ‘biological’ tends to equate to abnormal and/or diseased, in contrast to the rest of us who are supposedly normal and healthy.

One aspect of the progress of psychiatry in the community is described as follows:

In most countries, psychiatry is now practised in the community rather than in institutions... The change has done much more than transfer the locus of care; it has converted patients from passive recipients of care to active participants with individual needs and preferences.

(Gelder et al., 2000: preface; my emphases)

Who can but praise such developments as they are presented above? Who can criticize the psychiatry which has “largely reconciled” the professions and brought about a conversion of patients to “active participants” through a community-focused balance between professionals and patients? However, I aim to show, with a close and critical reading of the chapter on ‘schizophrenia’, from within the same text, that such a positive and agentic view of patienthood does not hold sway in psychiatry.
Descriptive clinical features

Let us consider what are taken to be some of the descriptive clinical features of ‘schizophrenia’:

The clinical features of schizophrenia embrace a diverse range of disturbances of perception, thought, emotion, motivation, and motor activity. It is an illness in which episodes of florid disturbance are usually set against a background of sustained disability. The level of chronic disability ranges from a mild decrease in the ability to cope with stress, to a profound difficulty in initiating and organizing activity that can render patients unable to care for themselves.

(Liddle, 2000: 571; my emphases)

Liddle makes it clear that ‘schizophrenia’ has a typically chronic course and that it results in a diverse range of disturbances and disabilities. It is unclear in the above extract whether Liddle is describing variations which are supposedly within and/or across individuals.

In his subsection on disorders of thought and perception, Liddle notes that delusions have traditionally been regarded as hallmarks of insanity. He draws a contrast between “delusions of affective psychosis, which have a content consistent with the prevailing emotional state” and delusions in ‘schizophrenia’ which “often appear to reflect a fragmentation in the experience of reality” (p. 571). One manifestation of this is a lack of internal consistency between the components of the belief. For example, a man who believed that he had no head and also that there was blood all over his face. Another manifestation is a logical inconsistency between the belief and the (external) common understanding of what is possible. For example, a patient who believed that his head was split in two by an axe.

Fragmentation in the experience of reality is also said to be apparent in that “the relationship between the delusional belief and any action that might flow from it is
unpredictable” (p. 571). For example, in some instances, the patient believes he has a special role or identity but, for the most part, lives a mundane life which is barely influenced by the belief. However, Liddle states, several paragraphs later, that

although the delusions most characteristic of schizophrenia have an incongruous quality, it is not uncommon for schizophrenic patients to have coherent delusions that are internally consistent and produce predictable behavioural responses. In particular, coherent persecutory delusions are common and can lead to defensive actions such as barricading oneself in one’s room with blinds drawn.

(2000: 572)

Hallucinations are also included in this subsection on disorders of thought and perception. Hearing voices in the third or second person is given special mention as a Schneiderian first-rank symptom (ie, it is supposedly a key symptom of ‘schizophrenia’). Examples of third person voices, as described by eminent psychiatrists, are as follows:

Sometimes the content is mundane, as in the instance when a patient of Bleuler (1950) heard a voice saying ‘Now she is combing her hair’ which she was grooming in the morning. In other instances there is an implied criticism, as in the case reported by Schneider (1959) of a woman who heard a voice saying ‘Now she is eating; here she is munching again’, whenever she wanted to eat.

(Liddle, 2000: 572)

Second person voices are also common in ‘schizophrenia’, being present in some 65 per cent of cases (WHO, 1973). Liddle describes both negative and positive voices:

Such voices are often derogatory, although it is not uncommon for a patient to hear both derogatory and comforting voices. Voices might issue commands that the patient obeys. In some instances, the patient engages in a dialogue with the voices.

(2000: 572)
It is worth noting here that the voice of Socrates does not fit neatly into the above account. The daemon was always described by proponents of Socrates in a positive light. It was not derogatory or otherwise negative. The daemon was considered to be an authoritative guide which was always followed, rather than an issuer of commands per se. In the above extract, Liddle does not directly attach negative evaluations to voices issuing commands or to voice hearers dialoguing with voices. However, nor does he positively evaluate them or develop a discussion to explore such matters. Liddle’s subsection is entitled “Disorders of thought and perception”, after all.

Instead, Liddle moves onto a brief consideration of differences between auditory hallucinations in acute and chronic phases of the illness. For typical patients:

During the acute phase of the illness, auditory hallucinations usually have the same sensory quality as voices arising from sources in the external world. The patient might change accommodation in a fruitless attempt to escape from them. In some instances the voice is attributed to a radio-transmitter implanted in the body, especially in the teeth.

(Liddle, 2000: 572)

Here we have acutely ‘ill’ voice hearers with ‘schizophrenia’ who are said to be fragmented in their experience of reality because they perceive and believe their voices to arise from the external world. The same people may also perform rational actions in response to such experiences and yet their voices may be intermixed with certain bizarre delusions.

In contrast, voice hearers with ‘schizophrenia’ in its chronic phase are rather more in touch with reality:

In the chronic phase, the voices are often recognized as coming from within the person’s own mind. Kraepelin (1919) reports: ‘at other times they do not appear to the patient as sense perceptions at all; they are “voices of conscience”; “voices which do
not speak with words”. These experiences are pseudohallucinations, but nonetheless they are a significant feature in many cases.

(Liddle, 2000: 572)

In the first-rank group of symptoms, the two symptoms which are clearly voices-related (voices commenting and voices discussing or arguing) are listed along with the other somewhat auditory experience (audible thoughts) and the eight even more delusion-related symptoms (thought insertion, thought withdrawal, thought broadcast, made will, made acts, made affects, somatic sensitivity, and delusional perception).² Liddle reports that Mellor (1970) emphasizes two aspects of these first-rank phenomena: the experience of loss of autonomy and the delusional attribution of alien influence. But as we shall see later (eg, regarding Leudar and colleagues, in Chapter 5), even this seemingly simple statement about loss of autonomy does not hold with most voice hearers, with or without a diagnosis of ‘schizophrenia’. Recall Socrates, who invariably obeyed his voice. He did so, after consideration, because it was a respected authority, not because he was compelled or even more directly impelled to act.

The degree to which first-rank symptoms are specific to ‘schizophrenia’ is, however, considered somewhat debatable, even in mainstream psychiatry. Liddle notes that Schneider’s definitions were rather imprecise and open to interpretation. For example, O’Grady (1990) applied a precise set of first-rank symptom definitions and found that 73 per cent of patients with ‘schizophrenia’, compared to no patients with affective psychosis, exhibited at least one first-rank symptom on admission to hospital. However, when applying looser definitions of first-rank symptoms, at least one symptom was

² ‘Made will’, ‘made acts’, ‘made affect’, and ‘somatic passivity’ may be described as experiences that one’s will, physical actions, emotions, and bodily functions, respectively, are performed or directly controlled by an ‘alien’ influence that is not of oneself. Delusional perception may be (omnisciently) defined as the attribution of a totally unwarranted meaning to a normal perception.
present in 14 per cent of patients with affective psychosis. Thus, (a) one patient can be
diagnosed as schizophrenic in the absence of first-rank symptoms of ‘schizophrenia’,
and (b) another patient can experience a first-rank symptom but receive a diagnosis
other than ‘schizophrenia’. And yet, as we saw in Chapter 1 of this dissertation, the
DSM diagnostic criteria continue to be built around the notion that delusions and certain
voices are central and quintessential to ‘schizophrenia’.

Berrios (2000) notes that our understanding of ‘schizophrenia’ is typically presented
as a having undergone a continuous progression from its inception to the present day.
Instead, Berrios argues that the history of ‘schizophrenia’ has been a discontinuous
“patchwork” of “contradicting research programs” (p. 567). Hence the muddle that is
‘schizophrenia’ today. Ironically, Berrios makes his arguments alongside the other
contributors to the textbook, most of whom, like Liddle, liberally sprinkle the likes of
Kraepelin, Bleuler, and Schneider into their continuity presentations of ‘schizophrenia’.

Returning to Liddle’s (2000) subsection on disorders of thought and perception, we
next move into a consideration of disorders of the form and flow of thought. These are
in contrast to delusions, which are largely considered to be disorders of content.
Disorders of thought are almost exclusively assessed in clinical settings via assessments
of speech. A direct causal relationship between thought and speech is taken as a given:
“The speech of schizophrenic patients is often difficult to understand because of
abnormalities of form of the underlying thought” (p. 573). However, Liddle at least
acknowledges that there are still major challenges in the clinical assessment of thought
disorder to be addressed:

This is due in part to the fact that the essential features of the impediments to verbal
communication in schizophrenia have yet to be defined in a fully satisfactory manner.
Furthermore, thought disorder is usually manifest during spontaneous speech, making it
difficult to create circumstances in which the phenomena can be elicited reliably.

(2000: 573)
According to Liddle, Bleuler’s (1950) term “loosening of associations” is still considered to adequately describe several such phenomena. These include derailment, tangentiality, incoherence, and loss of goal. In addition to a loosening of associations, there is the unusual use of language. This includes metonyms and neologisms.

In addition to a subsequent discussion of impaired cognition, Liddle also describes lack of insight in the context of disorders of thought and perception. Lack of insight is held to be “one of the defining characteristics of psychotic illness” (p. 574). Here, the insight in question is to do with the nature and origin of the person’s psychotic symptoms. It is a “failure to accept that one is ill and to appreciate that symptoms are due to illness” (p. 574). In one major study, a lack of insight was found in around 90 per cent of schizophrenic patients (WHO, 1973). Liddle writes that insight may be partial and he furnishes his point with the example that, “even in instances in which a patient acknowledges suffering from an illness, he or she might fail to accept that psychotic symptoms such as delusions or hallucinations are a manifestation of the illness” (p. 574). Liddle balances this glass-is-half-empty kind of negative evaluation with an acknowledgement that lack of insight is just one of the factors which can contribute to a patient’s unwillingness to accept psychiatric treatment. Indeed,

...the clinician should be aware that other factors, including lack of appropriate education about the illness and justified fear of side-effects of treatment, can also impede the development of a therapeutic collaboration between physician and patient.

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3 ‘Derailment’ may be described as wandering off the point during the free flow of conversation, ‘tangentiality’ as providing answers to questions which are off the point, ‘incoherence’ as a breakdown of the relationships between words within a sentence so that the sentence no longer makes sense, and ‘loss of goal’ is described as a failure to reach a conclusion or achieve a point.

4 ‘Metonyms’ are said to be unusual uses of words (eg, hand-shoe instead of glove) and ‘neologisms’ may be defined as new words invented by the patient. Ironically, the term ‘schizophrenia’ originated as a neologism invented by Bleuler.
Nevertheless, this account is framed in terms of what the patient lacks, in apparent recognition of what is taken to be clear psychiatric truth.

The rest of Liddle’s section on clinical features of ‘schizophrenia’ attests to the wide scope of symptoms which are said to be associated with the illness. These include disorders of emotion (blunted affect, inappropriate affect, excitation and depression), motor disorders (from subtle disorders to catatonia), disorders of volition (disruptions of motivation and will; eg, leading to impulsive actions or underactivity and described as being among the most disabling of symptoms), anxiety, and somatic disorders.

A repeating feature of Liddle’s and many another contemporary orthodox account of ‘schizophrenia’ is the stated value of searching for multiple disease processes in ‘schizophrenia’. This is because the search for single disease processes continues to be fruitless. Such accounts shift the focus to further research on ‘schizophrenia’ and/or its symptoms rather than to another way of explaining such phenomena (Boyle, 2002a). ‘Schizophrenia’ is said to be such a complex matter that only ever more complex research and treatments - some might say ‘fragmentary’, ‘split’, or ‘splintered’, in parody of Bleuler’s term ‘schizophrenia’ - will show progress.

Perhaps using the principle of Occam’s razor would be of some benefit, here. According to this principle, entities should not be unnecessarily multiplied. Thus, in science, one adopts the most simple of available hypotheses which can explain the evidence. In the case of ‘schizophrenia’, some argue (notably Boyle, 2002b) that the simplest hypothesis which is most in keeping with the evidence is that ‘schizophrenia’ does not qualify as a scientific concept.

In line with ‘schizophrenia’ and complexity, however, Liddle argues that evidence from factor analytic studies (eg, Liddle, 1987) now points heavily towards segregating the characteristic symptoms of ‘schizophrenia’ into three dimensions. The reality
distortion dimension comprises delusions and hallucinations; the disorganization dimension comprises thought form disorder,\(^5\) inappropriate affect, and bizarre behaviour. The psychomotor poverty (core negative symptoms) dimension comprises poverty of speech, blunted affect, and decreased spontaneous movement. Neurological evidence is being sought and apparently found accordingly:

> An accumulating body of evidence (Liddle, 1999) from brain imaging studies indicates that the three characteristic syndromes are associated with three distinguishable patterns of cerebral malfunction involving the areas of association cortex and related nuclei, which serve higher mental functions.

(Liddle, 2000: 575)

The following is given towards an explanation of how the disease processes may be neither directly related nor entirely independent:

> Overall, the evidence [from brain imaging studies] indicates that the heterogeneity of symptom profiles in schizophrenia does not reflect the existence of several discrete illnesses, but rather, the existence of several dimensions of psychopathology, each arising from disorder of a specific neuronal system that serves an aspect of higher function. In an individual case, several of these neural systems might be involved.

(Liddle, 2000: 575)

Correspondingly - rather than seeking the simpler, more obvious explanation that the notion of ‘schizophrenia’ and/or its symptoms should be abandoned - some order is sought and found in the application of a multiple syndromes hypothesis to the diverse clinical features of ‘schizophrenia’:

> These syndromes do not reflect separate illnesses, but different dimensions of illness, in the sense that a patient might exhibit more than one of the syndromes. In an individual

\(^5\) Presumably this is synonymous with ‘formal thought disorder’ and ‘disorders of flow and form of thought’.
case, the three syndromes vary independently in severity over time, while the symptoms from within each syndrome tend to vary in parallel (Arndt et al., 1995).

(Liddle, 2000: 574)

**Neuropsychology**

A similar fragmentation is evident in accounts of the neuropsychology of ‘schizophrenia’. But first let us consider other ways in which neuropsychology is used to bolster the position of ‘schizophrenia’ research. David’s (2000a) subsection is entitled “Neuropsychological features of schizophrenia: The clinical neuropsychology of schizophrenia” (David, 2000a). The inclusion of “clinical” in the latter part of the title seems to reflect the author’s opening claim that “[n]europsychology forms a bridge between the phenomenology and clinical features of schizophrenia, and the underlying pathology” (p. 576).

For David, the validity of a bridge between immediate experience and observed clinical features on the one hand, and disease(s) on the other hand, is taken as a given. In neuropsychology, this ‘bridge’ is made from the ‘findings’ of psychological assessments which, it is assumed, measure various aspects of brain function. Furthermore, the principal causative role of biological abnormality in ‘schizophrenia’ is also taken as fact, as indicated by his statement that the neuro- prefix in neuropsychology is a “relatively new addition” that “simply reflects the often tacit acceptance of a biological basis for the changes observed” (p. 576; my emphasis).

However, David does observe that the cognitive sciences are not atheoretical and that their adoption in this area has both pros and cons:

The cognitive sciences have been increasingly adopted as a framework for discussing such features at the expense of purely descriptive psychopathology. The advantage of this is that cognitive models strive to be mechanistic and explanatory although, like
phenomenology, they sometimes succeed only in displacing one lot of arcane jargon for another.

(2000a: 576)

In contrast with the criticism of the cognitive sciences and phenomenology, it is notable that the objectivity of clinical observations and the atheoretical and principal causative role of pathology in ‘schizophrenia’ have not come into question.

David does describe the clearly paradoxical nature of ‘schizophrenia’ with regards to certain neuropsychological findings:

There are aspects of schizophrenia which are akin to a dementia (i.e. an apparent decline in function across several cognitive domains) in conjunction with other aspects most unlike a straightforward dementia, such as the variability of test performance across and within individuals, and lack of inexorable progression.

(2000a: 576)

He states that this present day paradox points back to differences between Kraepelin, with his emphasis on clear-cut intellectual decline in ‘dementia praecox’ and Bleuler, with his notion of ‘formal thought disorder’ to explain how the “knowledge remains preserved... but it is not always available or it is employed in the wrong way” (Bleuler, 1950; cited by David, 2000a: 576). In the light of Berrios (2000), such ‘differences’ might rather be considered incompatibilities. David observes that “attempts to distinguish schizophrenia from neurological disorders on the basis of neuropsychological tests have failed - the overlap in test scores is surprisingly large and classification rates on this basis, no better than chance (Heaton, Baade and Johnson, 1978)” (2000a: 567). He argues that the answer for progress appears to be a move away from “all-embracing psychological theories of schizophrenia”, since nowadays “empirical findings outweigh theoretical speculation” (p. 567). That is, as in the general switch to searching for multiple rather than single disease processes, neuropsychology
has shifted from all-embracing explanations to multiple areas of investigation. Yet the
all-embracing diagnosis of ‘schizophrenia’ remains.

Those are some of the problems, but what are some of the findings, according to
David? David states that “the majority of patients with schizophrenia have cognitive
impairment (McKenna, 1994)” (2000a: 576). According to David, there have also been
many largely fruitless attempts, using a range of neuropsychological tests, to pin-point
specific cognitive deficits in relation to ‘schizophrenia’.

On the topic of hearing voices, voice hearers are said to exhibit failures in their
ability to correctly distinguish between auditory hallucinations and ‘real’ voices:

Building on the assumption that auditory hallucinations are the products of the subject’s
own mind (and not from aliens from outer space), reality monitoring provides a model
whereby normal inner speech is mislabeled as not coming from the self.

(David, 2000a: 578)

As David puts it, a voice hearer fails to distinguish between inner speech and aliens
from outer space. Note that, in emphasizing the extent of the voice hearer’s failure,
David did not choose the voice of God - in some circles, a rather more socially
acceptable voice - as an example. How are voice hearers supposed to make such errors?

One suggestion is that if inner speech or other internal images are particularly vivid, the
subject may confuse them for reality, although evidence for this is lacking.

(2000a: 578)

No references are provided for whatever evidence and theories exist in this regard.

In relation to cognitive theorists, although psychiatry has tended to more clearly
separate ‘mentally ill’ patients from normal people - on the assumption that a patient’s
mind is diseased and does not operate like a normal mind - this does not prevent the
proponents of cognitive theories from cross-fertilizing and mutually supporting
neurology. An example of this is David’s use of Frith’s (1992) deficit model:
...our brains continually monitor or check our actions to see whether they tally with our intentions. If an action occurs (my arm reaches an object or I ask a question) but the brain had not registered a prior intention (owing to some failure of feedback), the action may be regarded as alien.

(David, 2000a: 578)

We may see even more clearly that Frith and colleagues provide their model with a neurological endorsement in David’s description that they “suggest that intentions arise from systems connecting the dorsolateral prefrontal cortex, the anterior cingulate, and the supplementary motor area” (David, 2000a: 578.). I revisit issues of mutual support between psychiatry and psychology when considering cognitive-behavioural therapy for psychosis, in Section 2.

**Diagnostic classification**

David (2000b) opens his section on the diagnosis and classification of ‘schizophrenia’ with a testament to the recent progress of psychiatry in this area:

Until the early 1970’s, the diagnosis of schizophrenia was one of the most contentious and fraught issues in the whole of psychiatry. Since then a massive international effort has been put in motion out of which explicit diagnostic criteria emerged. Some achieved widespread and even international agreement, allowing the painstaking process of calculating diagnostic specificity, sensitivity, reliability, and (perhaps) validity to begin.

(2000b: 579)

Here, the problem of diagnosis is located in the past. The solution is existing and future research practices. David goes on to concede that this view does have its critics but that they are mostly located outside of psychiatry (an implied criticism). It seems that, according to David, most psychiatrists agree, without naivety, that there has been
progress and that current diagnostic criteria may be ‘as good as it gets’ for the time being:

Although criticism of the diagnosis of schizophrenia continues, mostly from outside psychiatry, the vast majority of psychiatrists look upon the major sets of diagnostic criteria with weary acceptance, seeing them as flawed but useful and possibly ‘as good as it gets’ given our current state of knowledge/ignorance.

(2000b: 579)

David also closes his section on diagnosis with a ‘we are not-naive of criticisms, nor are we insensitive’ presentation of psychiatry:

It used to be argued that a diagnosis of schizophrenia in itself caused disability and morbidity due to social ‘labelling’ and stigmatization. Evidence that this accounts for schizophrenic disability is lacking but the reality of the stigma of mental illness and negative attitudes towards ‘schizophrenics’ cannot be denied. Hence making a diagnosis of schizophrenia should not be taken lightly.

(2000b: 579; my emphasis)

But this is not as even-handed as it may first appear. David places the entire critical argument against the diagnosis of ‘schizophrenia’ in the past. He also states the argument - that the diagnosis and its associated actions and responses promote ‘mental’ distress - in extreme, all-or-nothing, terms. The implication is that this criticism is, or should be, entirely silenced due to lack of evidence and that no other related criticisms legitimately exist in the present. However, David is prepared to countenance the real stigma, the one which psychiatrists know about and can address. This implies that the critical argument he presented earlier was a figment of imagination.

Indeed, the answer to the problem of stigma through diagnosis can be reduced by psychiatrists who are sensitive to the issues:
In the author’s experience very few psychiatrists spontaneously convey the diagnosis to the patient. If a patient asks whether he or she has schizophrenia, the clinician should first try to understand the motivation behind the question and the patient’s knowledge and understanding of the term. Ultimately there is seldom justification in withholding the diagnosis if it is established. A schizophrenic diagnosis can be framed in a relatively positive light - this is a condition which we are now beginning to understand and for which there are effective treatments - and may lessen the burden of responsibility and blame that the patient and his or her family may carry for the disorder.

(David, 2000b: 579)

Thus, the diagnosis and the diagnostic process of ‘schizophrenia’ stand as progressive and good. They are presented as leading to “effective treatments” which “may lessen the burden of responsibility and blame” for patients and families. The way in which these arguments are constructed renders them difficult to dispute without constructing oneself as uncaring.

**Epidemiology: Lifetime risk and consequences**

Turning now to epidemiology, two of the questions which Jablensky (2000a: 585) raises as an issue for population studies in ‘schizophrenia’ research are “Who is at risk and what forces determine or influence the risk of developing schizophrenia?” and “Do the incidence, manifestations, and course of schizophrenia vary in relation to factors of the physical and social environment?” (my emphasis). Nevertheless, as we shall see presently, the use of the term “social environment” extends only to highly defined, quantitative, aspects of supposed macro social determinants of ‘schizophrenia’. Although, epidemiology is somewhat removed from the individual pathology focus of biopsychiatry, both rest on quantitative methodologies which aggregate measured aspects of individuals together. Neither biopsychiatry nor epidemiology are concerned with how qualitative aspects of social interaction are related to ‘mental’ distress.
According to Jablensky’s (2000a: 590) epidemiological consideration of lifetime risks and consequences, although ‘schizophrenia’ is renowned for developing in young adults, there is quite extensive variation within a range from childhood to beyond middle age. ‘Schizophrenia’ also apparently brings with it an increased chance of dying and of suicide.

Jablensky also provides us with some overall conclusions on geographical and cultural variation:

To date, no population or culture has been identified in which schizophrenic illnesses do not occur. Also, there is no strong evidence that the incidence of schizophrenia varies widely across populations, provided that the populations being compared are large enough to allow a low-incidence disorder such as schizophrenia to ‘breed’.

(2000a: 592)

Although Jablenksy states that “evidence that psychosocial factors or culture play an aetiological role in schizophrenia is also weak” (p. 592; my emphasis), he goes on to describe a series of WHO studies which suggest some sociocultural influences on the course and outcome of ‘schizophrenia’. In particular there is well-replicated evidence of “a higher rate of symptomatic recovery and a lower rate of social deterioration in traditional rural communities” (p. 592; my emphasis; see Jablensky et al., 1992). That is, developing countries such as India and Nigeria have a higher proportion of recovering or improving patients than developed countries. Jablensky concludes that:

Such a general effect on the outcome of psychiatric disorders may result from psychosocial factors, such as availability of social support networks, non-stigmatizing beliefs about mental illness, and positive expectations during the early stages of psychotic illness, from unknown genetic or ecological (including nutritional) factors influencing brain development, or from an interaction between cultural and biological factors.

(2000a: 592)
It is worth noting that, not surprisingly, this account does not include any kind of historical or social constructionist perspective on culture and time. That is, in performing the research and in interpreting the ‘findings’, there is no attempt to investigate the social influence of psychiatric and research practices across different cultures and periods of history. Thus, the assumptions that epidemiologists and all researchers make, which inevitably influence the construction their questions and ‘findings’ are not considered. Such a social constructionist ‘point of view’ is just as applicable to quantitative research, with its narrow approach to what researchers deem to be acceptable responses to their questions, as it is to qualitative methodologies. Indeed, quantitative research, more than some kinds of qualitative research, inevitably tends to ‘find’ results in terms of what it seeks; the proof of the occurrence or non-occurrence of a phenomenon will only ever be recorded in terms of the frame(s) of reference which are held by the researchers.

Included in Jablensky’s section on epidemiology is a paragraph on the “burden” of ‘schizophrenia’ on society, entitled “The disease and disability burden of schizophrenia”:

According to World Bank and WHO estimates (Murray & Lopez, 1996) no less than 25 per cent of the total ‘burden of disease’ in the established market economies is at present attributable to neuropsychiatric conditions. Measured as proportion of the disability-adjusted life-years (DALYs) lost, schizophrenia, bipolar affective disorder, and major depression together account for 10.8 per cent of the total, i.e. they inflict on most communities losses that are comparable to those due to cancer (15 per cent) and higher than the losses due to ischaemic heart disease (9 per cent).

(2000a: 592; my emphases)

Given the prime positioning of the World Bank in this extract, it appears that economic considerations drive this part of the account.
Antecedents, risk factors, and aetiology

According to Jablensky (2000a: 593), the “weight of the evidence... suggests that genetic vulnerability is necessary but not sufficient to cause schizophrenia and that environmental risk factors must play a role”. Correspondingly, environmental factors are also seen as necessary but not sufficient causal factors in ‘schizophrenia’. However, perhaps because of their biological nature and the current need of psychiatry to be seen as a biological science, genetic factors are also generally attributed a primary and principal causal role. Much of the validity of any such attributions rests on whether the genetic anomalies which are presumed to predispose towards ‘schizophrenia’ can ever be directly observed and reliably related to the clinical manifestations (symptoms) of ‘schizophrenia’ and to other (non-genetic material) biological signs and, in this, psychiatry is on very shaky ground indeed. Such problems relate to fundamental flaws in the very foundations of ‘schizophrenia’, as described below.

It is incorrect to suggest that there are medical signs for ‘schizophrenia’ (see Boyle, 2002b). The MEDLINEplus Merriam-Webster online medical dictionary defines a ‘sign’ as “an objective evidence of disease which is observed and interpreted by a physician rather than by the patient or lay observer <arteriosclerosis is a sign of vascular disease>” (latter emphasis in original). In contrast, the same dictionary defines a ‘symptom’ as “subjective evidence of disease or physical disturbance observed by the patient <a headache is a symptom of various ailments>” (latter emphasis in original). Unfortunately, both professionals and lay people often use these terms rather loosely and interchangeably. Nevertheless, for a medical syndrome to exist, by definition, a sign needs to be “reliably observed” and “reliably associated with whatever events are called symptoms in such a way as to support the assumptions that the whole cluster [of signs and symptoms] forms a pattern and that the sign is an antecedent of the symptoms”
Boyle relentlessly shows that neither a valid *pattern of symptoms* nor a *valid sign* have ever been discovered for ‘schizophrenia’.

Boyle also argues that it is not *medically* valid to take observations of *behaviour* in lieu of symptom reports by the patient, without a syndrome having been established (both generally and in that particular patient) through a recognizable and otherwise valid combination of symptoms and at least one *biological* sign. But that is exactly what psychiatrists do with ‘schizophrenia’. Consider, for example, when ‘disordered speech’ is taken to reflect ‘thought disorder’. And if the diagnosis is not agreed to by the patient or if they do not fully consent to treatment then, in psychiatry, the word of the clinician can be privileged over that of the less powerful patient and diagnosis and treatment can carry on regardless.

Consider also the similar but crucially different case of a person who is presumed to be ‘out of touch with reality’ through, say, a fever with delirium. In this case, the symptoms of high temperature and increased perspiration, along with delirious speech, etc., can be directly observed by a doctor. It seems valid to me for a diagnosis to be made and for medication to be administered, in such cases, even though the patient cannot consciously report their symptoms or provide consent for treatment.

Now, let us imagine that a supposed primary causative agent or process has *never* been identified for such fevers but that an objective biological sign, such as the supposed product of infection in the blood, which is indicative of a pattern of greater complexity, *has* been identified. Let us imagine also that the symptoms mentioned above regularly occur with each other and with the sign, and that the sign apparently precedes the symptoms in some *supposed* chain of aetiology. This hypothetical fever is a *syndrome* (see Boyle, 2002b: 13 ff.; especially re ‘schizophrenia’; to whom I am indebted for much of this discussion).
All syndromes are hypothetical constructs: they are concepts; abstractions from observables which cannot be ‘had’; as are patterns with greater aetiological content. One can never see a syndrome, just as one can never see patterns which can be recognized with greater degrees of confidence. Thus, it can only ever be an abbreviation to say that someone has a syndrome or disease. Rather, a particular pattern may be inferred when a person exhibits a particular combination of signs and symptoms.

But that is not the only important aspect of a syndrome, here. To be valid, even a syndrome (which has a lower evidentiary status compared to a pattern which can be recognized with a greater degree of confidence) must meet certain conditions. Although a cluster of symptoms is necessary for a syndrome, symptoms alone are not sufficient. This is because such a pattern can frequently occur (and recur) either by chance or due to some other factor which is unrelated to the aetiology on which it is supposedly based. Rather, the status of a syndrome comes from two sources. First, it needs to be generally established that at least one objective biological sign co-occurs with the cluster of symptoms. Second, the identifying syndrome needs to facilitate useful predictions following its diagnosis, including, for example, that certain treatments which are theoretically related to the syndrome in question are sufficiently effective in such cases. Although much of the aetiology which seemed to underlie our hypothetical fever was never identified, the syndrome was a valid and useful construct in diagnosing and treating the delirious patient. Yet, in all cases of ‘schizophrenia’ (and many another or all ‘mental illness’), a patient’s behaviour, non-specific biological findings, and a non-specific response to treatment are the only ‘substance’, besides the social action of others, upon which the ‘illness’ is founded.

Returning to the New Oxford Textbook of Psychiatry, Murray and Castle begin their section on aetiology with an admission of the difficulties which research into the causes of ‘schizophrenia’ has faced:
After many years of fruitlessly seeking a single cause for schizophrenia, sometimes sarcastically termed ‘the search for the schizococcus’, almost all researchers have come to the conclusion that there is no single cause.

(Murray & Castle, 2000: 599; my emphases)

Murray and Castle then uncritically describe the step which has been taken by so many ‘fruitless’ researchers to link ‘schizophrenia’ with medical syndromes:

Instead they have concluded that, like other disorders such as ischaemic heart disease and diabetes mellitus, schizophrenia results from the cumulative effects of a number of risk factors. These may be crudely divided into the familial-genetic and the environment.

(Murray & Castle, 2000: 599; my emphasis)

Here, ‘schizophrenia’ is unquestioningly considered to be a multifactorial disease, along with “ischaemic heart disease” and “diabetes mellitus”. Thus, ‘schizophrenia’, which is not valid as a syndrome, gains biological credibility through association with syndromes from the rest of medical science, which are valid (Boyle, 2002a).

The notions of a ‘genetic predisposition’ and ‘stress-vulnerability’ are well-worn explanatory tools in ‘schizophrenia’ research. For example, both notions are often invoked to explain why identical twins do not show 100 per cent concordance for ‘schizophrenia’. Thus, genetic factors are not exclusively sufficient for ‘schizophrenia’. We will come to a brief discussion of stress-vulnerability models soon. As for genetic predisposition:

The fact that an individual can have the same genes as their schizophrenic co-twin but have a better than evens chance of remaining non-psychotic indicates that it is not schizophrenia per se which is inherited but rather a susceptibility to it. Further evidence

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6 Often the ‘stress’ and vulnerability’ components of the term ‘stress-vulnerability’ are reversed to ‘vulnerability-stress’. I take these as being synonymous.
in support of this comes from a study which showed that the offspring of the identical but well co-twins of schizophrenic individuals have a risk of the disorder similar to that of the offspring of the affected (Gottesman & Bertelsen, 1989). Thus the predisposition is transmitted without being expressed as schizophrenia.

(Murray & Castle, 2000: 600; original emphasis)

The notion of genetic predisposition accommodates a considerable degree of looseness in explanations of how the ‘disorder’ itself may be expressed. This is in the absence of direct evidence of ‘schizophrenia’ gene(s), or parts of genes. For example, it is understood that “sometimes the predisposition may be expressed as non-psychotic spectrum disorders” (p. 600). Furthermore, “family studies show that relatives of schizophrenic patients also have an excess of other psychotic disorders” (p. 600). Hence, the coining of the term ‘schizophrenia spectrum disorder’ in this area of research, although it does reflect a similar need for looseness elsewhere in ‘schizophrenia’ research. For example, the following extract combines the looseness of clinical observation/presentation with the looseness allowed by genetic predisposition explanations:

Within schizophrenia, researchers have asked whether the classical Kraepelinian *subtypes are differentially inherited*. The results have in general been negative which is not surprising since *clinicians know* that an individual patient can appear predominantly *hebephrenic on one admission and schizoaffective on another*. However, there has been a consensus that paranoid schizophrenia is less familial than other types and is associated with a lower monozygotic twin concordance.

(Murray & Castle, 2000: 600; my emphases)

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7 In general medical parlance, the phenotype is the observable physical structure which results from the genetic makeup, the genotype. But, since no reliable physical signs have been identified for ‘schizophrenia’, the notion of clinical/behavioural phenotype has been established as a substitute.
An explanation which is often invoked along with ‘genetic predisposition’ is that of the ‘polygenic’ disorder. This is one of the genetic models that is given to account, for example, for the large number of family studies which have shown that around 89 per cent of patients with a diagnosis of ‘schizophrenia’ do not have a parent with the diagnosis (see Gottesman, 1991). One interpretation of such results is that inherited genetic anomalies are not even a necessary factor for ‘schizophrenia’. However, the interpretation currently favoured by ‘schizophrenia’ researchers is that of a polygenic model, in which a number of genes each have a small effect (Murray & Castle, 2000: 600). Thus, a number of genetic factors may be required to occur in combination for the various manifestations of ‘schizophrenia’ and related spectrum disorders. If, for example, 6 genetic factors were needed for a person to be diagnosed as schizophrenic, then say three factors could be gained from each parent, without either parent exhibiting any symptoms of the condition. Such a model is compatible with genetic predisposition and stress-vulnerability explanations. Thus, as with all psychiatric explanations related to the aetiology of ‘schizophrenia’, the indirect, statistical study of the genetics of ‘schizophrenia’ has generally displayed an increasing level of complexity in an effort to account for complex, problematic findings.

Returning to Jablensky’s consideration of environmental antecedents and risk factors, there are a number of findings which have led researchers to conclude that the “environmental insults at the early developmental stages” play a causal role in ‘schizophrenia’ (2000a: 593). One such possible risk factor is maternal obstetric complications. However, Jablensky notes that, although these are widely cited as an established risk factor, none of the related explanatory models have been directly tested and “the association between obstetric complications and adult schizophrenia remains

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8 I obtained this figure by subtracting the reported lifetime risk ratio of 11, for a child with a parent who has been diagnosed as ‘schizophrenic’, from 100.
tenuous (Geddes & Lowry, 1995)” (Jablensky, 2000a: 593). Season of birth is another possible risk factor for which the evidence is far from conclusive.

Jablensky then moves onto evidence concerning certain aspects of the social and family environment, including social class, migrant and ethnic minority status, urbanization, marital status, and the early rearing family environment. He states that it has been known from numerous studies since the 1930s that the diagnosis of ‘schizophrenia’ is over-represented the economically disadvantaged. One explanation for this is the social selection theory (‘drift’), where vulnerable individuals gravitate towards poverty. Another explanation is the social causation theory (‘breeder’) which suggests that “the greater socio-economic adversity characteristic of lower-class living conditions could precipitate psychosis in genetically vulnerable individuals who have a constricted capacity to cope with complex or stressful situations” (Jablensky, 2000a: 594) (see Mischler & Scotch, 1983). Jablensky argues that, as a result of a single study in 1960 which supported the social selection hypothesis (Goldberg & Morrison, 1963),

[a]etiological research in schizophrenia in recent decades has tended to ignore such ‘macrosocial’ variables. However, the possibility remains that social stratification, socio-economic status, and acculturation stress are important factors in the causation of schizophrenia.

(2000a: 594)

9 Such models include: (a) perinatal hypoxia (oxygen starvation at around the time of birth), even if genetic liability for ‘schizophrenia’ is weak or absent; (b) a genetically predisposed sensitivity to lesions from less severe complications; (c) a genetic predisposition to ‘schizophrenia’ causing abnormal foetal development, which leads to obstetric complications; and (d) maternal factors, partially influenced by genes, such as small physique or proneness to risks such as drugs or smoking increasing the risk of obstetric complications and foetal brain damage (Jablensky, 2000a: 593).
He also notes that recent epidemiological findings of moderately higher incidence rates of ‘schizophrenia’ in urban areas have revived interests in social causation and social selection hypotheses, although “[i]t remains unclear whether the effect is linked to a factor operating pre- or perinatally, or a factor influencing postnatal development” (p. 595). Thus, Jablensky appears to favour at least the possibility of the partial social causation of ‘schizophrenia’, although he continues to seek evidence of a causal biological nature in connection to such socio-economic factors.

An alarmingly high incidence rate of ‘schizophrenia’ (about 6.0 per 1000) has been found in the African-Caribbean population of the United Kingdom (eg, Bhugra et al., 1997) and certain immigrant populations in The Netherlands (Selten, Slaets, & Kahn, 1997). The rate is even higher amongst British-born, second generation migrants. Jablensky reports that the causes of this remain obscure. Caribbean studies do not indicate any excess levels of ‘illness’ in the indigenous populations and, according to (Jablensky, 2000a: 594), explanations based on biological risk factors “have received little support”. A family study has also found a significantly higher incidence of diagnoses of ‘schizophrenia’ amongst the siblings of diagnosed second-generation African-Caribbeans, compared to the siblings of white people who have a diagnosis of ‘schizophrenia’ (Hutchinson et al., 1996). There is no such increase in the parents of second-generation African-Caribbeans. Jablensky concludes that

[s]uch a ‘horizontal’ increase in the morbid risk suggests that an environmental factor may be modifying (increasing) the penetrance of the genetic predisposition to schizophrenia carried by a proportion of the African-Caribbean population. Psychosocial hypotheses involving acculturation stress, demoralization due to racial discrimination, and blocked opportunities for upward social mobility have been suggested but not yet properly tested.

(2000a: 594; my emphasis)
It seems that a combination of ‘macro’ and ‘micro’ social factors, albeit as hypothesized in the individual, take on a degree of explanatory prominence, here. However, it is the influence of these factors on the genetic predisposition which is being considered. Thus, the combined explanation still rests on a biological substrate. Also, it is worth noting that explanations involving the diagnostic behaviour of psychiatrists are not mentioned.

Further evidence which is consistent with hypotheses concerning the influence of social factors on ‘schizophrenia’ comes from marital status data. For example, single males are over-represented in ‘schizophrenia’ samples, such as in the WHO 10-country study (Jablensky et al., 1992). Jablensky draws the following two lines of explanations from such findings:

Since both overt schizophrenia and preschizophrenic social impairments reduce the chances of marriage, married schizophrenics may represent a selected group with a milder form of the disease. Alternatively, marriage itself (or living with a partner) may have an effect of delaying the onset of schizophrenia or cushioning its impact.

(2000a: 595)

In addition to the antecedents and risk factor topics covered thus far, Murray and Castle (2000) consider adverse life events, expressed emotion, and drug abuse in their section on aetiology. They note that there have been conflicting findings concerning life events and schizophrenic relapse. However, a recent study by Bebbington et al. (1993) is described as managing to avoid many of the methodological problems of earlier studies when it compared psychotic patients (half of whom were diagnosed with ‘schizophrenia’) with general population controls. A significant relationship was found between life events and the onset of a ‘schizophrenic relapse’. Murray and Castle consider these results as follows:

One possibility is that certain types of schizophrenic patients are particularly vulnerable to relapse following adverse life events. For example, Bebbington et al. (1993) found
females to be particularly prone, while van Os et al. (1994) found life events to be associated with a less severe good-outcome illness.

(2000: 603)

Studies of expressed emotion are then described in the context of life events:

There is also evidence that families who exhibit high ‘expressed emotion’ (comprising critical comments, hostility, and/or overinvolvement) can provide an environment which enhances the risk of relapse in a family member with schizophrenia. Again, cause and effect are difficult to tease apart. Thus, it is possible that patients with more severe and intractable illnesses may induce more expressed emotion in their relatives.

(Murray & Castle, 2000: 603)

The presented evidence on life events and expressed emotion suggests that such factors cause an increased risk of relapse in people who are diagnosed with ‘schizophrenia’. Boyle (2002a: 12), however, argues that such ‘schizophrenia’ research as that presented systematically constructs “the association between schizophrenia diagnoses and social factors as consequential rather than antecedent or causal”, thus obscuring evidence of social ‘causes’. Boyle argues that this is part of a larger illusion that ‘schizophrenia’ is a brain disease.

I argue that stress-vulnerability models are widely invoked to gloss over a multitude of gaps in a biopsychiatric understanding of ‘schizophrenia’. Murray and Castle explain that stress-vulnerability models come in two broad forms. The additive model:

[sees] individuals on a stress-vulnerability continuum in which genetic and environmental factors act in an additive manner until a threshold of liability for expression of psychosis is passed. An individual might, for instance, inherit schizotypal personality but not develop frank psychosis unless exposed to some cerebral insult which causes cognitive impairment; the sum of the two factors could produce the psychotic illness.

(Murray & Castle, 2000: 603; my emphases)
It seems that even in this additive model - from Murray and Castle’s presentation of it, at least - a genetic vulnerability is probably necessary for ‘schizophrenia’. Also, with what seems to be its genetically-dependent notion of a “threshold of liability for expression”, this explanation also manages to avoid being a ‘true’ continuum theory - one in which a single quality of the items from a chosen category can be objectively measured.

However, Murray and Castle reason that an interactive model is more in accordance with the evidence:

As van Os and Marcelis (1998) point out, it seems that certain individuals exposed to an environmental risk factor have a high risk of developing schizophrenia while others with a different genotype are at low risk.

(2000: 603)

Murray and Castle go on to cite adoption studies and studies of obstetric complications to show that environmental factors appear to “interact with, and compound, a genetic liability” (p. 603). Thus, the interactive stress-vulnerability model appears to hold that a genetic liability is a necessary factor for ‘schizophrenia’, even more so than the additive model. All this modelling in the absence of any direct evidence which reliably and with predictive utility links genetic material to the diagnosis of ‘schizophrenia’ (Boyle, 2002b: chap. 6).

How do Jablensky and Murray and Castle finally conclude their reviews of the aetiology of ‘schizophrenia’? The following extract appears to sum up Jablensky’s conclusions and hopes for the future:

Notwithstanding the difficulties accompanying the genetic dissection of complex disorders, novel methods of genetic analysis will eventually identify genomic regions and loci predisposing to schizophrenia... Clarifying the function of such genes will be a complex task. Part of the solution is likely to be found in the domain of epidemiology,
since establishing their population frequency and association with a variety of phenotypic expressions, including personality traits and environmental risk factors, is a prerequisite for understanding their causal role. Thus a molecular epidemiology of schizophrenia is likely to be the next major chapter in the search for causes and cures.

(2000a: 595; my emphases)

Thus, according to Jablensky, despite the complexity of the task, a marriage between epidemiology and molecular genetics will pave the way for further advances in the search for causes and cures for ‘schizophrenia’.

Also, apparently in relation to treatments based on knowledge of aetiology, Murray and Castle consider the “theoretical possibility of reducing the prevalence of certain risk factors and thus reducing the incidence of the disorder” (2000: 604). According to Murray and Castle there may be hope from advances in antenatal care and vaccination programs, although interventions are not yet targeted on schizophrenia-specific factors in high-risk groups. It is, however, important to remember that “most babies who are exposed to even severe obstetric complications will not later suffer from schizophrenia” (Murray & Castle, 2000: 604) and so focused targeting of any such interventions would be most important. An as yet rare example of such targeting is the extra care which can be taken in the delivery of children from mothers who are diagnosed with ‘schizophrenia’.

Murray and Castle also point out this problem of non-specificity in relation to early interventions aimed at the cognitive and social impairments of ‘preschizophrenic’ children:

Unfortunately, the childhood characteristics of preschizophrenics are non-specific... i.e. many children who show such deviation from normal in terms of early development, do not later manifest schizophrenia, whilst other children who later develop schizophrenia have perfectly ‘normal’ early development. Furthermore, any such abnormalities must be seen in the total context of development, and it should be remembered that many
such abnormalities are not static, but may be evident at some stages of development and not at others. Thus, with a few exceptions, there is as yet little that can be done systematically to reduce the incidence of schizophrenia.

(2000: 604)

Similar criticisms relating to non-specificity can, I suggest, be levelled at early interventions for people who exhibit their first so-called ‘prodrome’ of psychosis (ie, supposedly pre-psychotic ‘symptoms’). Needless to say that a cessation of diagnosing ‘schizophrenia’ is not yet on the mainstream psychiatric agenda.

**Neurobiology**

The neurobiology of ‘schizophrenia’ is covered by Harrison (2000) in the *New Oxford Textbook of Psychiatry*. For example:

The neurobiology of schizophrenia may be divided into functional and structural aspects. Significant progress has been made in both areas as a result of imaging modalities and the emergence of molecular techniques to study the underlying cellular processes.

(p. 605; my emphasis)

Despite the many uncertainties, there are now established facts about the neurobiology of schizophrenia... There is ventricular enlargement and decreased brain volume. Although the cellular correlates remain poorly understood, they involve the size, density, and organization of neurones and the synaptic contacts... In vivo studies show differences in cerebral metabolism and other parameters of cerebral function, with a pattern indicative of aberrant connectivity between brain areas. Dopaminergic, 5-HT [serotonin], and glutamatergic systems are all affected, but the specific details of their involvement in schizophrenia, and how they relate to the functional and structural findings, are still frustratingly unclear.

(p. 605; my emboldening; original italics)
In short, ‘schizophrenia’ researchers are presented as having made ‘significant progress’ in identifying the neurochemical and structural basis of ‘schizophrenia’, although much is still to be understood. Elsewhere, Harrison also mentions a need for more studies of drug-naive, first episode subjects - those who are free from the confounds of the effects of medication on brain structure and function.

Despite (or because of) the admitted lack of early progress and “frustratingly unclear” findings, the section appears to reflect a continuity, rather than discontinuity, view of ‘schizophrenia’. Even Kraepelin receives a mention, by proxy:

Alzheimer, a colleague of Kraepelin, began the search for the neuropathology of schizophrenia. However, only recently has progress been made. The major advances have come from structural imaging (CT and MRI)... (Harrison, 2000: 607)

And it is the approach of Bleuler - ironically, discussed in the same volume by Berrios (2000) as being conceptually incompatible with that of Kraepelin - which Harrison then associates with current interest in cerebral architecture and neurodevelopmental hypotheses:

Bleuler’s view that the key symptoms of schizophrenia are those of ‘psychic splitting’ now have their counterparts in the functional imaging studies and neuropsychological models... which have implicated aberrant functional connectivity between different brain regions and the putative mechanisms of psychosis. It is suggested that the cytoarchitectural features of schizophrenia represent its neuroanatomical basis (Harrison, 1999).

...The neurodevelopmental model of schizophrenia... has become the prevailing pathogenic hypothesis; indeed the principle is now largely unchallenged... Overall... the neuropathological data are indicative... of an essentially developmental, as opposed to a degenerative, disease process, rather than as pointing to a particular mechanism or timing.
Thus, it is recognized that problems remain in determining the when and how of what are taken to be the structural ‘aberrations’ of ‘schizophrenia’ occur. Details of the disease process also remain apparently unclear. That schizophrenia is caused by “aberrant” brain structure and function, however, is somehow apparently certain. The fact that this assumption is made and that it is made despite the continuing absence of a biological sign for ‘schizophrenia’ does not receive a mention. Furthermore, central issues such as the non-specificity and inconsistent relationship to ‘schizophrenia’ of ventricular enlargement and of decreased brain volume, plus the lack of drug naivety in the subjects, are downplayed in this account (see Boyle, 2002a & b).

**Course and outcome**

Not surprisingly, Jablensky’s (2000b) section on the course and outcome of ‘schizophrenia’ also attests to the complex nature of the disorder and the enduring nature of the ‘concept’ over many decades of research. A lack of sustainability for ‘schizophrenia’ as a concept is notably absent:

> Studies conducted over many decades consistently demonstrate that schizophrenia presents a broad spectrum of possible outcomes and course patterns, ranging from complete or nearly complete recovery after acute episodes of psychosis to continuous, unremitting illness leading to progressive deterioration of cognitive performance and social functioning. Between these extremes, a substantial proportion of patients show an episodic course with relapses of psychotic symptoms and partial relapses during which affective and cognitive change becomes increasingly conspicuous and may progress to gross deficits.

(Jablensky, 2000b: 619)
It is known that neuroleptic medications can measurably alter neurological structure and function. Since the majority of ‘schizophrenic’ patients in the latter half of the 20th century and beyond are either currently taking or have at some time taken such medication, they may not reflect the ‘natural’ course of ‘schizophrenia’. Jablensky describes some studies which appear to shed light on this issue:

Two recent studies in Scotland (Geddes & Kendall, 1995) and India (Padmathavi, Rajkumar, & Srinivasan, 1998) estimated the proportions of never-hospitalized schizophrenic patients at 6.7 per cent and 28.7 per cent respectively. About half of the Scottish patients had been prescribed neuroleptics by their general practitioners while the Indian patients had been virtually untreated. However, in both settings the outcomes of these interesting samples (which presumably approximate the ‘natural’ history of the disorder) were heterogenous and, by and large, did not differ from the outcomes of treated groups.

(2000b: 613)

However, three important points are not discussed in connection with this “natural” history. Note that, in the extract above, the term “natural” is enclosed in inverted commas, presumably to indicate, as would I, that its use is problematic in some way. First, only those who come to psychiatric attention are included in such research. Thus, even these studies contain samples which are likely to be biased towards people who are seen by psychiatrists as ‘classic’ cases of ‘schizophrenia’. Second, the samples (the Indian sample at least, according to the study’s title) are not from rural areas, where a somewhat improved prognosis for people diagnosed with ‘schizophrenia’ has been found. Third, given these findings, why is there not a huge bid to study such matters further? And why do authorities, in any country, continue to promote the expensive and almost exclusively medical management of ‘schizophrenia’?

After discussing several other studies, Jablensky does, however, add the following:
A tentative conclusion... would be that schizophrenia is not invariably a chronic deteriorating disorder and that the progression of the disease can be arrested, or even reversed, at any stage. The causes of such reversibility remain largely unknown, but research focusing specifically on the recovering cases will undoubtedly provide essential clues for understanding the nature of schizophrenia.

(2000b: 614)

Such conclusions are at odds with claims that gross abnormalities are directly related to ‘schizophrenia’. Nevertheless, whatever the reasons and despite all of the research to date, the current psychiatric prognosis for most people who are diagnosed with ‘schizophrenia’ is likely to be very poor:

Although no less than one-third of all patients with schizophrenia have relatively benign outcomes, in the majority the illness has a profound, lifelong impact on personal growth and development. The initial symptoms of the disorder are not strongly predictive of the pattern of course but the mode of onset (acute or insidious), the duration of illness prior to diagnosis and treatment, the presence or absence of comorbid substance use, as well as background variables such as premorbid adjustment (especially during adolescence), marital status, and the availability of a social network allow a reasonable accuracy of prediction in the short to medium term (2-5 years).

(Jablensky, 2000b: 619)

**Treatment and management**

Finally, we come to Cunningham Owens and Johnstone’s (2000) section on the treatment and management of ‘schizophrenia’. The primacy of prescribed drugs in the treatment of people who are diagnosed with ‘schizophrenia’ is evident from the introduction of this section onwards. The section begins with an introduction to a brief historical consideration of various treatment types:
Historically, therapeutic interventions in patients with psychotic disorders were largely palliative and predicated on essentially psychosocial principles (Clouston, 1884), although the administration of medicines and other physical techniques has been recommended since antiquity (Adams, 1856) and actively employed in Britain for some 300 years (MacDonald, 1981).

(Cunningham Owens & Johnstone, 2000: 621)

Thus, the existence of psychotic disorders in antiquity is taken as a given, psychosocial interventions are associated with “largely palliative” effects, and medication is associated with a very long history indeed. The next paragraph then distances the pharmaceutics of modern psychiatry from certain other, largely discredited, physical techniques:

Over the last 50 to 60 years, a number of physical treatments of schizophrenia have aimed at promoting more specific benefits. Insulin coma, electroconvulsive therapy (ECT), and prefrontal leucotomy (Johnstone, 1998) became widely applied on the basis of enthusiasm rather than scientific study, but since the development of safe and effective medications they have largely fallen into disuse. Since chlorpromazine was introduced in 1952 and shown to have specific antipsychotic properties (Owens, 1999), numerous antipsychotic agents have come into use, which, along with a range of psychosocial interventions, have been favourably evaluated.

(Cunningham Owens & Johnstone, 2000: 621)

That is, “antipsychotic agents” are “favourably evaluated”, “along with a range of [modern] psychosocial interventions”, and in contrast with crude and less than fully scientific types of physical treatment.

However, psychiatrists are presented as not being naive about problems and criticism. Cunningham Owens and Johnstone describe their concerns in terms of discrepancies between the demonstrated efficacy of drug treatments with their not always satisfactory performance for patients:
There remains an obvious discrepancy between the generally favourable results of especially drug, trials in this field and an ongoing concern about the difficulties posed by schizophrenia. Some of this can be explained by the difference between responses evident in clinical trials (efficacy) and those that pertain in ordinary circumstances (effectiveness).

(2000: 621)

Fault is attributed, not to the notion of ‘schizophrenia’ or to the treatments, per se, but to the rarified conditions which constrain research trials:

The unique conditions of the controlled trial provide essential information on which to base rational therapeutic decisions, but not necessarily information that translates to all clinical contexts.

(Cunningham Owens & Johnstone, 2000: 621)

This implies that psychiatrists in the field may need to be practical and creative and not merely “rational”. Thus, in this context at least, it is acknowledged that psychiatry requires art, as well as science, to help in highly challenging and varied clinical contexts. Cunningham Owens and Johnstone then rely on research trials (the bases of which have been already undermined by them) to consider the efficacy of various treatments; drugs first. Their plain statement of truth leaves no room to doubt the legitimacy of medication as the prime treatment for “positive” features of ‘schizophrenia’:

That standard antipsychotic drugs promote resolution of positive symptomatology characterizing acute schizophrenic episodes cannot be doubted. In a review covering the first two decades of antipsychotic use, Davis and Garver (1978) found that 86 per cent of controlled studies showed chlorpromazine to be superior to placebo...

The question of ‘acute’ efficacy is now settled to a sufficient degree that further attempts at replication would probably be unethical. Furthermore, this effect, or
magnitude of effect, is not shared by other psychotropic agents and can be considered a
class effect and a valid basis for classification.

(Cunningham Owens & Johnstone, 2000: 622)

Thus, being favourably compared to a placebo pill - rather than a credible alternative
treatment - is sufficient to prove that standard antipsychotic drugs are efficacious and to
prove that such drugs have a different class of action to other drugs. All this, in the
absence of clear and direct evidence linking specific drug actions to biological signs of
positive symptoms. Cunningham Owens and Johnstone, however, do explain that
“[w]hile these drugs can be dramatically effective in individual cases, overall their
efficacy in acute states is only partial” (p. 622).

But what of new-generation antipsychotics? Cunningham Owens and Johnstone cite
supportive studies in noting that, with the exception of clozapine, all the antipsychotic
drugs (standard or new-generation) are of equal efficacy in treating positive symptoms.
The benefits of clozapine are stated as perhaps only relating to its use in “treatment-
resistant cases” (p. 622). Cunningham Owens and Johnstone also discuss the benefits of
the new-generation drugs in producing less of the dangerous side-effects which are
found with standard antipsychotics:

Where the new-generation drugs appear to have advantage is in neurological tolerability
(Owens, 1999), although it is as yet hard to quantify the extent of this. New-generation
drugs seem to have a reduced liability to promote dystonias, and are associated with
lower levels of parkinsonism and akathesia. While it would seem reasonable to
conclude that these benefits will translate into reduced rates of tardive motor disorders
also, for which some supportive data have been presented (Chouinard, 1995; Tollefson,
Beasley, Tamura, Tran, & Potvin, 1997), firm evidence for this remains to be accrued.

(2000: 622)

It is important to note that this consideration of dangerous side-effects - a phrase which
is not actually used by Cunningham Owens and Johnstone - is their only discussion of
such matters. Furthermore, this account is in the context of their presentation of themselves as being diligent scientists, who fully accept only “firm evidence”. Thus, by implication, their other ‘facts’ (such as the existence of ‘schizophrenia’ as an object rather than a construct) are presented as scientific and without hidden assumptions. Life-altering and brain-altering possible side-effects are also downplayed.

Before moving on to the treatment of ‘negative’ features of ‘schizophrenia’, let us consider how Cunningham Owens and Johnstone present a comparative study of physical and talking therapies:

Despite their limitations, antipsychotics are unquestioningly the most satisfactory treatment modality for acute episodes. In a unique study, May (1968) compared response rates and outcomes in a large group of schizophrenic patients randomly assigned to one of five treatment regimens: individual psychotherapy alone, antipsychotics alone, individual psychotherapy plus antipsychotics, ECT, and ‘milieu’ therapy (i.e. a ward environment).

(2000: 622)

Once again, in their opening, the primacy of drugs for acute ‘positive symptoms’ is deemed to be without question. Also, in fairness to psychological therapies, the individual psychotherapy (which Cunningham Owens and Johnstone refer to in a later subsection as “psychodynamic psychotherapy”: p. 625) is likely to have been rather different from the dominant psychological therapies of 2000 and beyond. Plus, the patients (referred to in a later subsection as “first-episode schizophrenia” patients; p. 625) were all in-patients throughout the treatment period; something which may well have affected their “response”. Yet, this unique study is the only direct comparison between drugs and a psychological therapy (or any other adjunct or alternative) in the entire chapter on ‘schizophrenia’. Perhaps, given the primacy which is afforded to antipsychotic medications - despite their shortcomings; despite cross-cultural evidence of better outcomes in developing, rural areas and despite evidence of positive outcomes
from non-drug-promoting, non-hospital-promoting approaches which are not even mentioned in the *New Oxford Textbook of Psychiatry* - ongoing direct comparisons would be considered by the biopsychiatric establishment to be, to use Cunningham Owens and Johnstone’s own term from earlier in this section, “unethical”.

The authors describe how the results of the May (1968) study were clearly in favour of physical treatments, drugs in particular, over psychotherapy and milieu therapy (with the latter being described elsewhere in the chapter merely as a “ward environment”: Cunningham Owens & Johnstone, 2000: 622). Whether or not the psychotherapy added to the effects of antipsychotics is not mentioned:

> Patients who received physical treatments clearly did better in terms of increased rates of discharge, reduced lengths of stay, and decreased need for additional treatments. Two years after discharge, twice as many of those treated with antipsychotics as with psychotherapy were in employment (May, Tuma, Yale, Potepam, & Dixon, 1976), while in the 3 years post-discharge, the drug-treated patients spent less time back in hospital (May, Tuma, Yale, & Dixon, 1981).

(Cunningham Owens & Johnstone, 2000: 622)

Cunningham Owens and Johnstone go on to discuss some of the results from this study which have a bearing on the recent push towards early drug intervention in first episode patients with a diagnosis of ‘schizophrenia’:

Data from this trial *suggested* that those not subjected to antipsychotic treatment early on fared less well in terms of long-term outcome than those who had received it in the initial phase of the investigation. This topic has assumed considerable prominence in recent years and the impression is that early intervention is associated with a better outcome than a policy of ‘wait and see’ (Wyatt, 1991). The implication is that antipsychotic drugs achieve their best results when administered as soon after the onset of illness as possible. How long is ‘soon’ remains unclear, although there is a *suggestion* that those with first episodes in whom exposure is delayed for longer than
12 months may have a worse long-term outcome than those coming to treatment earlier (Crow, Macmillan, Johnson, & Johnstone, 1986).

(2000: 622; my emphases)

Thus, we can see that it is conceivable that, on the basis of “suggested” evidence, alternative approaches and even alternative diagnoses are likely to fade further into the background as professionals attempt to use medication pre-emptively to reduce the supposed period of untreated psychosis. However, we know so very little about the phenomena in question, let alone any pre-cursors to those phenomena. Taking a primarily medical route (with the drawbacks of being diagnosed and treated with antipsychotics, in addition to any benefits) may seal off the exploration of other, non-medical and potentially fruitful, socially orientated avenues for effecting change or avoiding unnecessary treatment. Also, the discovery of any new biological tests for precursors of ‘schizophrenia’ or ‘symptoms’ would be founded on flawed ‘concepts’ and are likely to lead to the continuing pre-eminence of biological treatments of the phenomena in question. Furthermore, since the full-blown ‘symptoms’ of ‘schizophrenia’ are so non-specific to that diagnosis, and since there are no laboratory tests for ‘schizophrenia’ or its supposed pre-cursors, then many early intervention cases are likely to be false positives who are unnecessarily treated, according to psychiatry’s own criteria. This would be true for children or youths evidencing ‘pre-schizophrenic abnormalities’ (David, 2000a: 581; Jablensky, 2000a: 595; and Murray & Castle, 2000: 604), for youths or adults evidencing ‘prodromal symptoms’ (proximal, ‘pre-psychotic symptoms’), and for people experiencing what might be called their ‘first episode’ of ‘psychosis’. That is, a major drawback of early intervention in any of these populations

10 ‘Non-specific’ is a term used by Boyle (2002b) in describing how the ‘symptoms’ of ‘schizophrenia’ are common in people who do not even closely approach the criteria for inferring ‘schizophrenia’. Murray and Castle (2000: 604) use the term ‘non-specific’ in the context of “pre-schizophrenic” risk factors.
is the difficulty in establishing whether treatment is required, on balance, in each case within that population. Largely medical treatments would be applied in novel and larger populations compared to the current treatment of ‘schizophrenia’ and ‘symptoms’. On what basis can one say whether the person in question is ‘psychotic’ or on their way towards ‘it’? Or would they improve sufficiently without treatment? Such concerns about the screening of populations are over and above the controversies which surround ‘schizophrenia’ and ‘psychotic symptoms’, including whether they are valid scientific concepts, and whether a given treatment is effective and of more benefit than harm.

Some of these issues of early intervention - especially in relation to young people - come to the fore in the light of Cunningham Owens and Johnstone’s startling comments concerning behavioural issues:

Efficacy studies of antipsychotics seldom consider behaviour as a separate dimension of disorder. It is clear, however, that particular, largely confrontational, behaviours such as hostility, belligerence, and resistiveness do improve with antipsychotic treatment (Klein & Davis, 1969). This is usually taken as secondary to improvements in other domains, especially positive features.

However, behavioural disorganization in schizophrenia may not reflect a single dimension of disorder. In long-stay patients, behavioural disturbance appears to correlate with negative symptomatology and not positive (Owens & Johnstone, 1980). Antipsychotics are thus unlikely to be efficacious in treating all behavioural disorders with which schizophrenia patients may present.

(2000: 624; my emphases)

I use the word ‘startling’ because, as I have already stated, such matters are considered in the absence of direct and consistent evidence linking any kind of ‘schizophrenic symptom’, ‘disorder’, or “dimension” with a biological sign and in the absence of even a brief consideration of social factors which might occur in connection to the delivery and receipt of psychiatric treatment. Neither are the behaviours that are said to
“improve” (such as ‘resistiveness’) discussed in the light of evidence concerning neurological and neuropsychological changes which result from antipsychotic medication. Such medication-induced changes can be equated to the pharmaceutical restraint of the patient, for the duration of taking the drugs and beyond (Gosden, 2001). It is these medications, in varying doses, which are used in both early and later intervention cases.

Once someone has been given a full diagnosis of ‘schizophrenia’ and once they have become established on antipsychotic medication for their ‘symptoms’ then they tend to remain on such medication, even, and especially, if their ‘positive symptoms’ reduce. As Cunningham Owens and Johnstone put it, “[t]he long-term use of antipsychotic drugs in the treatment of schizophrenia is most frequently aimed at minimizing the risk of florid exacerbations of a disorder usually characterized by some persisting symptomatology” (p. 624). Such treatment for the supposed prevention of relapse is known as ‘maintenance’ medication.

Given that ‘schizophrenia’ is seen as a mental illness which is “characterized” by the persistence of symptoms, the taking of medical steps to reduce the supposed risk of a worsening of symptoms would seem to be a logical outcome for most if not all patients. According to the previous quotation, the “long-term” nature of ‘schizophrenia’ is “frequent”, after all. Indeed, the “persisting” nature of ‘schizophrenia’ is apparently taken as so much of a given by some researchers as to justify the use of long-term maintenance medication in even ‘first episode’ cases:

While most studies have concerned patients with established recurrent illness, there is additional evidence that long-term treatment is effective in preventing relapse after first episodes also. In the Northwick Park First Episode Study (Crow et al., 1986), significantly more patients in the placebo group than in the active treatment group relapsed over 2 years (62 per cent versus 46 per cent respectively: p < 0.002).

(Cunningham Owens & Johnstone, 2000: 624)
Thus, despite known problems with medication and despite the alternatives, (1) long-term medication is typical for people diagnosed with ‘schizophrenia’; (2) there are moves to establish people on long-term medication after what is taken to be only their first episode of psychosis; and (3) there are moves to put people on medication after prodromal experiences, even before a supposed first episode. We may note the fact that it was not mentioned in the above account that the active treatment was found to only have a 54% success rate. Also, $p = 0.002$, not $p < 0.002$, is the statistical standard for establishing scientificity.

Returning to more “established recurrent illness”, Cunningham Owens and Johnstone present a seemingly balanced position, with evidence that maintenance medication is efficacious, both before and after a mentioning of certain shortcomings in the data/reporting:

> [t]he efficacy of antipsychotics in preventing relapse has also been extensively investigated and is beyond doubt (Janicak, Davis, Preskorn, & Ayd, 1993). Despite this, it remains difficult to quantify this effect, as the published literature presents figures that are widely discrepant. Nonetheless, reviewing the randomized, double-blind trials of antipsychotic versus placebo covering variable follow-up intervals, Janicak et al. concluded that on average 55 per cent of those on placebo relapsed compared with 21 per cent on active medication (1993). Statistically, these figures provide overwhelming support for the maintenance action of antipsychotics ($1 \times 10^{-7}$).

(2000: 624; my emphasis)

However, one is left without any information concerning the magnitude of the discrepant figures and why such discrepancies might occur, besides perhaps the implication that such discrepancies may be related to measurement or presentational issues (see italics). Such accounts also draw attention away from patients who are not helped by antipsychotics and from the fact that the so-called ‘concept of schizophrenia’ itself is problematic. Also, given the physical effects of antipsychotic medication, it is
important to note that the perhaps crucial information of whether any of the subjects were drug-naive is absent from Cunningham Owens and Johnstone’s account. Furthermore, comparisons of the ‘relapse’ rates of people who have all been diagnosed with ‘schizophrenia’, one group receiving ‘the best of’ medical treatment, another group receiving ‘the best of’ non-medical treatment (whatever that may be), and another group receiving no treatment per se, do not appear to have been conducted. Perhaps ‘ethical’ constraints would make such research difficult to conduct, given that the principal use of antipsychotics is taken as the only ‘proven’ efficacious course of action. But how then can alternatives be assessed? With this double-bind operating, alternatives to drugs are typically not assessed. However, certain ‘adjunctive measures’, as Cunningham Owens and Johnstone call them (p. 625), have been assessed, as I will consider presently.

As to the matter of how long is sufficient for maintenance medication before it can be discontinued, Cunningham Owens and Johnstone cite evidence to undoubtedly conclude that maintenance doses should continue to be taken over a very long time indeed. For example, Johnson (1979) compared patients who were discontinuing medication with those who were continuing medication. ‘Relapse’ rates for discontinuing patients at 18 months were similar, regardless of whether they had been in ‘stable’ maintenance for 1-2 years, 2-3 years, or 3-4 years (80 per cent, 90 per cent, and 70 per cent, respectively). These results were significantly higher than in those who continued with medication (35 per cent, 15 per cent, and 19 per cent, respectively). Sealing this conclusion still further, a number of other supportive studies are cited with intervals from 12 months to 8 years, in addition to a study of patients who had responded particularly well to treatment. Thus,

[t]he implication seems to be that, no matter the duration or quality of well being on antipsychotic medication, relapse is inevitable following discontinuation in those with
an established relapsing-remitting pattern of illness, with a time course that, in general, is consistent for each individual.

(Cunningham Owens & Johnstone, 2000: 624)

It is perhaps not so remarkable that identified “relapsing-remitting” patients who are deemed to ‘respond well’ or very well to medication tend to be continued on that medication, as long-term patients. Given the commonly available evidence and the professional lack of consideration of drug-free options, they are considered to have an ongoing likelihood of ‘relapse’, after all. However, although it is not stated above, it is perhaps more remarkable to consider that patients who do not ‘respond well’ may never be taken off medication. On occasions, this may continue in the event of deleterious or even life-threatening ‘side-effects’ and in the event of involuntary administration of medication. So why is not more being done to ascertain which patients are likely to ‘respond’ and which ‘patients’ had better not be put on antipsychotics in the first place?

Maintenance dosages can be lowered only so far before their margin of effectiveness is compromised. Also, a trade-off exists between a typically effective dosage and adverse side-effects:

Kane and colleagues showed that while relapse rates were higher in the low-dose group, neurological adverse effects and psychosocial/quality-of-life parameters were superior. (Kane, Rifkin, & Woerner, et al., 1983) Similarly, the Northwick Park First Episodes Study found that at endpoint, significantly fewer of those treated with active drug achieved some specific advance or attainment in their life than those on placebo (Johnstone, Macmillan, Frith, Benn, & Crow, 1990). This raised concern that maintenance antipsychotic treatment may have hidden costs.

(Cunningham Owens & Johnstone, 2000: 624; original emphasis)

Given the evidence which is embedded within even the New Oxford Textbook of Psychiatry, one wonders how much longer those costs can be considered “hidden”.
We can now turn our attention to the status attributed to formal psychosocial interventions in orthodox psychiatry accounts of ‘schizophrenia’. First, in Cunningham Owens and Johnstone’s section and in psychiatry more generally, psychosocial interventions are considered to be *adjuncts* to medication; additional, non-essential, subordinate. Second, such approaches are often described as ‘measures’ and ‘interventions’, rather than ‘treatments’. Third, and in keeping with the first two points, studies of psychosocial interventions are often presented in a way which implicates their somewhat lower scientific status compared to, for example, drug trials:

*Adjunctive measures*

While antipsychotics can clearly protect against relapse, it has also been strongly advocated that additional benefits can be achieved when medication is combined with other forms of management, especially social/family interventions. This principle has considerable support in the literature (Davis, Metalon, Watanabe, & Blake, 1993), although *difficulties persist with most studies*.

...Controlled studies of psychosocial interventions are less extensive than those concerning drug treatments, and assessments in many studies have not been blind, but *it is possible* for the psychosocial therapy of schizophrenia to be evidence based.

(Cunningham Owens & Johnstone, 2000: 625; my emphases; original title)

Thus, by implication, the satisfactory empirical status of drug-based studies is assumed to be generally achieved, whilst it is merely “possible” for psychosocial studies.

Furthermore, and only receiving a mention within the context of professional-mediated psychosocial adjuncts to medical management, alternatives to hospitalization assume an ‘also ran’ position:

The major types of [psychosocial] intervention are as follows:

- psychodynamic psychotherapy
- social skills training and illness self-management programmes
• family interventions

• cognitive-behavioural therapy.

A further group, while strictly relating more to administrative measures, may nonetheless be conveniently considered here:

• alternatives to hospitalization.

(Cunningham Owens & Johnstone, 2000: 625)

Whilst on the subject of alternatives, it is worth noting that approaches which promote credible drug-free options do not receive a mention anywhere in the entire chapter on ‘schizophrenia’.

In keeping with a medication orientation, Cunningham Owens and Johnstone largely frame social skills training programs in terms of “illness self-management”. For that, read ‘compliance with medical management’. Also, “[i]ndividuals with substantial cognitive deficits and/or high levels of conceptual disorganization are poor candidates for most social skills training programmes” (p. 625). That many psychosocial interventions are less likely to attract and help those who appear to need it the most is a ‘well-known’ catch-22. Those who uphold psychosocial interventions have not yet developed the talking therapy equivalents of a involuntary admissions, community treatment orders, and depot injections to ensure ‘compliance’.

Cunningham Owens and Johnstone’s consideration of cognitive-behavioural therapy (CBT) stands out from their other psychosocial topics in that the focus and results of studies are presented with even less discussion. This may be, at least in part, because there is further consideration of CBT elsewhere in the textbook. There is a separate chapter on “Treatment methods in psychiatry”, with a section on “Cognitive-behaviour therapy for schizophrenia” (the first author of which is Max Birchwood, a clinical psychologist). However, being in a separate chapter, this broader consideration of CBT does not form part of the main chapter on ‘schizophrenia’. The result, for the chapter on
‘schizophrenia’, is the somewhat stark, businesslike presentation of a relatively few CBT studies, for example:

In recent years, controlled trials of cognitive-behavioural therapy in schizophrenia have been published. Tarrier et al. (1993) randomly allocated 27 patients with residual symptoms on antipsychotic medication to coping strategy enhancement or problem solving, and compared them with 22 patients allocated to a waiting list condition. Both treatments reduced positive symptoms, but not negative symptoms or social functioning.

(Cunningham Owens & Johnstone, 2000: 626)

Perhaps the issues are sufficiently evident to speak for themselves. Nevertheless, this is in keeping with the chapter being focused on biomedical, rather then psychological and/or social, understandings of ‘schizophrenia’. It is also worth noting that, unlike accounts of biological psychiatry, there is no history presented here, continuous or otherwise. One might say that this is simply because there is no history to relate. However, the history of CBT for depression and anxiety, over several decades, as well as early cognitive interventions for delusions (e.g., Beck, 1952), could have been invoked.

Another aspect of the above extract is the use of subjects with “residual symptoms”. The patients who entered the Tarrier et al. (1993) study - and most if not all CBT studies to-date in connection to ‘schizophrenia’ - still experienced somewhat concerning ‘symptoms’ despite being stabilized on medication. That is, CBT tends to only ever be used as a secondary (i.e., last-ditch) approach to standard treatment; when there is nothing to lose, as it were.

The use of patients with ‘residual’ and/or ‘treatment resistant’ ‘symptoms’ in CBT studies is related to a highly important issue regarding the dominant psychiatric approach to ‘schizophrenia’ which is not directly stated (but repeatedly implied) in the *New Oxford Textbook of Psychiatry*. In biological psychiatry, patients are generally
directed to ignore their voices and let medication and other aspects of the medical management of their ‘illness’ do whatever work that there is to be done. Once there is sufficient information for a diagnosis to be made, the content of potentially personal topics such as ‘voices’, ‘delusions’, ‘madness’, and so on, are seldom if ever directly addressed, let alone more fully explored. As I will argue later, even CBT tends to have an underlying ‘done to’ - rather than ‘done with’ - ‘treatment’ approach, which is apparently borrowed from medicine. The fact that respectful acknowledgement of the experiencer as having a valid (co-constructed?) ‘point of view’ is, more or less, absent from prominent professional instructional texts and certain ‘therapeutic’ encounters is something which this dissertation aims to show. This lack appears to be related to a paucity of concern for social issues, in theory and interaction.

Cunningham Owens and Johnstone raise a different issue in connection to another study, this time involving cognitive therapy:

Drury et al. (1996) undertook a controlled trial of cognitive-behavioural therapy in drug-treated patients with ‘acute non-affective psychosis’. Subjects were randomized to cognitive therapy or equivalent hours of therapeutic input. Of 117 patients, 69 satisfied inclusion criteria and 62 were randomly allocated to the two treatments, but 22 were withdrawn, essentially for non-cooperation. Both groups showed a decline in symptoms, but this was more marked (p < 0.001) in the cognitive therapy group.

(2000: 626)

Cunningham Owens and Johnstone mention, but do not explore, the fact that so many patients were selected out from the study for “non-cooperation”. This may be alluding to the ‘classic irony’ of psychosocial interventions only helping those who need it the least, to which I referred earlier. Such factors/practices are likely to exclude many people with a diagnosis of ‘schizophrenia’. One wonders whether the resources which were originally allocated to therapy were made available in more appropriate formats for those who withdrew, or whether they missed out because their ‘non-cooperation’
was deemed inappropriate. A related issue is raised, but not discussed, in connection to a series of studies by Garety, Fowler, Kuipers, and colleagues:

The London-East Anglia randomized controlled trial of cognitive-behavioural therapy for psychosis (Garety, Fowler, & Kuipers, et al., 1997; Kuipers, Fowler, & Garety, et al., 1998) allocated 60 patients with at least one positive schizophrenic symptom resistant to medication to cognitive-behavioural therapy + standard care, or standard care. Fifty per cent of the cognitive-behavioural therapy group, as compared with 31 per cent of the control group, improved over 9 months. A major determinant of improvement with cognitive-behavioural therapy was ‘cognitive flexibility concerning delusions’.

(Cunningham Owens & Johnstone, 2000: 626)

Here, there is an oxymoron: “delusions” with “flexibility”. It represents a compromise between traditional psychiatry (which holds that delusions are, by definition, firmly held despite incontrovertible evidence) and the position of a growing number of professionals, especially psychologists (who argue that ‘delusions’ can be amenable to evidential persuasion - ie, cognitive therapy - just like other ‘beliefs’). Yet, even among psychologists who use CBT for ‘delusional beliefs’, accounts of ‘delusions’ still retain much of their dominant psychiatric meaning. That is, within the above oxymoron, ‘delusions’ are implicitly held to occupy a normality-abnormality, beliefs-delusions continuum.

As already noted, Cunningham Owens and Johnstone’s “Alternatives to hospitalization” subsection in the Oxford textbook does not address less medical or drug-free alternatives. Rather, it briefly considers “assertive (or intensive) case treatment” and “case management” by “multidisciplinary teams” (of mental health professionals, typically led by one or more orthodox psychiatrists), working with “mentally ill people” (Cunningham Owens & Johnstone, 2000: 626). Such so-called “alternatives” are presented as being benevolently and necessarily performed by the
“teams”, “working assertively” “on an ‘as-required’ basis to avoid hospitalization” (p. 626). But I shall not consider these approaches any further.

I am now in a position to let the first part of Cunningham Owens and Johnstone’s summing up of psychosocial interventions conclude this critical analysis of the *New Oxford Textbook of Psychiatry* on ‘schizophrenia’:

While antipsychotic drugs may be considered the cornerstone of the treatment of schizophrenia, the most competent prescribing of these does not provide a comprehensive programme of management. Even if no formal programme is followed, all patients and their relatives will require appropriate information about the nature of the illness and the therapeutic possibilities. They will need support in coming to terms with the *limitations that the illness may impose* upon the expectations they have had, and guidance about alternative paths...

*Antipsychotic drugs* can (and indeed overwhelming evidence indicates that they should) be given to *all patients* in whom the diagnosis of schizophrenia is appropriately made. This is not the case with *psychosocial interventions*. In general, these require co-operation from patients and/or relatives, and some of them can only be applied to *certain types of patient*.

(Cunningham Owens & Johnstone, 2000: 632; my emphases)

Thus, the blameful “limitations” of ‘schizophrenia’ are located in the “illness”, not within psychiatry, the patient, family, or society. Therefore, antipsychotic drugs “should” be given as “treatment” of the “illness” to “all patients” who are “appropriately” diagnosed.

In this dominant approach to dealing with supposedly quintessential psychiatric phenomena, psychosocial approaches are little more than sugar on the psychiatrist’s pill. That is, for those patients who have nothing to lose and who are compliant. Alternative approaches in which medical management is either not present or not dominant do not even receive a mention.
It is remarkable - but not surprising given its biomedical focus - that the *New Oxford Textbook of Psychiatry* does not explore the content of voices and so-called delusions, let alone present readers with any actual speech from ‘psychotic’ people. This is notable given that so much is made in mainstream psychiatry of language showing thought disorder, quite apart from its disregard for the views of the ‘questionable person’. It is this medically orientated view of hearing voices and ‘delusions’ which currently, mutually, is the basis of contemporary Western commonsense understandings of madness (see Georgaca, 2001; Hansen, McHoul, & Rapley, 2003).

Yet, as we saw in Chapter 1 with Leudar (a psychologist) and Thomas (a psychiatrist), there are some professionals who are interested in the form and function of voices rather than purported pathology. Other psychiatrists, such as Double (2002), are also not shy in subjecting their own profession to critical account. But before we concentrate on alternative approaches to the phenomena in question, let us consider an approach from mainstream clinical psychology.

**SECTION 2. CBT: TOWARDS A RECONCEPTUALIZATION IN PSYCHOLOGY**

To continue my analysis of canonical texts, I now turn to literature concerning cognitive-behavioural therapy for ‘psychosis’; a clinical approach to the phenomena in question which has gathered steam over the last decade.

CBT is now the most prominent psychological treatment of voices and ‘delusions’, particularly in the UK. It is also the dominant approach in clinical psychology more generally. Advocates of CBT - most notably clinical psychologists - have tended to adopt models of ‘psychosis’ in which single ‘symptoms’ are dealt with more or less separately. This practice supposedly avoids many of the contentious issues surrounding
troublesome supposed concepts such as ‘schizophrenia’. Thus, with single ‘symptom’
models there is the potential for voices to be seen as distinct from, say, ‘delusional’
beliefs\textsuperscript{11} and each ‘symptom’ \textit{may} be more or less distanced from the medical
framework which underlies ‘schizophrenia’. However, the description of such reported
experiences as ‘symptoms’ remains pervasive and problematic. Indeed, more general
distinctions between ‘normality’ and ‘pathology’, between the ‘mentally ill’ and the
‘mentally well’, are not so very far below the surface, as we shall soon see. A number of
these problems are considered by the authors as accountable issues in my chosen texts
for this section.

In recent CBT accounts, the term ‘psychosis’ and a focus on single ‘symptoms’ have
tended to be used in favour of ‘schizophrenia’. As we shall see, the titles of my analyzed
texts bear witness to this change. Using the term ‘psychosis’ instead of ‘schizophrenia’
may serve a number of purposes. First, it acknowledges that ‘schizophrenia’ is
problematic and suggests that ‘psychosis’ is, overall and for the time being, a preferred
term. Second, it opens the way for one or more ‘psychotic symptoms’ to be the main
unit of interest rather than the entire syndrome. Third, it continues to allow the
‘symptoms’ and the accounts thereof to be associated with severe ‘mental illness’,
despite or because of the ‘normalization’ aspects of psychological models. Boyle

\textsuperscript{11} The phrase ‘delusional belief’ may be taken as a moderation of the psychiatric term ‘delusion’ with the
softer (more ‘normal’) term ‘belief’. In this section, we shall see the use of this term operating within a
mentalist framework. In that context, I tend to place the term in inverted commas to indicate its status as
being problematic. However, when I use the term without inverted commas, it is as an abbreviation of the
social constructionist notion of beliefs only coming into being as reported beliefs, by primary or
secondary sources, and so on. This is in line with Boyle’s use of the word (without inverted commas) to
mean ‘‘the persistent claim that such and such is the case’’; a belief claim (2002: 271). In turn, these
conceptualizations of ‘delusions’ are in line with Sarbin’s (1978) consideration of hearing voices as
reported imaginings.
(2002b: 247) alerts us to the already occurring use of ‘psychosis’ in place of ‘schizophrenia’, in texts which leave intact many of the underlying assumptions of ‘schizophrenia’. This may merely have the effect of giving ‘schizophrenia’ a fresh coat of paint. In this section, I will show how the analyzed texts use ‘psychosis’, in line with many of the assumptions and related practices of the dominant psychiatric approach to ‘schizophrenia’.

This section, then, is to provide a detailed critical analysis, further to Boyle (2002b), of how the CBT texts present voices and ‘psychosis’.

**Overview of CBT**

The term ‘cognitive-behavioural’ (with or without a hyphen) can encompass a varied and sometimes disparate group of therapy procedures and practices, which may be more easily characterized by what they are not rather than by what they have in common. I shall not consider the relationship between CBT and theory here. However, Garety, Fowler, and Kuipers (2000) provide the following description of CBT for ‘psychosis’:

> The principal aim of cognitive-behavioural therapy for medication-resistant psychosis is to reduce the distress and interference with functioning caused by the psychotic symptoms. The thoughts, beliefs, and images experienced by people are the core material with which cognitive-behavioural therapists work. The approach draws extensively on the cognitive therapy of Beck and colleagues (e.g., Beck et al. 1979), both in terms of therapeutic style and of content. In terms of style, the therapist works collaboratively, setting agendas and therapy goals, and takes an actively enquiring stance towards the clients’ accounts of their experiences. The content of therapy involves identifying thoughts and beliefs, reviewing evidence for those beliefs, encouraging self-monitoring of cognitions, relating thoughts to mood and behaviour, and identifying thinking biases. However, the standard cognitive therapy approach must be modified to effectively address the particular problems of psychosis, including the
special difficulties of establishing a therapeutic relationship, the complexity and severity of the problems presented, [and] the need to take account of neurocognitive deficits...

The above extract contains examples of many of the characteristics of professional accounts about CBT for ‘psychosis’ which I will discuss further in the following sections. These characteristics include a ‘normalizing’ focus on the person as being more or less rational (“works collaboratively”, “the clients’ accounts of their experiences”). In connection to this, there is a focus on the person’s cognitions and cognitive “biases” and “deficits”, rather than more clearly on their biological pathology (“distress”, “thoughts, beliefs, and images experienced by people”, and the reference to Beck relates to arguably less severe ‘neurosis’ rather than ‘psychosis’). Thus, the person is, to some degree, presented as an active ‘client’ rather than a passive ‘patient’ who simply receives treatment. Nevertheless, CBT and the person are also placed within what is primarily a medical system (“medication-resistant”, “psychotic symptoms”, “neurocognitive deficits”) and their problems (both biological and psychological) have particular “complexity and severity”. Note also that, like medicine, this CBT account focuses on individual characteristics rather than social contexts. More specifically, for CBT, the focus is on cognitions and the psychological aspects of other purported mental states and processes rather than explicitly on observable behaviour. And, despite the collaborative “style”, there remains an impression that the therapist assumes the role of, say, a sculptor, moulding the client into a professionally sanctioned form (“the core material with which cognitive-behavioural therapists work”).

In a little more detail, and separate from ‘delusions’, Boyle provides an outline of the CBT toolkit for hearing voices:

For hallucinations the procedures may include the following: (1) Enhancing or adding to strategies already used by people to lessen voice-hearing or its aversiveness (e.g. distraction); modifying environmental stimulation; interfering with sub-vocalisation;
activity scheduling and relaxation. (2) Focusing on the experience of voice-hearing (e.g. on the characteristics of voices); identifying antecedents of voice-hearing and developing constructive ways to manage or ameliorate them; relating voice content to the person’s thought and worries, particularly those which are difficult to discuss; encouraging the person to accept voices as self-generated; linking voices to past aversive experiences. (3) Examining and questioning potentially distressing beliefs associated with voices (e.g. that the voice is all-powerful, or cannot be controlled or must be obeyed).

(2002b: 292-293)

Boyle also provides an outline of the toolkit for ‘delusions’:

For ‘delusions’, cognitive-behavioural interventions may include the following: (1) Identification of events and experiences associated with ‘delusional’ inferences. (2) Reviewing evidence for beliefs, allowing the person to voice and explore their own doubts. (3) Suggesting consideration of alternative interpretations of events and experiences. (4) ‘Testing’ interpretations against outcomes using an agreed ‘test’.

(p. 293)

Finally, she mentions procedures which are common to both:

For both voice-hearing and ‘delusions’, interventions may also involve examination of more general negative beliefs about the self (e.g. ‘I deserve to be punished’), as well as discussion of the ‘normality’ of the person’s experience in terms of their physical and psychological state, and circumstances. In addition, three elements have been emphasised: first, the importance of a collaborative, trusting relationship between therapist and clients; second, the need for flexibility - sessions of varying lengths, perhaps conducted in different places and possibly over a long period of time; and, third, the need for a graded approach (e.g. discussing, first, less strongly held beliefs or less threatening voices)...

(p. 293)
On a more general note, cognitive-behavioural therapists tend to lay claim to the empirical, research-based, foundations of their work as ‘scientist-practitioners’.

My data in this section comes from the therapy manuals, *Cognitive Therapy for Delusions, Voices, and Paranoia* by Chadwick, Birchwood, and Trower, (1996; with a cognitive focus) and *Cognitive Behaviour Therapy for Psychosis*, by Fowler, Garety, and Kuipers (1995; also largely with a cognitive focus, but including coping skills training and strategies designed to address social disability and risk of relapse).

**Introduction to ‘normalization’**

There are many aspects of the therapy manuals which may be described as ‘normalizing’ reported experiences and beliefs which would otherwise tend to be considered bizarre by the person in question and/or others. ‘Normalization’ occurs in accounting practices throughout the books, such as the use of ‘psychosis’, focusing on single ‘symptoms’ and specific cognitive biases or deficits rather then ‘schizophrenia’ as a whole, and the representation of ‘clients’ as being more or less rational and somewhat active in their own personal change.

The foreword by Aaron Beck for Chadwick et al.’s book is an example of ‘normalization’. Not only does Beck and his work provide a somewhat continuous historical context, but, given that Beck was the foremost pioneer of cognitive therapy, it also lends prestige. Furthermore, Beck’s foreword ‘normalizes’ ‘psychosis’ by linking it with the traditional cognitive therapy realms of ‘depression’ and ‘anxiety’, which are typically held as being more ‘normal’ and more open to psychological therapy:

> This work by Chadwick, Birchwood, and Trower is a significant breakthrough in the treatment of psychotic symptoms. It represents a surprisingly effective application of cognitive therapy to one of the most distressing and intractable set [sic] of clinical
problems. From the very early years... cognitive therapy was found to be an effective approach to depression and anxiety disorders...

(Foreword by A. T. Beck; in Chadwick et al., 1996: ix)

This account can also be seen as managing a tension between the ‘normality’ and ‘severity’ of “psychotic symptoms” by describing progress in treatment. This serves to justify the continuation of CBT in this realm. In such matters, the author is managing a tension between ‘normality’ and ‘abnormality’. On the one hand, ‘psychosis’ is constructed as being ‘normal’ enough to be considered amenable to a talking therapy. On the other hand, the dominant psychiatric approach (which is derived from a model of ‘psychosis’ being discontinuous with ‘health’ and ‘reality’ and which constructs the meaning of ‘symptoms’ in purely biomedical terms) is not to be fully challenged. Hence, under such circumstances, CBT is “surprisingly effective”. All this, plus ‘psychosis’ is constructed so that the phenomena in question are not so ‘normal’ that CBT professionals are rendered redundant, or left open to blame for being deficient as professionals, for contributing to a lack of results in comparison to clients who are more able than typical psychiatric patients.

Symptoms vs syndrome?

How do the authors of our texts account for the use of ‘psychosis’, ‘symptoms’, and/or ‘normalizing’ approaches? The prologue to the manual by Chadwick et al. focuses on validity problems with ‘schizophrenia’ and on the advantages of the symptom model. Several elements are put to use towards uniting the pro ‘schizophrenia’ and the pro ‘single symptoms’ perspectives. First, Sarbin (1990) is cited, highlighting the problem of reifying the metaphor of ‘schizophrenia’. Next, though, the door is left open for ‘schizophrenia’ and/or its ‘symptoms’. There is the difficult to dispute experience of
expert ‘clinicians’, along with the distress and disturbance which ‘symptoms’ surely cause:

Schizophrenia is not a ‘thing’ or object. Much has been written about this epistemological fallacy, as philosophers would call it, i.e. the fallacy of reifying - turning a metaphor into a real ‘thing’ (Sarbin, 1990). Most clinicians can usually agree that schizophrenia is a scientific concept invoked to describe certain symptoms (delusions, voices, thought disorder, etc.). We know that the individual symptoms exist, that they often appear together, and that individuals, their families and friends are frequently very distressed and disturbed - this is not in doubt. What is in doubt is if and how to group or categorise symptoms...

(Chadwick et al., 1996: xvi)

That is, the blow from writers like Sarbin is apparently absorbed, with little impact. In other words, one ought not to treat ‘schizophrenia’ as an object but ‘clinicians’, clients/patients, and families can assert that the “individual symptoms exist” (more or less as things), in practice, at least. That Sarbin (1990) advocates a non-individualistic, contextualist framework to understand and support a troubled person in developing what they find (rather than what CBT professionals implicitly direct) to be a more functional interpersonal and existential self-narrative, in the context of their social environment, is not included in Chadwick et al.’s account (see also Sarbin & Mancuso, 1980; Sarbin, 1997). In contrast, with their focus on ‘symptoms’ Chadwick et al. construct a largely individualistic account of ‘the problem’ and they describe a largely prescriptive ‘therapy’.

In the above extract, there are two bottom line, eyewitness-verified arguments in favour of ‘schizophrenia’/‘symptoms’: (a) clinicians and scientists agree to the existence of ‘schizophrenia’ as a scientific concept, and (b) we clinicians/researchers, clients/patients, their families, and friends say and/or show that ‘symptoms’ exist. In connection to (a), writers such as Boyle (2002a & b), Sarbin (eg, 1990), and almost all
of the many and varied contributors in Bentall (1990c) discount the status of ‘schizophrenia’, some even as a *concept* in the scientific sense of the word. In connection to (b), the experience or witnessing of distress and disturbance is not in question; what is at issue is how we understand and deal with such phenomena, on empirical grounds. A related issue, is that, if ‘schizophrenia’ should be rejected as being baseless and useless (and, in his concluding remarks, Bentall extends this criticism to all discrete diagnostic categories of psychopathology, 1990a: 284) then why does it perpetuate? What sustains ‘schizophrenia’? At best, I suggest that CBT does ‘schizophrenia’ little harm; at worst it contributes to the adaptation and continuation of an, at its core, unchanged biological and categorical approach to controlling the behaviour of people who do not conform to certain social norms.

Furthermore, ‘symptoms’ of what? Boyle (2002b: 245) writes of how the term ‘symptom’ comes from a medical framework, but that, within medicine, the abandonment of, say, the study of a useful and valid concept such as tuberculosis in favour of the study of coughing would hardly be considered progress. Thus, whatever comes from the long overdue abandonment of ‘schizophrenia’, in favour of the study of, say, hearing voices or ‘delusions’, will be more likely to achieve greater coherency and meaning if it is entirely free from medical frames of reference. This need not preclude all of biology, just that which *assumes a predominant* biological pathology, where such proof is not, and can never be, forthcoming.

In accounts of ‘schizophrenia’, and any account of ‘symptoms’ which includes normality-abnormality continua, notions of ‘normality’, ‘abnormality’, and ‘pathology’ overlay and jostle with each other at every turn; at every point on each continua. Thus, in social and psychological frames of reference, ‘normality’ and ‘pathology’ should be considered to be irrelevancies, unless they are issues raised by the patient (the principal
eyewitness to the events in question), and/or they fit into a theoretical framework on some other basis of evidence and utility.

Problems from the overlaying of largely different frames of reference - the psychological onto the medical - are heightened when, as is the case with ‘schizophrenia’ and all ‘mental illness’, there is insubstantial evidence of a primarily biological aetiology. Indeed, in the case of ‘schizophrenia’, there remains a lack of any biological factor which can be said to be a sign in the medical sense. In such ‘psychopathology’, behavioural ‘symptoms’ are stood in place of biological signs and symptoms. Such ‘disorders’ are based on circular reasoning in which the ‘disorder’ and behaviour each appear on both sides of the causality equation: for example, “unwanted behaviors are taken to be symptoms of schizophrenia; [and] schizophrenia is the cause of unwanted behaviors” (Sarbin, 1990). To use Boyle’s phraseology, ‘schizophrenia’ itself is all “smoke and mirrors” (2002a).

Returning to Chadwick and colleagues’ management of such conundrums, they go some way further to smooth over any binary opposition of pro ‘schizophrenia’ versus pro ‘single symptoms’ camps. For example, in agreement with Bentall, Jackson, and Pilgrim’s (1988) arguments for studying ‘psychotic symptoms’ rather than ‘syndromes’:

This recommendation has considerable appeal. On the one hand it satisfies those who reject the idea of syndromes, such as schizophrenia, and prefer to work with what is known. On the other hand it is still a sensible tactic for clinicians who do believe in syndromes and will continue to seek the most helpful way to categorise clinical problems, but who also recognise that the current concept of schizophrenia is flawed (e.g. Costello, 1993). Indeed, understanding individual symptoms is important even if one were to reject all the above criticism and embrace the current concept of schizophrenia.

(1996: xvii)
Such a moderate stance appears diplomatic and fair, yet functional; it ought to please the psychologists and psychiatrists, the scientists, the scientist-practitioners, and/or that vague category of presented-as-benevolent professionals known as “clinicians”. Indeed, this stance articulates how ‘symptom’ approaches need not directly challenge ‘schizophrenia’ and biopsychiatry. In part, this diplomatic coexistence with syndrome-supporting “clinicians” is achieved through describing them with invocations of mental states (“sensible tactic”, “believe”) and with externalizing devices (“recognize”). That is, the actions of these particular “clinicians” are on the one hand described in terms of internal states which are contingent on social events (tactics affected by their beliefs in order to be helpful for others) but on the other hand they objectively “recognise” the conceptual flaws of ‘schizophrenia’ which are really (externally) present. Thus, opposing beliefs and actions, appearances and realities, can be described with little or no criticism.

At the end of the extract, even the advocates of contemporary orthodox ‘schizophrenia’ are embraced. And, for those who might change, the phrase “the current concept of schizophrenia” leaves the door ajar for the ushering in of a new, less problematic, ‘concept of schizophrenia’, for some, if not for the authors. Nevertheless, Chadwick et al., themselves, go on to discuss how fruitful the study of ‘symptoms’ has been for our understanding of the psychology of such matters. ‘Symptom’ accounts are promoted, apparently at no-one’s expense. Here, they certainly are not in full opposition to dominant psychiatry. Elsewhere, on at least one occasion, the term ‘illness’ makes a seemingly unproblematic entrance while Chadwick and colleagues refer to a particular client: “one client’s first episode of illness first began soon after the death of his father”

12 According to Woolgar, “the externalizing device provides for the reading that the phenomenon described has an existence by virtue of actions beyond the realm of human agency” (1988: 75; cited by Potter, 1996: 150).
(1996: 50). It may be that, in practice, especially when describing clinical practice, such terms are even more difficult to avoid.

The CBT manual by Fowler et al. (1995) includes a more explicit blending or overlaying of aspects of biological and psychological frames of reference. For example, hospitalization is overtly taken to be an integral (albeit hopefully avoidable) part of the structure of care in which CBT operates. In addition to this positioning within medicine-led health services, Fowler et al. emphasise the value of CBT in rehabilitation services, which, presumably, are also largely attached to medical services. Instead of focusing exclusively on ‘symptoms’, as do Chadwick et al., considerable column inches are spent describing the use of CBT for enhancing coping skills in relation to relapse and social disability. There is no symptoms vs syndrome debate but rather a do-it-all approach to treating ‘symptoms’ and living with whatever symptoms and disability remains:

All of these people [prior case studies] report distressing and disabling problems associated with psychotic symptoms, despite taking neuroleptic medication. The psychotic symptoms themselves are probably the most immediately striking features, but emotional disturbance, and problems associated with risk of relapse and social disability are also prominent problems. In an attempt to address what are often complex and multidimensional problems, the therapy described in this book focuses on a number of different goals. Psychotic symptoms such as hallucinations and delusions provide important targets for therapy, but other goals may include fostering feelings of control, and promoting hope for the future and self-esteem. Other aims may include working collaboratively with the person to decrease the likelihood of further relapses and hospitalisations, and to prevent and manage social disability. In the following pages we will provide more detailed information about the problems of people with psychosis that constitute targets for cognitive behaviour therapy.

(Fowler et al., 1995: 5)
These references to rehabilitation and living with social disability can be taken as a recognition by Fowler et al. that people do not often change all that much from psychological intervention, not in a lasting way which is beneficial for the person as well as society. The dialogical approach of Leudar and colleagues (see Leudar & Thomas, 2000) may also be taken as a recognition that people do not often change in that way. However, Leudar and colleagues argue that CBT is quite different from co-equal dialogue; something which is borne out in this dissertation. CBT, like psychiatry, tends to lock patients into medically derived frameworks and social power asymmetries. In contrast, dialogue tends to open up the availability and moral accountability of whatever might make sense of experiences in life, in addition to promoting co-equal power relations.

Returning to Fowler et al., on more than one occasion the term ‘schizophrenia’ makes an apparently unproblematic entrance into a case study: “the therapist did not insist that Lawrence accepted [sic] that his problems were symptoms of schizophrenia” (p. 14). The implication, here, is that Lawrence’s experiences were really ‘symptoms of schizophrenia’ but that he did not accept the truth. On another occasion, the account is about a researcher’s proposal about a vulnerability-stress model: “This model provides a convenient summary of several of the factors which are likely to increase susceptibility to schizophrenia...” (p. 19).

In the absence of a symptoms-versus-syndrome debate anywhere in their book, one is left to assume that ‘schizophrenia’ is not highly problematic for Fowler and colleagues. Indeed, the authors lend their own voices to ‘schizophrenia’ on at least one occasion, before changing to ‘psychosis’ in more direct connection to their own multifactorial approach:

We believe it to be unlikely that all the symptoms and signs of schizophrenia could be accounted for in terms of some discrete biomedical syndrome deriving from a single
biological cause. While it is important to take account of possible biological influences on psychotic disorder, consideration should also be given to the psychological and social factors that may be involved...

(Fowler et al., 1995: 18; my emphases)

It is a mystery which “signs of schizophrenia” Fowler and colleagues could possibly have been referring to. And, in keeping with their consideration of ‘psychosis’ rather more than ‘symptoms’ - a ‘psychosis’ which is more or less interchangeable with ‘schizophrenia’: “Psychotic symptoms rarely occur alone; much more often they occur in combination” (p. 7). Indeed, much is made of the complex and multidimensional nature of ‘psychosis’, on many different occasions:

The complexity and severity of the problems which may be presented by people with psychosis present a considerable challenge to therapists. ...[A] striking characteristic of people with psychosis is the diversity of problems presented. These can include almost every possible mix of delusions, hallucinations, perceptual abnormalities and subjective experiences of thought disorder as well as depression and anxiety. Such problems may not be stable but instead are likely to fluctuate over days and weeks, and even across hours of the day.

(Fowler et al., 1995: 72)

This complexity is then employed to justify the claim that CBT specialists alone (notably clinical psychologists), rather than, say, other therapists, nurses, or rehabilitation professionals, are needed for the job:

An important characteristic of our therapeutic approach is that we aim to take full account of what appear to be remarkable individual differences in the experience of psychotic symptoms. The particular strategies used are then carefully selected according to a detailed assessment and cognitive behavioural formulation of the symptoms presented in each case.

(Fowler et al., 1995: 8)
In line with the justification of CBT, following a discussion of problems with skills training approaches - a potential psychological therapy rival to CBT - the severity of ‘psychosis’ is emphasised. It is implied that ‘psychosis’ has a severity which may well benefit from the enhancements provided by the authors’ CBT:

Given the severe nature of psychotic disorders, some problems are to be expected in attempting to use any form of psychological therapy with people with psychosis. Some people may present with cognitive-neuropsychological deficits which may make it difficult for them to understand and tolerate the complex interpersonal context of therapy. Also, given the probable presence of biological pathology, rehabilitative goals may be the most appropriate expectations for many patients. Rather than expecting psychological therapy to induce radical changes, success may often be better judged in terms of minor, but clinically meaningful, changes in adaptation to disability. However, the limited benefits of behaviourally oriented therapies and the apparent ineffectiveness of psychodynamic therapies cannot wholly be explained away by recourse to these general factors. There is clearly room to improve on these treatments.

(Fowler et al., 1995: 24-25)

What we can see here, is an account which is couched in individualist, victim blaming terms: the patient is constructed as not being intentionally difficult, given their “cognitive-neuropsychological deficits” but, nevertheless, the fault lies in them, rather than professionals per se. Professionals should therefore not expect too much improvement in patients, given the “probable presence of biological pathology” (my emphasis). However, this does not mean that psychologically orientated professionals should not be employed in improving talking therapy procedures as much as is possible: “There is clearly room to improve on these treatments”.

In line with their primary emphasis on pathology, it is not until a later chapter (chapter 4) that Fowler and colleagues begin much work on the ‘normalization’ of
patients. In chapter 2, though, there is an instance of ‘normalization’, in an introduction to vulnerability-stress models:

Although our current understanding is still in its infancy, considerable advances have been made towards grasping the complex nature of psychotic disorders. The findings of research carried out over the past three decades have led many scientists to question some of the traditional dogmas about the nature of psychotic disorder (Bentall, Jackson and Pilgrim, 1988; Boyle, 1990). It is now much more widely accepted that psychotic disorders are probably a heterogeneous group of disorders which lie on a continuum with normality (Claridge, 1985; Crow, 1986). Advances in the neurosciences are making considerable progress towards the understanding of possible biological aetiologies of these disorders... while vulnerability-stress models suggest that interaction between biological, psychological and social factors probably underpin the clinical and social outcomes...

(Fowler et al., 1995: 15)

This extract comprises another skilful juggling act. It manages to seemingly take on board critics of ‘schizophrenia’, whilst continuing the complexity theme (with the implication of severity), despite also apparently ‘normalizing’ ‘psychosis’. These matters are all constructed as being a part of the continual progress of psychology and biology, hand-in-hand, and as being well-represented by vulnerability-stress models. I described many of these features earlier, in connection to our psychiatric text, the New Oxford Textbook of Psychiatry.
Room for error?

Mixed continua

Akin to the inverse relationship between ‘normalization’ and ‘schizophrenia’, I shall now consider the pairing together in our texts of ‘normalization’ and what Boyle (2002b) describes as a ‘discourse of deficit’ (p. 312). According to Boyle, this latter discourse appears to be withstanding any erosion of the notion of ‘schizophrenia’. Indeed, in and through the discourse of deficit, ‘schizophrenia’ and/or its ‘symptoms’ are being recast in a somewhat softer mould, as an individual’s perceptual-cognitive deficits, biases, and errors.

Early on in their book, Chadwick et al. distance their approach from one of deficit, per se, and towards a somehow separable position in which ‘delusions’ are continuous with normality:

...the empirical evidence points to a continuity between psychotic and other phenomena, not a discontinuity. For example, research shows that paranoid people show exaggerations of ordinary defences, such as the ‘self-serving bias’ whereby responsibility for failure is attributed externally and success internally (Bentall, 1994). Psychotic phenomena appear in other diagnostic groups, and research shows that the tendency to hallucination and bizarre (delusional) thinking appears to be spread across the population at large (Claridge, 1990). In spite of prodigious research endeavour, there is no convincing evidence for the idea that delusions result from qualitatively different reasoning; some studies indicate a bias towards conceptual thinking (‘top-down’) but others towards stimuli driven thinking (‘bottom-up’), but none offers convincing evidence of a deficit.

(1996: xv)
Immediately following the above extract is an account which indicates how the ‘normality’ of ‘schizophrenia’ justifies the use of cognitive therapy:

Thus we have argued that the insistence that schizophrenia is outside ordinary psychological functioning is unjustified and we think has retarded exploration of the applicability of cognitive theory and therapy.

(Chadwick et al., 1996: xvi)

In this section and the next, we shall soon see whether Chadwick and colleagues manage to keep their approach completely free from psychopathology; from the ‘impurity’, as it were, of ‘abnormality’ and disease. In this regard, we may consider the central model of Chadwick et al.’s cognitive therapy approach; what is known as an ABC model. Here, activating events are said to trigger beliefs about those events, which then have emotional and behavioural consequences. The model’s application to ‘delusions’ and hearing voices reflects the ‘normality’ of such ‘symptoms’ since it is the same model as that which is applied to ‘depression’, ‘anxiety’, and even “everyday life”:

Out of the events and facts of everyday life each one of us builds over time a unique picture of the world, our selves and our interpersonal relationships. We make judgements about these interpretations and depending upon those judgements, we react with positive and negative emotions and in ways to defend or enhance ourselves interpersonally. However, our understanding can be distorted and our evaluations extreme and negative, and we experience emotional and behavioural problems. ...In this chapter we have introduced this general framework for thinking about ordinary behaviour and shown how it applies very well to delusions and voices, experiences thought to be outside the realm of such analyses.

(Chadwick et al., 1996: 23-24; my emphases)
Notice the use of ‘us’, ‘our’, and ‘we’, denoting the applicability of the model to all people; to all cognitions, emotions, and behaviours. The following extract, more or less, continues with this position:

The reader may raise an important question about using cognitive psychotherapy... Surely it is not appropriate to use ‘ordinary’ cognitive psychotherapy - developed for and practiced with a wide range of ‘ordinary’ problems, such as anxiety disorders, depression, or anger problems - with clients who are so different, who have such extreme experiences as hallucinations, delusions, and paranoia? This assumption undoubtedly has contributed to the delay we have lamented in introducing this form of therapy to psychosis sufferers. But as we argue in Chapter 1, there is no evidence for such an assumption, psychosis sufferers are not discontinuous from sufferers of any other mental health problems. They experience the same emotional and behavioural problems as other people and we suggest for this very reason ordinary cognitive therapy is indeed relevant and effective for this group.

(Chadwick et al., 1996: 37)

However, in this second extract, note the use of the term “psychosis sufferers”, which invokes a degree of severity and urgency of need, in balance with the otherwise presented ‘normality’. Note also that “psychosis sufferers” are likened to “sufferers of any other mental health problems” and not to ‘normal’ people, which would have been even more contrasting and challenging to the hypothetical reader’s question with which the extract began.

Nevertheless, the above two extracts appear to contain ‘pure’ ‘normality’ continua, without the underlay of pathology. For example, the term ‘symptoms’, which is a medically derived term, denoting disease, is notably absent. When we look more closely, though, given that a continuum represents gradations of difference, even an underlying reliance on the apparently simple and ‘normal’ metaphor, ‘continuum with normality’, is problematic. There is an implication that we are talking about something
which is not fully ‘normal’ (ie, ‘abnormal’), at one end of the continuum. Perhaps this is merely conceptual looseness on the part of how such matters are described; a mere curiosity of the interplay between ‘normal’ psychology, ‘abnormal’ psychology, psychiatry, and medicine. However, the term ‘abnormal’ is generally able to accommodate both a quantitative deviance from the ‘norm’ and a qualitative distinction between ‘normality’ and ‘abnormality’. The terms ‘condition’ and ‘clinical’ can also contribute to this feat. Where would the call for health and allied-health professionals be with problems which are always entirely ordinary, after all?

The ongoing ramifications of such representational practices may be extremely important. For example, the constructed ‘normality’ or ‘abnormality’ of a voice-hearer is likely to influence how they are otherwise treated in society, and in therapy, if they are considered to need it. It may be possible to identify the same person as a company manager, a client who chooses to undergo therapy, or a dangerous psychiatric patient for whom there is an imperative to treat. I suggest that the category in which a person is constructed, as determined by an amalgam of representational practices (rather than the use a single label such as ‘patient’ or ‘client’), systematically increases the likelihood of a variety of actions being done by and to the person in question.

Recalling the conclusions which I drew in Chapter 1, concerning continua (conclusions which also rely on a somewhat individualist approach), there are only two coherent alternative views with regards to ‘normality’ and ‘mental illness/health’: to either say that we are all ‘abnormal’ (ie, containing psychopathology) or all ‘normal’ (ie, with no psychopathology). Indeed, ‘normality’ immediately becomes an invalid comparison, a non-issue (except for those interested in statistics or morality). Various continua can then be constructed for whatever empirical properties are of interest, but we are all, more or less, in the same boat. Perhaps the all-normal option should be chosen, because it has the most positive spin. Alternatively, perhaps the all-abnormal
option more readily supports moves towards medication for everyday life. How are we to choose?

In their final chapter, Chadwick et al. topicalize continuity and its relationship to ‘symptoms’:

A key feature of our work on these symptoms has been an assumption of continuity between psychotic and nonpsychotic phenomena... Once the delusion concept was unshackled from the hypothesised syndrome, it became far easier to consider how delusions were like other beliefs... One of the main achievements of the cognitive approach to symptoms has been to reveal how the assumption of discontinuity between ordinary experience and psychotic experience was imaginary - there is considerable commonality between delusions and strongly held beliefs, and what differences exist are often subtle and represent variation on common themes.

(1996: 176; original emphasis)

One is left wondering how such ‘symptoms’ can otherwise be presented as being so ‘severe’. And, if there is “unshackled” continuity between this ‘normality’ and ‘abnormality’, then what are the ‘symptoms’ of non-psychotic phenomena? Is this quasi continuum any less “imaginary”, any more coherent than the “hypothesized syndrome” of ‘schizophrenia’?

The very next paragraph bears strongly on these issues:

To this extent our cognitive approach may be described as seeking to normalise an individual’s experience. However, it is important to be clear about what is being normalised. We take the view that in cognitive therapy for delusions and voices the important task is to normalise psychological processes, but we are cautious of advocating this for content too. So we would empathise with a client who believed people could read his mind and were plotting to kill him, and convey how these beliefs render his fear and avoidance understandable. ...But we would stop short of saying that perhaps people can read a client’s mind and perhaps there is a plot to kill him because
to do this would be to confuse the issue of what requires explanation. Is it how an individual comes to believe, in a distorted way, that the world is threatening, hostile and unsafe, or why other people should come to be reading his mind and planning to kill him?

(Chadwick et al., 1996: 176; original emphasis)

Thus, with a distinction between process and content, people with ‘delusions’ are rendered as being the same yet different by degree; ‘normal’ yet somehow ‘abnormal’ and requiring ‘normalization’. How can the presented-as-out-of-touch description of the content of ‘delusions’, here, do anything other than suggest a qualitative difference between those ‘deluded’ people and ‘we’, the readers? It is implied that the authors/therapists, their readers, and presumably everyone else, besides the ‘delusional’ person and other similar ‘delusional’ people, are able to consistently see the patent difference between the assumed objective reality of people not being able to mind-read and the “distorted” belief that people can. That this flies in the face of the bizarreness of many a ‘normal’ person’s beliefs is left unsaid. Thus, on the one hand, ‘normalization’ renders ‘delusional’ people as ‘normal’ enough for a surface level of social acceptability and ‘normal’ enough for therapy. Yet, on the other hand, the content of their beliefs are also presented as so obviously ‘abnormal’, despite their argued for potential for complete understandability.

It is a pity that, here, psychologists are arguing that ‘delusional’ thought processes are ‘normal’ but that ‘delusional’ content is in opposition to reality (and in that sense, ‘abnormal’, compared to those of us who know the ‘truth’). This is akin, to orthodox psychiatry’s practice of ignoring the content of ‘delusions’ because it is considered irrelevant and incomprehensible; a practice which psychology is supposed to have rectified with its construction of all people as, more or less, rational. Here, rationality is only extended so far, depending on the need at hand. Unless of course one holds with
the contradiction that rationality is present, regardless of whether a person is in or out of touch with reality.

And if a cognitive therapist were able to assist a ‘deluded’ person to see the ‘error of their ways’ with regards to all of their ‘delusions’ (however ‘abnormal’) would they then be cured of their ‘condition’? Does it simply take a change of opinion? Or will there always remain a difference, a matter of ‘abnormality’ by degree, fudged with some inherent and elusive ‘illness’, which, it is assumed, people just cannot quite be talked out of?

Fowler and colleagues also include a number of explicit or implicit references to mixed continua. An extract which we saw earlier contained a tentative reference to a continuum at its apparently most simple:

It is now much more widely accepted that psychotic disorders are probably a heterogeneous group of disorders which lie on a continuum with normality (Claridge, 1985; Crow, 1986).

(Fowler et al., 1995: 15)

This extract comes from the authors’ introduction to vulnerability-stress models. It is immediately followed by a brief review of advances in biological studies. The extract manages the delicate business of posing a polite challenge to psychiatric orthodoxy, without undermining advances in the neurosciences. The basic layout of the supposed continuum is clarified, as a normality-abnormality continuum, here: “…it may be more valid to view normal experience and psychosis as existing at two ends of a continuum” (Fowler et al., 1995: 39). Further ‘normalizing’ detail is, however, then provided. For example: “…it may be more useful to think of frank psychosis as a more severe manifestation of some of the anomalies in thought and experience that may affect normal people at some time or another” (p. 39).
The established view which is being challenged, above, was earlier constructed by Fowler et al. as: “Traditionally, it has been assumed that psychotic symptoms are unique signs of biological pathology which are discontinuous with normal experience and therefore by definition bizarre and abnormal” (p. 38; my emphases). Notwithstanding the potentially misleading description of ‘symptoms’ as also being ‘signs’, it is worth noting that the extract is suggestive that a unitary disease model is being opposed (one with “unique signs”). Thus, multifactorial disease and psychobiological models of ‘symptoms’ are left largely unchallenged. It is notable also that the outdated single disease model is presented as being one of “abnormality”, in contrast to a continuity model. Thus, on the surface, the normality-abnormality continuum which is upheld appears to contain no ‘abnormality’ at all.

The coupling of ‘normalization’ and ‘deficit’ is an inherent part of normality-abnormality continua. Nevertheless, the ‘deficiencies of psychosis’ are described as entailing more of a quantitative difference than a qualitative difference, compared to ‘normality’. Thus, to describe ‘psychosis’ as being due to cognitive and/or perceptual errors or deficits, rather than a disease, implies a ‘normalizing’ continuity rather than discontinuity with ‘normality’. We all make errors after all. But is it a ‘good thing’ to ‘normalize’ ‘psychosis’ and its variants when such ‘concepts’ are so clearly problematic? Should we promote the acceptance of an invalid concept, a ‘concept’ which fuels the social power to coerce or co-opt people who do not ‘fit in’?

And this ‘normalization’, of course, only goes so far. Otherwise, the social control constructed, in part, from justifications about the need for treatment and protection for self and others - would be lost. The cognitive and/or perceptual errors of ‘psychosis’ are generally represented on what are more or less mixed normality-abnormality continua. These apparently comprise not only a quantitative difference but also a qualitative distinction between the ‘normal’ and the ‘abnormal’, the ‘well’ and the ‘diseased’. To
put it another way, quantitative and qualitative differences (a purely ‘normal’ psychology and a purely ‘abnormal’ psychology, respectively) are somehow supposed to occupy the same space in the spatial metaphor which underlies much or all of modern ‘psychosis’ and its variants. It is incoherent, by definition, for the ‘concepts’ of ‘psychosis’ and ‘symptoms’ (with their inherent ‘abnormality’) to occupy even a metaphorical continuity with the ‘concept’ of ‘normality’. These incoherencies are patently nonsensical when one considers that such different ‘concepts’ are reified as objects which are said to occupy the same place on the same, yet somehow mixed, continuum.

‘Delusions’ about voices

In our CBT manuals, voices are constructed in terms of their supposed relationship with ‘delusions’. A fair bit of persuasion is done in this regard. For example:

The case for viewing voices from a cognitive ABC perspective may appear less obvious than that for delusions - after all, delusions are beliefs, the cornerstone of the ABC framework. Our progress in developing a cognitive model of voices began with the insight that voices are not thoughts (Bs), they are activating events (As). This simple observation was the clue to our cognitive formulation of voices (Chadwick & Birchwood, 1994): a voice is seen as an activating event (A) to which the individual gives a meaning (B) and experiences associated emotional and behavioural reactions (C). This manoeuvre has a profound impact upon the psychological understanding and treatment of voices because it make clear that distress and coping behaviour are consequences not of the hallucination itself, but of the individual’s beliefs about that hallucination.

(Chadwick et al., 1996: 19)

Thus, the linking of voices to ‘delusions’ via beliefs is portrayed as “progress” (and not the retrograde step that it might be considered by many people involved in the Hearing
Voices Network; see Chapter 4 of this dissertation). Voices are described as “hallucination[s]” and the ground is laid for cognitive therapy to remedy the ‘error’.

Chadwick and colleagues identify several areas of beliefs which they consider to be of particular importance: beliefs about the voice’s identity, purpose (is it trying to harm me?), power, and what will happen if it is obeyed or not obeyed. As with ‘delusions’, the content of voices now becomes relevant to clinicians; an important difference from orthodox psychiatry: “We have found the meaning individuals attach to their voices renders their coping behaviour and affect understandable; when beliefs are not taken into account, many responses seem perplexing or incongruous” (p. 23). What could be wrong with that? Chadwick et al. even write of voices believed to be “benevolent” in addition to those believed to be “malevolent” (p. 19). And they describe how “an inventive study by Romme and Escher (1989) has revealed how voices frequently do not evoke a sufficiently strong reaction to bring the individual to the attention of services, even when the content is extremely serious” (p. 20). With all this talk about ‘beliefs’, it may seem that I am jumping to conclusions about ‘delusions’ and the ‘pathology’ which such constructions entail. However, the evidence mounts.

First, benevolent voices are not presented as entirely positive:

*Losing confidence.*

‘Benevolent’ voices evoke a positive affect which is not itself problematic; few benevolent hallucinators present to services (Romme & Escher, 1994). However, disempowerment, dependence and loss of confidence are common to this group. In our series [of studies] there have been many who hold secret fears about the impact of their engagement and involvement with their voices.

(Chadwick et al., 1996: 94; original title)

Notice the inverted commas which problematize all benevolent voices, despite the citation of Romme and Escher who do nothing of the sort. Notice also how, as far as
this account goes, the problem appears to be located in the individual and not, say, in society’s reaction to people who report hearing voices. Similarly: “we find that voices believed to be benevolent most commonly function by masking negative self-evaluation - for example, advising a woman on how to care for her family, so hiding her own sense inadequacy” (Chadwick et al., 1996: 122; my emphasis). Here, the phrase “believed to be” serves to undermine the voice hearer’s understanding of their ‘own’ experiences. The alternative ‘belief’ (that benevolent voices ‘mask negative self-evaluation’) is not offered as a candidate version of possible truths but as the truth about what is really happening (ie, the professional knows better). According to this view then, these particular voice hearers are ‘deluded’. Chadwick and colleagues also include more than a chapter on the subject of conducting a detailed ‘cognitive assessment’ for voices therapy, for which they have also produced a questionnaire (see Appendix 2 of the manual). This is a far cry from the positive reception which Socrates’ reported daemon received from others for much of his life.13

Now we get to the crunch about voices and their relationship with ‘delusions’:

[There are] aspects of cognitive intervention that are unique to working with voices and do not occur in work with all types of delusions. The peculiarities relate to: the fact there are always multiple delusions, which should be tackled in a specific sequence; the process of engaging clients in disputing and testing; the use of hypothetical contradiction and disputing; to methods of empirical testing.

(Chadwick et al., 1996: 115; my emphases)

13 Like Leudar and Thomas (2000: 14 ff.), I depart from Socrates’ view of his voice originating from a celestial being. Nevertheless, I am not attempting to dispute Socrates’ view in a therapy session with him, as a CBT professional would be encouraged to do by Chadwick et al.’s manual. I am not fully adopting Socrates’ view of his daemon, but, unlike CBT, I am not trying to ‘change his mind’, from a position of greater social power.
In this account, in relation to cognitive intervention, it is assumed that all voice hearers are deluded. Indeed, one of the additional “peculiarities” of hearing voices, besides being considered ‘delusional’, is that there are “always multiple delusions”. Furthermore, these are problems which “should be tackled”: there is an imperative for intervention, for procedures which are presented as actively “engaging clients” in “disputing”, “contradiction”, and “testing” their ‘delusions’. In medical psychiatry, the treatment of ‘symptoms’ requires that a remedy be administered to a patient. In our above CBT account, however, the matter of whether the disputation is between the patient and their ‘delusions’ or between professional and patient is not directly addressed. The following description of ‘symptoms’ and their ‘remedy’ is also notably vague in this regard, despite the prominent use of the notion of a ‘symptom’:

**Symptoms**

For practical reasons the book has addressed separately three symptoms: delusions, paranoia, and voices. In fact from a psychological perspective the three are not independent and our approach to all three has focused on weakening delusions as a means to ease distress and disturbance.

(Chadwick et al., 1996: 175-176; original title)

Thus, at least amongst those clients seen by Chadwick and colleagues (and, I argue, those likely to be seen by other CBT practitioners), all voice hearers are considered to be ‘delusional’ and it is the ‘delusions’ about voices which are seen as the ‘symptom’ which can be specifically dealt with through the performing of cognitive therapy on (or with) voice hearers.

Curiously though, in line with ‘normalization’ but without entirely departing from orthodox psychiatry, these beliefs about voices are seen paradoxically as ‘reasonable’, given the experience of hearing voices, and ‘delusional’:
We view beliefs about voices as *reasonable attempts* to make sense of what is a puzzling and emotionally provocative experience. Beliefs about voices are formally speaking either partial or full delusions. When working with voices a therapist is always interested in multiple delusions.

(Chadwick et al., 1996: 116; my emphases)

The assumption is that all pre-intervention beliefs about voices are problematic “partial or full delusions”. Fowler et al. are no less presumptive in their chapter which is tellingly entitled “Techniques to address delusions and beliefs about voices”. Here is an extract from their section on “Working within delusions”:

As we have already noted, many cognitive strategies do not require delusional beliefs to be fully rejected. Instead, the person’s relationship with their voices or their beliefs may be accepted, but attempts may be made to work within the delusional belief system to reduce distress.

(Fowler et al., 1995: 133-134)

It is a relief to know that some professionals are prepared to get personal and “work within the delusional belief system”, even if it is only an *attempt*. Of course, it is only a “person’s relationship with their voices” - not the voices’ content and not the voice hearer’s other points of view - which are actually accepted by the therapist. But at least *only some* of a person’s beliefs need to be “rejected” for the purposes of “cognitive strategies”. Thus, cognitive therapy appears to be quite forgiving of a person’s madness. It has to balance maintaining its relations with patients and psychiatry, after all.
The biological box

Illness vs disease?

Explicit references to biology and pathology are notably absent in the CBT manual by Chadwick et al. Their manual is, however, largely based on a symptom model. This is something which the book’s frequent ‘normalization’ and their final chapter, “From a symptom model to a person model”, shows to be accountable. Chadwick and colleagues describe their book as already having begun to progress from a symptom model and its origins in ‘illness’. We will consider that a little later.

As for the other manual, in their chapter entitled “Vulnerability-stress models of psychotic illness”, Fowler et al. draw a distinction between ‘illness’ and ‘disease’:

The use of the term ‘illness’ in Western societies implies an attempt to understand the life predicaments of people with psychological and physical disorders in a way which, first, explicitly acknowledges suffering and implies the need for provision of help, and second, infers the presence of a particular pattern of biological, psychological and social factors in the development and maintenance of the disorder.


Notice how “psychological” comes before “physical” in this account. This is as one would expect from authors who are psychologists. However, despite Fowler and colleagues’ claim of “Western societies” as their point of reference, the definition of ‘illness’ as an “attempt to understand the life predicaments of people” occludes rather more widespread definitions of ‘illness’ and ‘disease’. For example, the Concise Oxford Dictionary defines ‘illness’ as “a disease, ailment, or malady” and “the state of being ill”. Thus, ‘illness’ is much like ‘disease’. Similarly, the Concise Oxford defines ‘disease’ as “an unhealthy condition of the body (or a part of it) or the mind; illness, sickness”, “a corresponding physical condition of plants”, and “a particular kind of
disease with special symptoms or location”. And, notably in relation to ‘normalization’, ‘diseased’ is defined as “affected with disease” and “abnormal, disordered”. There is nothing of “life predicaments” or the “psychological” in any of those dictionary definitions.

It may be fair to say, as Fowler et al. claim, that ‘illness’ conjures up a rather larger picture than ‘disease’. However, both terms generally trade on being either analogous to or more directly rooted in physical pathology, even if it is a ‘mental illness’ which is being described. Partial confirmation of this comes from the Concise Oxford’s definition of ‘mental illness’: “a condition which causes serious abnormality or disorder in a person’s behaviour or thinking capacity, esp. irrespective of intelligence; a disorder of the mind”. Note that this definition includes “serious abnormality” and “disorder”, even though there is no actual mention of physical pathology. Fuller confirmation comes from the MEDLINEplus Merriam-Webster online medical dictionary definition of ‘mental disease’: “a mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual - called also mental illness”. It is also worth pointing out, here, that ‘condition’ performs much the same duty of vagueness and association with physical pathology as ‘disorder’.14 Tellingly, the MEDLINEplus Merriam-Webster does not have a separate entry for ‘mental illness’; it is included along with ‘mental disease’.

14 The Concise Oxford Dictionary defines ‘disorder’ as “a lack of order; confusion” and “Med. a usually minor ailment or disease” (my emphasis). The same dictionary’s pertinent meanings for ‘condition’ are “the state of being or fitness of a person or thing (arrived in bad condition; not in a condition to be used)” and “an ailment or abnormality (a heart condition)” (my emphases). That is, both of these terms are directly related to physical pathology in their general meanings, and not to anything psychological.
The use of such medically orientated language lends psychiatry the scientific and professional status of medicine and the biological sciences (see Boyle, 2002a). It also allows for the future expansion of such associations as biological science progresses. Moreover, it serves to actively exclude the people in question from ‘normality’, despite any official statements to the contrary. And, as Fowler and colleagues go on to point out in continuation from the above extract, patients may receive benefits from ‘illness’ being applied to them, by themselves and others:

The use of this term [illness] has a clear relevance for understanding the predicaments of people with psychosis in a way that is both sensible and therapeutic (see Sedgewick, 1982) for a detailed and enlightening argument). It should be recognised that the use of illness concepts can sometimes have disadvantages; for example, they can be abused and lead to marginalisation, stigma, and disenfranchisement (see Szasz, 1961; 1993; Goffman, 1961). However, the explicit use of illness concepts can also have many benefits. Illness concepts can help to provide an orienting framework for approaches to the understanding of an individual’s predicament that are both empathic and therapeutic (Sedgewick, 1982; Leff, 1993).

(1995: 18; my emphasis)

This account includes criticism of ‘mental illness’ by hard-hitting authors such as Szasz. However, its inclusion also undermines potential blame of Fowler et al., demonstrating that they themselves are aware of the pitfalls. Similarly, the description that illness concepts “can be abused” and that illness concepts can “lead to marginalisation, stigma, and disenfranchisement” can be, on the one hand, lauded for not pulling any punches. However, on the other hand, though this is somewhat akin to an extreme case formulation (Pomerantz, 1986; cited by Potter & Wetherell, 1987: 47, and Hutchby &
Wooffitt, 1998: 209)\textsuperscript{15} it is constructed as being non-literal; the kind of extreme which is an unusual, possible occurrence, which can surely be avoided with diligence. In this account, it is “illness concepts” which can be abused. Actual patients are not described until the positive description of “understanding an individual’s predicament”. The fact that the disadvantages of ‘illness’ are sandwiched between descriptions of the benefits also absorbs the criticism and implies that the disadvantages are under control. Furthermore, in the above account, ‘illness’ is constructed as merely a “concept”, whereas in the rest of Fowler et al.’s book it is typically presented as being far more intrinsically real.

Indeed, Fowler and colleagues present the “[a]cceptance of psychotic illness” (p. 27) as the adaptive thing to do when “[c]oping with psychotic illness” (p. 26); a subsection title and chapter title, respectively. That is, after subsections entitled “Denial and lack of awareness of psychosis” and “Resignation or engulfment into the social role of a chronic mental patient”, the moderate acceptance account begins:

**Acceptance of Psychotic Illness**

Other people with psychosis may find a middle road, which to most professionals appears to be associated with the best outcome. This pattern of reaction may involve an ability to adopt a sick role when necessary. This may involve making adjustments to lifestyle and behaviour, taking medication, using the services of health professionals, while otherwise seeking to maximise independence and maintain a personal identity separate from that of a person with chronic mental illness. Autobiographical and

\textsuperscript{15} My thanks go to Derek Edwards (2004) who noted in a personal communication that “[t]he example of an ‘extreme case formulation’ does not fit how Pomerantz defined it. The clearest examples are superlative adjectives (‘best’, ‘worst’) or other logically-semantically extreme expressions (‘as good as it gets’, ‘brand new’, ‘always’, ‘never’, etc.), rather than just the impression of saying something strong”, as in my example here. See also Edwards (2000) on extreme case formulations for irony.
anecdotal accounts suggest that this last strategic approach to adaptation to psychotic illness is often only achieved after a long and bitter struggle with a range of problems which may be associated with psychotic symptoms, the social adversity associated with chronic illness, and the Health Service system (Wing, 1975; 1987).

(Fowler et al., 1995: 27; original title)

It is convenient that what “appears to be the best outcome” to professionals involves being an ideal, middle of the road patient; not so independent as to be belligerent but not so dependent as to be a burden. Notice also that being saddled with Fowler et al’s label, an “Acceptance of Psychotic Illness” role, is not included in the “range of problems” described above. Instead, adopting a “sick role” is positively evaluated, so long as it is deemed to occur “when necessary”, according to the professionals. Notice also that the frequent use of “may” in this account, along with the phrase “autobiographical and anecdotal accounts” rather than more authoritative forms of evidence, manages the fact that this is very uncertain ground whilst also holding to a firm position on the way these matters really are. The use of the term ‘acceptance’ in the title, in connection to ‘psychotic illness’ renders ‘illness’ as fact. That is, this account constructs the patient as needing to finally accept the truth, that they are mentally ill. According to Fowler and colleagues, this “long and bitter struggle” - with the “symptoms”, the “social adversity”, the “Health service system” and, by implication, with accepting that one is mentally ill - is not an easy one. Nor is it a forgone conclusion that patients settle into one or other of the three ‘types of psychological reaction’:

It is important to note that the patterns of reaction described above are only illustrations. In reality the pattern of reaction is often more confused. Within an individual there can often be any combination of the above... often cycling between denial, acceptance and resignation.

(Fowler et al., 1995: 28)
Overall, however, compared to what are described as denial, lack of awareness, or resignation, “acceptance” is presented as the most rational thing to do. This is despite the above confession of things not being nearly so simple in practice and despite ‘acceptance’ being described earlier as a “strategic approach” rather than an unavoidable realization. The “pattern of reaction” being described as “confused” suggests that it is the patient who is confused. Coupled with the evaluations from the earlier contiguous extract, it is still presented as best that the patient reaches a less “confused”, more “stable” (p. 28), and final “adaptation to psychotic illness” (p. 27). It appears that what we have here is Fowler et al. considering patients to be only fully (ie, truly) rational on the occasions when they accept the dominant professional view of ‘mental illness’. Thus, the goal posts of orthodox psychiatric insight into one’s ‘illness’ have been moved but not removed.

Medication

In Fowler and colleagues’ CBT manual, the authors make a special point that ‘symptoms’ may be ‘drug-resistant’, in some patients. For example, the first section of Fowler et al.’s first chapter is taken up with case studies of people who are described as follows: “All of these people report distressing and disabling problems associated with psychotic symptoms, despite taking neuroleptic medication” (Fowler et al., 1995: 5). The second section of this chapter is entitled “Drug-resistant psychotic symptomatology”. The section begins with a review of studies which suggest that “a conservative estimate of prevalence is that somewhere between a quarter and a half of people who at some time have received a diagnosis of schizophrenia may still have problems with continuing psychotic experiences and beliefs despite the prescription of neuroleptic medication” (p. 6). We may, of course, wonder how these drugs can still be considered to have a specific anti-psychotic action, given their poor success rate, their
sedative effect, and the type and degree of their side-effects. Would a 50% effective antibiotic be allowed onto the market? However, Fowler and colleagues’ discussion of drug-resistance sets the scene and need for CBT for ‘psychotic symptoms’ as described in the rest of the manual. Here, CBT co-exists with medical management. But it is not an equal existence. It is a place where medical treatments such as prescribed drugs are the a priori treatment of choice for ‘psychosis’ and where CBT has a foothold somewhere perhaps about halfway up the monument of psychiatry: “It is increasingly recognised that a range of cognitive behavioural strategies may offer a very useful adjunct to medication in helping patients to manage their experiences” (Fowler et al., 1995: 8; my emphasis).

It is worth looking at this term ‘adjunct’ rather more closely (see also Boyle, 2002a). The Concise Oxford Dictionary defines it as “a subordinate or incidental thing” and “an assistant; a subordinate person, esp. one with temporary appointment only” (my emphases). The MEDLINEplus Merriam-Webster online medical dictionary is in accordance with the latter meaning: “a person associated with or assisting another in some duty or service”. The Dillons Modern English Dictionary adds yet another aspect to ‘adjunct’: “something that is incidental or not essential that is added to something else” (my emphasis). So we have, “subordinate”, “incidental”, “assistant”, “temporary”, and “added”. Being an adjunct hardly seems like something to aspire to or self-proclaim. Yet this is exactly where Fowler et al. and, to a lesser but still significant extent, Chadwick et al., position CBT. This is an adjunctive niche for a talking therapy in a psychiatric service, using language which is well-known in medicine.

It is clear that in these CBT manuals the service being assisted and/or added to is primarily one of medical management. The modern psychiatric approach to dealing with voices, ‘delusions’, and the so-called ‘negative’ and ‘disorganized symptoms’ of ‘schizophrenia’ is principally through pharmaceutical treatments, with adjunctive
psychosocial interventions as part of an overall medical management package. Orthodox psychiatry typically ignores the content of voices, and encourages its patients to do the same. CBT appears to challenge this aspect of orthodox psychiatry alone, and it does so from the delicate position of being a tacked-on addition to a medically-inspired service.

One of the most prominent duties of CBT, besides helping the patient in the use of psychological strategies, is therefore to assist in keeping the patient within the mental health system. In their chapter on “Strategies to address social disability and risk of relapse”, Fowler et al. have a section on “Providing information about what action can be taken to manage illness and clarifying general goals for the individual” (Fowler et al., 1995: 151). The section begins with a reliance on the long term implication of ‘psychosis’ in terms of the medical model: “The therapist attempts to draw implications from the model of psychotic illness relating to specific tasks for the individual in managing disability” (my emphases). Next up, CBT is mentioned, initially adding something different to, but then easing the application of, the medical model: “Clarification about such issues may involve returning to discussion about which cognitive behaviour strategies may be useful in fighting specific symptoms as they emerge. Other general issues such as the dangers of sinking into passive engulfment by a sick role may also be discussed”. And this provision of information account soon opens into a two-item list on the management of psychotic disorder, a list in which the item on pharmaceutical treatment comes before the item on psychological treatment:

Topics which are useful to highlight include:

(1) The importance of using medication as a way of coping with symptoms.

Where the effects of medication are discussed, it is often more useful to relate such effects to benefits in terms of the experience of specific symptoms (eg thought disorder, hallucinations, paranoid thinking) rather than to the presence of schizophrenia, which
patients may not accept. It can be useful to identify how medication can be used as a coping strategy to help the person manage specific psychotic symptoms.

(2) The importance of strategic rather than passive avoidance.

Many clients have learnt that social avoidance can be a useful coping response. However, few have discovered how to use it strategically...

(Fowler et al., 1995: 151 original titles)

Arguably more in keeping with a solely psychological approach, and in contrast with Fowler and colleagues, it is notable that Chadwick et al. do not topicalize medication. I will return to this presently.

Vulnerability-stress models and CBT

These models are yet another part of the extensive biological package which can co-exist, more or less, with normality-abnormality continua. That is, vulnerability-stress models are another, related way of representing ‘schizophrenia’ and ‘psychosis’. Boyle points out that vulnerability-stress models serve to contextualize ‘symptoms’ in terms of biology, psychology, and the environment (2002b: 296-297). This renders ‘symptoms’ such as hearing voices as ‘understandable’, side-stepping the dilemma that psychologically and socially ‘understandable’ phenomena such as hearing voices cannot sensibly be symptoms if adhering purely to an orthodox medical model. That is, through vulnerability-stress models, medical notions can nonsensically be interspersed with psychological and social notions. We saw direct references to vulnerability-stress models in the New Oxford Textbook of Psychiatry, and they are an important ingredient in both of our CBT manuals.

Let us begin with a tentative and unnamed formulation of what might be considered a vulnerability-stress model which arises in Chadwick et al.’s first chapter:
...we have argued that it is the personal meaning events have for people which determines if they are distressed and disturbed, and we have examined some of the different cognitions involved...

But why is it that certain people have a generalized tendency towards, for example, negative self-evaluation? This is a very big question and a full answer is unavailable. It is likely that babies are genetically endowed with vulnerabilities towards anxiety, paranoia, depression, etc., and that their experience serves to maintain, enhance or diminish these individual propensities (Gilbert, 1992 [sic]). For the present purpose, one important conclusion may be offered - *early relationships have a profound impact and for the majority of patients it is here that the origin of their problems lies.*

(Chadwick et al., 1996: 9; original emphasis)

Thus, “genetic endowment” and “early relationships” produce ‘vulnerabilities’, which are linked with distressing and disturbing events (ie, stresses), which produce ‘disorder’. However, the gaps in current cognitive theory are shown to be an accountable issue for Chadwick et al. With their “But why...?” question and their stated-as-not-yet-adequate answer (introduced as “a full answer is unavailable”), Chadwick and colleagues pre-empt criticism of their explanatory and therapeutic model. This may serve to take some of the sting out of relatively obvious potential criticism by presenting the criticism as already known to them. They do, however, conclude with a statement which leans towards a psychological perspective on events (see italics). Presently, I shall argue that, although the text in italics concerns social relationships, such accounts are, in practice and upshot, relentlessly individualistic.

A similarly oblique allusion to a vulnerability-stress model comes later in Chadwick et al.’s book:

Voices are known to be common following sexual abuse, bereavement and other forms of emotional trauma, and occur in several diagnostic groups (e.g. schizophrenia, manic depression, psychotic depression). We find it helpful to think of them as a response to
extreme psychological threat. This view is not original, nor does it rule out the influence of biological factors because we have no explanation for why only certain people who experience these threats and traumas experience voices.

In therapy we work with individuals to try to make psychological sense of what their voices might mean. In particular, we seek to understand the individual’s psychological vulnerability, in terms of fears about loss...

(Chadwick et al., 1996: 122; my emphasis)

Once again, biology is brought in to fill the gaps of psychological theory. Once again, this fact is ‘confessed’. This time, however, the impact of potential criticism is also reduced with a personalized, experienced, and clinically pragmatic “we”. This “we” develops into an ‘it’s therapeutic business as usual’ approach to the theoretical issues (an applied vs theory distinction). Thus, any theoretical gaps become more or less academic.

As far as I am aware, vulnerability-stress models do not appear as a named topic in Chadwick and colleagues’ manual. Fowler et al, however, explicitly describe vulnerability-stress models. For example, there is the chapter title, “Vulnerability-stress models of psychotic illness and their clinical implications”. Notice the coexistence of the “models” with “psychotic illness” and “clinical implications”.

The following extract gives another indication of the importance of vulnerability-stress models:

Although our current understanding is still in its infancy, considerable advances have been made towards grasping the complex nature of psychotic disorders. ...Advances in the neurosciences are making considerable progress towards the understanding of possible biological aetiologies of these disorders (Frith, 1992; Hoffman and McGlashan, 1993[α]; Kortla and Weinberger, 1994), while vulnerability-stress models suggest that interaction between biological, psychological and social factors probably
underpin the clinical and social outcomes (Zubin and Spring, 1977; Strauss and Carpenter, 1981; Nuechterlein, 1987; Ciompi, 1988).

(Fowler et al., 1995: 15)

Vulnerability-stress models gain credence by being placed with “[a]dvances in the neurosciences”, despite the various models’ vagueness (Potter, 1996: 118) in relating to available evidence concerning what vulnerabilities and stresses are involved and how they interact to produce ‘psychosis’. The models then serve as a link between such “advances” and “clinical and social outcomes”. Notice also the large number of references for both neuroscientific studies and vulnerability-stress models; an indication of their importance in bolstering the CBT in this manual.

Given the implicitness of the active, rhetorical work to which such models are put, it is ironic that the turn of phrase used in the extract’s final sentence goes a little way towards attributing active abilities to the models themselves (“vulnerability-stress models suggest”; my emphasis). In a way, the models’ qualities seem to circularly transcend the evidence on which they are based; the models are rendered as objects rather than subjects (see Boyle, 2002a). Not only is it implied that the vulnerability-stress models themselves are objective proof (rather than metaphorically illustrating the truth or a version of it), over and above the individual pieces of evidence on which they are based, but it is implied that the models support the evidence on which they are based even though the evidence is the sole basis for the models. The models have taken on a life of their own; a life which is mutually supportive of ‘psychosis’.

What I describe as vagueness, above, Fowler and colleagues describe as “a useful and flexible working summary” and even “open-minded[ness]”:

Vulnerability-stress models can provide a useful and flexible working summary of the factors that may be involved in the development of psychotic illness. Vulnerability-stress models can integrate much of what is known about the nature of psychosis. Such models can also clearly highlight important implications for practice. Vulnerability-
stress models tend to be open-minded about the possible influences of biological factors on experiences and behaviours of people with psychosis, but also emphasise the role of psychological and social factors on the outcome of psychosis.

(Fowler et al., 1995: 19; my emphases)

Thus, the ‘openness’ of the models (including possibilities rather than ‘actualities’) is an accountable issue which, here, is framed as an advantage. Once again, note the links between research, models, and clinical practice. It is no wonder that vulnerability-stress models are so useful, since they seem to be able to serve as a professional-to-professional and professional-to-patient explanatory tool for almost anything which is deemed to be part of ‘psychosis’.

The models, for example, can be very useful in representing individual patient cases:

Vulnerability-stress models may be used, then, as a guiding framework to some of the factors which may be important in the aetiology and maintenance of any psychotic disorder. It may be important to note that these models offer considerable scope for individual variability. There may be different vulnerability models for different types of syndrome (ie negative or positive syndromes (see Nuechterlein, 1987)) or for different individuals. We suggest that in clinical practice these models may best be used as a basis for developing a highly individualised formulation of the particular factors involved in a specific case...

(Fowler et al., 1995: 22)

This extract begins to show how Fowler and colleagues use vulnerability-stress models as a both constitutive of, and a justification for, how patients are treated in “clinical practice”. In the following extract this account is widened to include psychiatric research and the development of new interventions:

Vulnerability models highlight a number of important possibilities for psychological intervention. First, they imply the possibility of moderating the influence of adverse environmental factors, such as life stresses and emotional criticism from others. A
focus on these factors has provided the stimulus for the development of family interventions (eg Kuipers and Bebbington, 1990). These have proved to be highly effective in moderating the risk of relapse (see Lam, 1991 for a review). Vulnerability-stress models also imply the possibility of promoting active coping on the part of the individual to moderate the influence of vulnerability factors (eg Wing, 1975; 1987; Hogarty et al, 1986; Liberman et al, 1994). Following from this formulation, psychological interventions have been developed which aim to promote understanding of psychotic illness by psychoeducation, provide clear rationales for the use of neuroleptic medication, and foster strategies likely to reduce relapse (such as monitoring early warning signs) and manage stressful environmental antecedents and social disabilities (see Birchwood and Tarrier, 1992).

(Fowler et al., 1995: 23; my emphases)

The interventions listed in this account include, somewhat paraphrased and in order: moderating the influence of environmental factors; intervening with family members; promoting ‘active coping’; promoting understanding of ‘psychotic illness’ by psychoeducation; providing clear rationales for the use of neuroleptic medication; monitoring ‘early warning signs’; and managing the patient’s environment and ‘social disabilities’. It is not clear how much of this involves influencing the patient in this regard, compared to more direct professional or carer action in the areas identified. Nevertheless, directly or indirectly, the account describes a considerable amount of supposedly therapeutic influencing and moderation of the patient. With this much coverage, it is not only the phenomena in question or environmental factors which are being managed, here; it is the patient overall. And it is all in the name and furtherance of vulnerability-stress models and the notion of ‘psychosis’.
Collaboration or conflict?

There have been several examples of actual or potential tensions in the therapist-patient relationship in previous sections. Boyle (2002b: 298) describes how the presentation of this relationship is a source of ambiguity in the CBT literature. For example, the language of collaboration (say, of a ‘cooperative exploration’ of ‘delusional’ beliefs) is used alongside the language of conflict (in which “beliefs are ‘disputed’, ‘challenged’ and ‘undermined’; ‘faulty’ cognitions are identified and ‘corrected’; therapists’ and clients’ different views are ‘put to the test’”). Thus, there is a tension in the therapist’s presented goals or actions; between collaboration and conflict.

Boyle makes it clear that the intentions of the authors are not at issue; nor is what actually happens in therapy. Rather, such conflict-related and even militaristic language has the potential to create client and therapist positions which are very different to collaboration. I suggest that a more isolated and less powerful client position is often the result. Similar combat-related language is commonplace in medicine but at least doctor and patient are considered to be on much the same side.

In CBT, however, because it is the clients’ beliefs which are being disputed (and not, say, a disease), the clients and/or their beliefs are positioned as being irrational, at least in part. Yet, more or less at the same time, clients are constructed as being ‘normal’ and rational-enough for a collaborative talking therapy such as CBT. The therapist’s point of view, on the other hand, is never constructed as anything other than rational and objective, to the extent of near omniscience. Thus, there is a tension constructed between the therapist and the patient (and/or their beliefs). (See also Proctor, 2003).

Let us return to our CBT texts to see what they show concerning professional-patient conflicts (potential or otherwise). Here is an example of an account by Fowler...
and colleagues of how therapist-client tensions can be managed, of how the therapist can be presented as ‘open’:

...it is not assumed that people will accept a traditional illness model of their problems. Within cognitive behaviour therapy it is still possible to continue to work, using the patient’s own language terms to describe their problems, even if the patient holds very strong delusional beliefs which are at odds with professional opinion. In such cases the aim is often to develop a ‘good enough’ set of self-regulatory strategies to manage relapse (or, using the patient’s words, perhaps ‘bad periods’ or ‘set-back’). This pragmatic approach focusing on ‘doing what is possible’ is characteristic of cognitive behaviour therapy.

(Fowler et al., 1995: 13)

That is, the therapist linguistically adapts or disguises their position. For good measure, Fowler and colleagues include two brief examples of using “the patient’s words” to describe their problems, although this does not address the rather more central concern of how to consider the “delusional” beliefs themselves. Thus, “relapse” (a term which is often used in illness-related contexts) becomes “bad periods” or “setback” (terms which are more universal). Also, the practice of “doing what is possible” is presented as therapeutic pragmatism; as a good thing. However, in presenting the therapist as being prepared to settle for second best, Fowler and colleagues are negatively evaluative of the patient’s position. As this raises the therapist’s status, it lowers the patient’s. The account comes close to presenting the therapist-patient complex as being more like ‘making the best of a bad lot’.

Below, a balance for this therapist-patient complex is struck by way of “cognitive neuropsychological deficits”:

The cognitive perspective does not suggest that people with psychosis are necessarily not rational, nor that people with psychosis are necessarily motivated to deny their problems (although this may sometimes be the case). The cognitive perspective
suggests that any person who had cognitive-neuropsychological deficits would have very bizarre experiences, and would probably come to develop strange theories to account for such experiences. From this perspective people with psychosis are then essentially rational people who are trying to make sense of a very unusual predicament. These assumptions provide a useful starting point for psychotherapy which is based on building a collaborative therapeutic relationship and on open discussion of the nature of the client’s problems with the client.

(Fowler et al., 1995: 52; my emphases)

Of the opening sentence, we may ask whether one can, sensibly, say that a person is ‘rationally psychotic’? However, in this account, “Cognitive-neuropsychological deficits” and resultant “very bizarre experiences” then takes some of the flak of negative evaluation away from the patient-as-a-person. More specifically, within this construction of the patient, a perception/experience vs rationality distinction is made. Due to their “deficits” the patient has “very bizarre experiences” which they process in a (more or less) rational way. Thus, the experience is ‘wrong’, rather than (so much) how it is handled. I say ‘more or less’ and ‘so much’ because the phrase “essentially rational” leaves even the patient’s rationality somewhat open to question. The term ‘essentially’ can be taken as meaning either ‘purely’ (ie, entirely) or ‘basically’ (ie, not entirely). The ability of the patient to have rational thought processes remains in question. Thus, the problem lies in a ‘deficit’ which is, to some extent, beyond the patient’s control and cannot be entirely avoided (“any person who had cognitive neuropsychological deficits would have very bizarre experiences”; my emphases). To some extent, then, the patient is judged less.

That such understandability flies in the face of the diagnostic criteria for psychosis (which hold that the phenomena in question are only ‘symptoms’ if they are not
understandable within the person’s culture) does not receive a mention either here or elsewhere in Fowler et al’s book.16

However, the problem remains located squarely within the patient, who is constructed as having reduced agency given their inability to be in full control of themselves on account of their deficits. This is an opening for the professionals, to try to make up for such deficits in therapy and rehabilitation. Thus, the evaluative ballast from raising the status of the therapist and others is not exactly taken away from the patient: their mutual relationship is such that when the ‘normality’ of the professional and others is increased still further, then the ‘normality’ of the patient is correspondingly lowered.

Furthermore, in connection to the circularity which plagues diagnoses of ‘schizophrenia’ and ‘psychosis’, “any person who had cognitive-neuropsychological deficits would have very bizarre experiences, and would probably come to develop strange theories to account for such experiences” is also mere tautology, a truism. It is the logical equivalent of saying that anyone with ‘psychosis’ would be ‘psychotic’.

The above extract from Fowler and colleagues also holds an apparent contrast, in terms of rationality, with part of their chapter summary on the following page: “Not all individuals have the abilities and interest to respond to such approaches: we have already emphasized a number of times that techniques that involve working ‘within’ delusional beliefs rather than offering fully reality-oriented information may be necessary for some patients” (p. 53; my emphasis). That is, the manual suggests that it is necessary, with some patients, to hold back from what is real and work (as if) ‘within’ the ‘delusion’. This negative evaluation implies that such patients are unable or unwilling to be in touch with reality. In other words, that some psychotics are really psychoticly psychotic.

16 See my endnote on bizarreness and understandability in Chapter 1 of this dissertation.
The following extract moves into focusing on a parity of status between therapist and patient, despite “the possibly large gap between the view of the world held by the therapist and the patient”:

Distortions of reality are also typically... extreme and can result in a radically different, or bizarre, view of the world. The process of therapy has to take some account of the possibly large gap between the view of the world held by the therapist and the patient, particularly in the early stages of therapy. Allowances for differences between therapist’s and patient’s perspectives may involve backing off from disagreements about delusions, or agreeing to disagree. Generally, it is useful to be open and honest about what the therapist’s perspective is. However, the patient’s perspective needs to be respected, and the patient assured that they are not going to be pressured or bullied into accepting the therapist’s viewpoint.

(Fowler et al., 1995: 78)

That is, a parity of viewpoints is constructed but only after there is a backdrop of the patient having “[d]istortions of reality”. Despite this evaluative backdrop, or rather because of this backdrop, the account takes great pains to construct the patient as being “respected” and “assured”. That is, there is still a contrast between how the patient is constructed within these accounts and how they are seen to be treated in these accounts.

Such a contrast comes to the fore, here: “Generally the therapist tries to appear open-minded and interested in finding out the details of exactly what has and has not happened” (Fowler et al., 1995: 97; my emphasis). As Fowler and colleagues point out, this style of questioning has been dubbed the ‘Columbo technique’ (p. 97; citing a workshop by Meichenbaum, Oxford, 1986). Just as the television character Columbo was a detective who acted as something he was not (in Columbo’s case, stupid) the manual, in effect, encourages therapists to act with respect whilst, covertly, negatively evaluating and being dominant over the patient. Remarkably, despite what I consider to be deception and despite the constructed gap between therapist and patient, Colombo
can be used to discursively unite a therapist and patient in a supposedly mutual investigative task:

The Columbo style of questioning may help to elicit key points of evidence without alienating the client. ...A careful and methodical approach to seeking out the sequence of events is particularly important when clients report events in a very confused way. In summary, the message to be conveyed is that the therapist has come to work with the client because he is a health professional and because the person has been viewed as mentally ill. However, the therapist suggests that the client appears to be a reasonable and rational person with very complex problems that are very confusing, both to the client and the therapist. The task for both therapist and patient is therefore to work together to try to make sense of the difficulties the client has and to work out how they developed.

(Fowler et al., 1995: 98-99)

Such “complex problems” require ‘open minds’, collaboration, and the kind of “careful and methodical approach” which needs a professional to show the way. At no point must the therapist break cover and risk “alienating the client”. Thus, the “therapist suggests that the client appears to be a reasonable and rational person with very complex problems” (my emphases), rather than someone they simply consider to be “mentally ill” and ‘delusional’ compared to others.

And, notwithstanding this apparent reasonableness, who is modifying whose beliefs?

Considerable time has to be spent preparing the patient, before attempting to modify their beliefs. ...Reassurance must be given that the therapist views the patient as a rational individual. The therapist may describe beliefs as being the patient’s accounts of their experiences, and say how everyone may be prone to biases and distortions in the process of developing accounts of their experience. ...The therapist only moves to consider alternative explanations for the patient’s ideas after full discussion about these
issues, and then only in the context of offering reassurance to the patient that they are not being bullied out of their views.

(Fowler et al., 1995: 124)

It is worth noting here that possible therapist “biases and distortion in the process of developing accounts” of the patient’s experiences are not mentioned. Notice also the caution which is being called for and the delicacy of the patient’s problem in the above account (“The therapist may describe beliefs as... and say how everyone is prone...”; “The therapist only moves... after full discussion”; “and only in the context of offering reassurance to the patient”).

These matters of ‘openness’, ‘rationality’, and ‘collaboration’ are clearly very delicate issues for the authors. There is the danger of a breakdown in the therapeutic relationship and of adverse effects for the patient; that the actions of the therapist may not always benefit the patient (eg, it may be better to push less and respectfully listen more). That is, the cautious nature of these accounts, which are ostensibly about showing how best to treat patients, also protect the authors, budding therapists, and other readers from the potential blame of getting the patient and the treatment ‘wrong’.

This, in turn, justifies the need for CBT professionals; those who are most skilled at such talking therapy (and at managing such delicate discursive work regarding identity). Ironically, the so-constructed identity of ‘therapist’ and the so-constructed identity of ‘mentally ill patient/client’ are mutually supportive of one another. Render the patient as too ‘normal’ and the therapist is not needed and thus redundant; render the patient as too ‘abnormal’ and the therapist is not able to do their work and thus redundant.

Besides the mutual investigative approach and the Columbo technique for finding “alternative explanations” (Fowler et al., 1995: 124), Socratic questioning is another tool which the authors present in this regard. Fowler et al.’s version is notably frank concerning the use of this method in ensuring the patient’s adoption of the therapist’s
position, although contradictions are not labelled as such. Comparable accounts of Socratic questioning (pp. 34 & 42) and collaborative empiricism (the ‘scientific method’) (p. 34) can be found in Chadwick and colleagues’ manual. Although Chadwick et al.’s accounts are far more softly presented in terms of their position on ‘information provision’ to the patient, the difference between texts in this regard appears to be a matter of degree.

We shall begin with Fowler and colleagues:

Alternative explanations for psychotic experience can probably be provided most effectively by using a framework of guided discovery. This means not just providing didactic information, but instead leading the patient to the idea that others may have had similar experiences, and that there may be an alternative, less threatening explanation for their experience.

Such therapy can be carried out in the form of a Socratic dialogue starting from a question such as: ‘You know you were telling me about your experience...how people on the television were talking about you? Do you think anyone else has had such experiences?’ Following this, information may be provided to correct wrong assumptions concerning the nature of psychotic experience, and to add weight to more adaptive appraisals...

In all such discussions the therapist needs to retain the attitude of an independent objective discussant, rather than someone with a vested interest in pushing the patient towards acceptance of any particular idea. The patient is assisted to draw their own conclusions about whether or not they have an illness.

(1995: 130-131)

Here, guided discovery and Socratic dialogue are, in part, contrasted with a merely didactic approach (“not just providing didactic information”). That is, Socratic dialogue is partially presented as ‘teaching’ through questions to uncover what is already known by the patient, rather than the provision of information. However, Socratic dialogue is
also (quite frankly, by the authors) not fully separated from information-giving (“not just providing didactic information”; “Following this, information may be provided”). Indeed, in further frankness, the therapist is then clearly constructed as having the “correct” point of view, compared to the patient (“information may be provided to correct wrong assumptions concerning the nature of psychotic experience, and to add weight to more adaptive appraisals”; my emphases). The therapist is encouraged to show that this ‘correctness’ stems from being “an independent objective discussant” and not “someone with a vested interest”. Not only can the professional offer a “less threatening explanation of events” (which is, in that sense, ‘better’ than the patient’s version) but they can also offer the one and only ‘correct’ version of reality. Thus, the therapist is encouraged to be, and is presented as being, a supreme judge over “wrong assumptions” and “more adaptive appraisal”. Apart from providing experiential information, the person who is most experienced with ‘delusions’, the patient, still has little to sway such professional decisions on what is real, important, and otherwise ‘good’. And what if the patient concludes that they do not have an illness?

And, according to Fowler et al., for some of those who do not want to change, there are the clear and unproblematic sub-diagnoses of “grandiose defences” and “low motivation to change”:

Grandiose defences often seem to be successful and appear to enable patients to avoid painful feelings of depression which they describe as highly aversive. We have found that people with grandiose delusions can be a particularly difficult group to engage in therapy as they frequently have low motivation to change.

(1995: 66)

In Chadwick et al.’s manual, it is harder to tease out potential therapist-patient tensions. In connection to Chadwick and colleagues’ ABC model of ‘delusions’:
The therapist hopes that through cognitive therapy the client will gain four insights regarding the delusion. First is the recognition that the delusion is a belief, and not a fact of life. Second is that it represents a reaction to, and attempt to make sense of, certain aspects of his life: in many cases there is a discernable psychological motivation for this (e.g. anxiety reduction, warding off negative self-evaluation). Third, is the recognition that the delusion carries an emotional and behavioural cost. Fourth, as the client considers, discusses and tests the delusion, he comes to recognise it is false and rejects it in favour of a more plausible and personally significant explanation (a new B) with which to make sense of his experience (A).

(1996: 72; my emphases)

This extract includes a number of assumptions about ‘delusions’. Many of these assumptions are presented as if they are truths, rather like objects to be recognized. For example, it is assumed that ‘delusions’ are beliefs rather than facts, that there is a cost involved (“the delusion carries an emotional and behavioural cost”), that ‘delusions’ are false (“he comes to recognise it is false”).¹⁷ There are also the related assumptions, following on from the recognition of falsity, that ‘delusions’ can, and had better be, rejected. It is also assumed that the therapist is instrumental in this, in helping the patient achieve (what is supposed to be) their own “personally significant explanation”.

Such professional-led personal significance is described as “meaning” in the extract below. It is framed in terms of the patient “gaining a common perspective”. In isolation, this could be taken as either a perspective which is jointly arrived at (stressing the commonality aspect) or one which comes from the therapist to the patient (stressing the gaining aspect):

¹⁷ And why not assume falseness? They are ‘delusions’, which are false by definition, after all. But did not these same authors earlier point out problems with the criterion of falsity?
...the therapist wishes the client to understand that the meaning events have for him (the Bs) is central to understanding his problem; gaining a common perspective on this point is essential to the process of change. First, she needs to clarify with the client that the A-C analysis is lacking in that the event alone (A) does not account for the client’s reactions (C). This is because he might in principle have responded differently - the therapist argues that what is lacking is an understanding of the personal meaning the event had for the client.

Thus, the therapist assumes the client has an AC theory about his problem, and the therapist seeks to inculcate an ABC theory - that we are disturbed not by things in themselves but by our interpretations of them.

(Chadwick et al., 1996: 31; my emphases)

However, there are several factors which suggest that this is a professional-led enterprise. First, the extract opens with the therapist wishing for the patient to “understand” meaning in a certain way (in a way which is justified in terms of being beneficial for the patient, of course). Indeed, Chadwick and colleagues present this wishing as an open matter, just as they present the therapist as arguing a case about meaning (“the therapist argues”) and making assumptions about the ABC model in relation to the patient (“the therapist assumes the client has an AC theory about his problem”). It is notable, and quite understandable, that, in the previous extract, ‘delusions’ were presented as patently false, whereas someone else’s personal meaning and a cognitive model being applied to someone else require open persuasion and assumption. These are, however, foundational aspects of cognitive therapy and so perhaps, in that context, effective persuasion of such matters is what a cognitive therapist ought crucially to do.

The term “inculcate” is part of this presentation of frankness concerning the job of cognitive therapists to persuade their clients in such matters. It is more than suggestive of this being a professional-led, persistent enterprise. Inculcation is not a half-hearted
measure. The *Concise Oxford Dictionary* defines ‘inculcate’ as: “(often followed by ‘upon’ or ‘in’), “urge or impress (a fact, habit, or idea) persistently”, “From the Latin *inculcare* (as in *calcare* ‘tread’, from *calx calcis* ‘heel’)”. This is hardly akin to Chadwick et al.’s presented-as-even-handed account of Socratic questioning and collaborative empiricism. Of course, it makes sense for a cognitive therapist to not appear ambivalent over such “essential” matters as the cognitive meaning of events.

Nevertheless:

> We do not believe that cognitive therapy is so powerful that individuals are swept along by it and somehow compelled to change, even if their will is not to. Our clients demonstrate numerous ways of not changing and we respect and accept this. Rather, cognitive therapy works well when the therapist and client share a common purpose and work together in pursuit of it, and our view is that a legitimate common purpose is to reduce distress and disturbance by weakening delusions.

(Chadwick et al., 1996: 71)

In this extract, the therapist and patient do not sound much like *inculcator* and *inculcated*. Here, patients are relatively powerful, compared to the therapeutic procedure (even if they are not quite so powerful in comparison to the therapist). The “common purpose” is to the fore. It is ironic, though, that “ways of not changing” are presented almost as achievements and indications of social power, whereas, more typically, even in this manual, they are constructed as negatively evaluated indications of problems in the patient; of the severity of the patient’s ‘mental illness’. It is worth also considering that many CBT recipients are not treated as private, autonomous, fee-paying “clients”. Rather, they are patients within a psychiatric system of institutionalized social power asymmetries in which the patients generally do what they are told.

Furthermore, the following extract about not denying therapy to people who might benefit from it can, perversely, be taken as implicitly opening the door for the
enforcement of talking therapy, just as pharmaceuticals are so accepted as a generally beneficial treatment as to be legally enforceable onto patients:

Yet for many people being deluded is associated with severe emotional and behavioural disturbance and it therefore seems, to us at least, questionable for a therapist to decide in advance to withhold therapy on the grounds of an unproven belief that deluded people are best left deluded. And should this argument not apply equally well to medication?

(Chadwick et al., 1996: 70)

Notice the extreme case formulation “severe emotional and behavioural disturbance”. Plus the phrase “deluded people” is more extreme than the ‘delusional beliefs’ which is more typical from these authors. These devices render the argument as toughened against refutation. The extract is from the chapter which is forcefully entitled “Challenging delusions”.

Here is another account of collaboration, of uniting against the common foe:

The process of cognitive therapy with voices is one of working in an atmosphere of ‘collaborative empiricism’. The goal of the opening, or engagement stage is to encourage the client to view the distress as arising from beliefs about voices, not being an automatic part of the hallucination. To achieve this the therapist needs to work with the client to overcome a number of obstacles to engagement, in the form of beliefs and expectancies the client has about the therapist, the process of therapy, and the voice’s likely reaction.

(Chadwick et al., 1996: 91)

In the construction of this common foe in therapy, a distinction is to be made, by the therapist and with the patient, between the actual ‘hallucination’ and beliefs about the ‘hallucination’ (aka ‘delusions’). In order to do this, “the therapist needs to work with the client to overcome a number of obstacles to engagement”. But why are there so many obstacles to engagement (which, presumably, threaten the cessation of therapy) if
this is a simple client-service provider agreement? That is, the manual presents the person in question as somehow being, simultaneously, both a free-thinking ‘client’ and a deluded ‘mental patient’, depending on the discursive work at hand.

In keeping with a theme of ‘delusions’ really being false, but this time in connection to voice-related ‘delusions’, Chadwick et al. state that “beliefs are interpretations, personal meanings, given to the voices, not facts of the hallucination” (p. 119). In a sense “facts of the hallucination” is an oxymoron which illustrates an important inconsistency in the ABC model as it is applied to ‘psychosis’. The events in the model (ie, the As) are said to be factual events. Thus, since voices are considered to be As, they are on the one hand said to be facts but on the other hand they are said to be ‘hallucinations’ (ie, unreal). It is a real experience but they are not real voices; personal experience and reality are somehow separated. Therapists and other sane people are placed in the privileged position of being able to judge what is real, over and above the person in question. That is, the following hypothetical is in keeping with the model: “I believe the voices are real, for you (but they are really hallucinations)”. This allows the therapist to side-step any potential disagreement over whether a voice is really real. The same can be said for the As which are said to precede other ‘delusions’. But how can anyone separate reality from the experience of it, except discursively through inevitable representation, that is?

I will now discuss further another tension which is apparent in Chadwick and colleagues’ CBT manual: the value of ‘delusions’ and voices. Earlier on, we saw that Chadwick et al. constructed ‘grandiose delusions’ as negative, even (or especially) when they appear beneficial to patients. Therefore, looking at this obliquely, it is possible that ‘delusions’ may be beneficial to patients; a possibility which may undermine justifications for therapy. Similarly, apparently harmful ‘delusions’, which are associated with distress and disturbance (both are psychological terms, here,
invoking mental states), may in fact be psychologically adaptive for the patient. It may be that the removal of such ‘delusions’ leaves the patient open to psychological harm. In a sense, as a psychological perspective, such arguments are a challenge to cognitive therapy on its own turf. They also represent potential tensions between Chadwick et al., patients, readers, and other researchers. The importance of this is suggested by Chadwick and colleagues addressing the topic and going on to provide several counter-arguments (which I will not consider for reasons of space).

But are the above challenges also inherent tensions within Chadwick et al.’s own position? Perhaps the following extract will clarify this question:

If following a cognitive assessment the therapist concludes that the client is not experiencing any distress or disturbance, then in our opinion cognitive therapy is not indicated. This is because the rationale for therapy has gone - that the client and therapist work collaboratively to ease the former’s distress and disturbance. Working merely to change beliefs is not an end in itself. Of course the delusion may be posing problems for others and this needs careful exploration and useful therapeutic options need to be considered, but not we think cognitive therapy for the client.

(Chadwick et al., 1996: 170)

This addresses the issue of performing cognitive therapy on someone who does not wish it. However, partial respect, misrepresentation, and coercion can be much less obvious and yet still more powerful than is presented here and elsewhere by Chadwick and colleagues. For example, the above account does not address matters which relate to the misrepresentation to patients (and sometimes readers) of cognitive therapy as giving equal credence to professional and patient views of reality. Indeed, it adds to the overall camouflaging of social power asymmetries which favour professionals over patients; a bias-in-action towards ‘sanity’ and professionals, the ‘super sane’ judges of reality. As I have shown, various features of both CBT manuals manage conflicts between assisting the patient and furthering the professional and the profession. I have attempted to show
ways in which professional concerns dominate over patient concerns. In doing this, I have demonstrated the operation of these kinds of power-related phenomena, as social events, in discourse, in action.

**Individualism vs context**

Boyle (2002b: 299 ff.) discusses how CBT focuses on the individual as the location of the ‘problem’ and the target of the ‘remedy’. CBT combines the individualistic frameworks of cognitive theory and psychiatry.

I have already argued that many of the above extracts from our CBT manuals are individualistic. Below is an excerpt from one extract per manual:

> Illness concepts can help to provide an orienting framework for approaches to the understanding of an *individual’s predicament* that are both empathic and therapeutic...

> (Fowler et al., 1995: 18; my italics and emboldening)

> We know that the individual symptoms exist, that they often appear together, and that *individuals*, their families and friends are frequently very distressed and disturbed - this is not in doubt. What is in doubt is if and how to group or categorise symptoms...

> (Chadwick et al., 1996: xvi; my italics and emboldening)

Notice that besides the individual person in question being the primary location of the ‘problem’ as a psychological ‘problem’, even the others who are included in the accounts (such as families; in bold) are considered in terms of their *individual* characteristics rather how they may contribute to *interpersonal* ‘events’. Recall also, in previous extracts, the lack of consideration of a person’s macro-social circumstances which does not entail a principal focus on how events psychologically affect the individual.

Boyle concedes that focusing on the individual has some merit. After all, it is individuals who are distressed and/or disturbed and it is often individuals (though not
always the person in question) who seek help. Offering someone a chance to talk about their problems and consider alternative ways of viewing them may be just the help they need. Also, CBT authors do go some way towards putting the individual in a wider context. For example, Chadwick and Birchwood (1996) “try to explore possible connections or personal significance, between the voice content and the individual’s history” (p. 79; cited in Boyle, 2002b: 300). The accounts of assessment in our CBT example texts include similar endeavours. Nevertheless, any such understandings of how life experiences and social conditions may influence ‘psychosis’ tend to remain what Boyle describes as ‘privatised’, either with the therapy relationship or in single case studies which carry less prestige than randomized controlled trial (RCT) studies. In RCT studies, the aggregation of data tends to ‘sanitize’ the context away for the sake of controlled experimental conditions. Furthermore, the basic individualistic assumptions of cognitive theory limit non-individualistic understandings and these basic assumptions feed through to CBT in practice. For example, Chadwick et al. (1996) maintain that it is the “personal meaning events have for people which determines if they are distressed and disturbed” (pp. 8-9; cited in Boyle, 2002b: 301; emphasis added by Boyle). A positive interpretation of this is that the account favours the views of the person in question over professional assumptions, including the assumption that the content of ‘psychotic symptoms’ is meaningless. However, the account also allows for the exclusion or reduced consideration of social factors in favour of causes and solutions which are located within the individual. As we have seen, a cognitive view can also be spliced with a biomedical view; both contributing to the potential exclusion of inter-personal factors (ie, the personal and the interpersonal).

This is a very narrow view of personal meaning, and of how it might represent someone’s personal and interpersonal life. For example, Boyle argues that it is difficult to understand a black man’s belief that he was born to white parents without recourse to
an understanding of ‘race’ and the position of black people in the white-dominated social hierarchy of Western society. Boyle also discusses the importance of understanding gender issues in society, given the gender related content of the majority of abusive voices. Finally: “in our concern with the person’s appraisal of events, we may neglect to ask, to paraphrase Sampson (1981), how these ‘events’ came to enter the person’s life in the first place” (Boyle, 2002b: 302).

**Symptom model shortcomings as topic**

As I wrote earlier, it is notable that Chadwick and colleagues’ do not topicalize medication. This is arguably more in keeping with a psychological approach than a biological approach. Recall, however, the operation of normality-abnormality continua in both manuals. That the trade which Chadwick et al. do with the medical model is recognized by them as an accountable issue is shown in their consideration of shortcomings of the *symptom* model and their suggestion of the need to (continue to) move beyond that, to a *person* model. It is worth considering Chadwick and colleagues’ accounts of inadequacies of the symptom model, which feature in the final chapter of their book (a chapter of final conclusions), because they might answer some of my criticisms of CBT.

In their section on “Shortcomings of the symptom model”, Chadwick et al. acknowledge that one inadequacy of the symptom model is that it takes as its starting point a ‘symptom’; “an abnormal behaviour; a medical concept tied to the idea of illness” (1996: 179). However, just as they did in the opening of their book, Chadwick and colleagues fall short of direct criticism of the medical model in this context, writing instead that “while faith in an underlying illness such as schizophrenia may be contested this cannot disguise the fact that conceptually a symptom is a product of something” (p.
That is, beyond ‘schizophrenia’, the question for the symptom model remains, a symptom of what? More specifically:

So, the symptom model stands accused of lacking an overarching theory with which to make sense of the emergence of symptoms, that it relies upon concepts like self which have complex hidden meanings, and that it is imprecise about what psychological vulnerability outlives a symptom. In this sense the banner of symptom based work may be seen as signifying more a rejection of syndromes than itself being a viable comprehensive psychological approach to clinical problems. 

The root of the problem is if one abandons the syndrome model and replaces it with no other overarching theory then an analysis of symptoms runs the risk of being groundless.

(Chadwick et al., 1996: 180)

With candid criticism of psychology, Chadwick and colleagues even refer to what might otherwise be called the careful vagueness (Potter, 1996: 118) of “concepts like self which have complex hidden meanings” and references to an “imprecise” “psychological vulnerability”. However, they are not so openly critical of biological frameworks, referring to “the syndrome” which has been abandoned rather than to medical approaches to ‘psychosis’ per se. Such criticism might be too damaging for CBT, for some readers, in the face of psychiatry and biological advances. Conversation analysts know this as recipient design (see ten Have, 1999: 119).

So then, the ‘problem’ here, as described by Chadwick et al., is the ‘psychological gulf’ which the symptom model does not address. This is presented as an understandable shortcoming: “It has happened this way historically, and understandably so, but the lack of a general conceptual framework becomes more and more apparent and embarrassing as approaches to symptoms become more mature” (Chadwick et al., 1996: 180). Notice that the criticism is prefaced by the concession of historical accident. That way, researchers are constructed as being less personally blameworthy. Also, this
mentioning of history fits with the section title, “From a symptom to a person model”,
and the earlier claim that:

...the move from a medical model to a symptom approach has considerable merit. ...the
next decade may require a paradigm shift from a symptom model to a person model,
and that in fact this shift is well underway as can be seen by our own work. We discuss
how this further paradigm shift would allow the advances seen in the understanding and
treatment of delusions and voices to be extended to other psychosocial interventions for
psychosis (e.g. family and EE work, early signs intervention).

(Chadwick et al., 1996: 175)

These descriptions suggest a rather gradual, progressive shift from ‘schizophrenia’ to
‘symptoms’ and beyond, with each stage building on the more or less intact foundations
which preceded it. The account comprises much politic in its association with, and to
some extent departure from, orthodox psychiatry. As such, it is highly reminiscent of
the continuity view of ‘progress’ which Berrios (2000) identified and criticized in
connection to the history of ‘schizophrenia’ in psychiatry.

The proposed solution is the ‘person model’. This progression is encapsulated in the
section entitled “From a symptom model to a person model”. Within this model,
Chadwick and colleagues advocate contextualizing (and in that sense, uniting) the
symptom approach within a model of “ordinary psychological development” (p. 180).
Notice the use of “ordinary” rather than ‘normal’, in an apparent sidestep from such
controversy. A little later, the person model is described as “a cognitive developmental
theory of the person” (p. 181). It is argued that “the solution to this problem [of
‘symptoms’] is to conceptualise a symptom or collection of symptoms that an individual
experiences as reflecting an enduring psychological vulnerability” (p. 180; my
emphasis). Thus, the syndrome model is to be replaced with another, this time
‘normality’-based, overarching model without exactly turning away from either
'symptoms’ or some kind of updated ‘schizophrenia’ (“collection of symptoms”). Normality-abnormality continua are hard to avoid it seems.

In Chadwick and colleagues’ presentation of their developing approach, “the foundation stone, for a person model is the central human endeavour of trying to construct a sense of self that is both valued and authentic (i.e. constructed by the person, not imposed by others)” (p. 182). However, in essence, Chadwick et al. are reaching for an overarching and professional theory. Despite a claim for personal authenticity, their theory has already been clearly introduced as a cognitive theory. That is, the account is pre-emptively individualistic. I will soon show that biology is not far away either.

Chadwick and colleagues use the notion of ‘the person’ and ‘psychological vulnerability’ to tout the ‘normalizing’ characteristics of their proposed model. The ‘self’ and ‘the person’ are common to all people and we are all psychologically vulnerable:

We have argued that people with delusions and voices, in common with all human beings, have a general need to construct a sense of self and are subject to threat to that construction. In asserting this, and making it the foundation of an approach to psychotic phenomena, we believe that the approach becomes truly person-centred and based on notions of continuity.

(Chadwick et al., 1996: 183; my emphases)

Surely, then, it must be that some of us ‘have’ different ‘vulnerabilities’ to others? The following extract not only presents this as being the case but offers “biological vulnerability” as the only candidate explanation:

For example, the [person] theory does not account for why an individual who is deficient in attachment or autonomy should become deluded rather than depressed or anxious. It is possible that there is a biological vulnerability which partly accounts for this.

(Chadwick et al., 1996: 183)
Thus, a shortcoming of the person model is described and biology is neatly (although still vaguely) positioned to take up the slack. Similarly, Chadwick and colleagues candidly note (without overt criticism) that “services to people with a psychosis reflect a confusing mix of either medical and psychological theory, or different and conflicting psychological theories, or both” (p. 183). Of course, this is what one would expect from a mixed continuum. Chadwick et al.’s implied solution to this state of affairs, however, is to simply systematize the mix, to “emphasise how a likely biological vulnerability (as yet undemonstrated) combines with early experience and adolescence to lay down a psychological vulnerability, which may or may not manifest in psychotic and neurotic symptoms” (p. 183). What hope does someone have of being granted full respect for their personal points of view in the face of such a well-promoted alliance of professions? And what chance do interpersonal and wider social considerations have in the face of such individualism?

Perhaps instead, rather than replacing one overarching professional-led model with another, professionals might begin with one simple, underlying principle. All of us, professionals included, have the option of starting from a position of understanding-in-action that we will never have all the answers. We can all aim for a better dialogue, with people and ideas. This is especially needed if we would otherwise privilege, a priori, our own and professional points of view over those of others, and individualistic accounts over the interpersonal.

SECTION 3. CONCLUSIONS

The chapter on ‘schizophrenia’ from the canonical New Oxford Textbook of Psychiatry presents an almost united front in which voices are typically seen as a ‘symptom’ of ‘mental illness’. Such ‘symptoms’ are constructed as severe, complex, and, above all
other causal factors, rooted in biology. Thus, medical treatments are imperative and
dominant; and psychiatry is built on elaborations of theory and technology, above all else.

Our CBT texts entail important departures from orthodox psychiatry, such as
considering the patient to be sufficiently rational to make it worthwhile focusing on the
content of ‘symptoms’ in therapy talk. As an alternative to biological psychiatry,
however, these CBT approaches, and arguably any approach which ultimately privileges
professional theories over personal and interpersonal matters, do not go far enough.
They remain bound to reductive, theory-driven, ‘normal’ versus ‘abnormal’,
individualistic, and biological explanations of behaviour. Variables to do with inter-
personal context are passed over and the dominance of biopsychiatry remains largely
unchallenged. In missing so much of the situated personal and interpersonal, these CBT
texts give insufficient weight to the functions of reported experiences and to the actual
practice of co-equal dialogue.

Although the CBT manuals do not transcend either the dominance of biopsychiatry
or professional-patient asymmetries, the approach they represent could have a psycho-
socializing influence on psychiatry. Perhaps, though, it will take more radically
different approaches to ‘mental illness’ than CBT in order to not rely on problematic
normality-abnormality continua. It is hoped that aspects of the currently non-
mainstream alternatives to ‘schizophrenia’ and ‘mental illness’ which we will review in
the next chapter, plus the kinds of critical discursive approach which is enacted in this
dissertation, will facilitate social change in this regard.
[‘Mental illness’] rests on a serious, albeit simple error: it rests on mistaking or confusing what is real with what is imitation; literal meaning with metaphorical meaning; medicine with morals. In other words, I maintain that mental illness is a metaphorical disease: that bodily illness stands in the same relation to mental illness as a defective television set stands to a bad television program. Of course, the word “sick” is often used metaphorically. We call jokes “sick,” economies “sick,” sometimes even the whole world “sick”; but only when we call minds “sick” do we systematically mistake and strategically misinterpret metaphor for fact - and send for the doctor to “cure” the “illness.” It is as if a television viewer were to send for a television repairman because he dislikes the program he sees on the screen.

(Szasz, 1961: x-xi).

In the preceding chapters, we have seen how the prevailing view of psychiatry, which is incorporated largely uncritically into contemporary clinical psychology, manages a certain tension between invocations of ‘normality’ and ‘abnormality’ in the diagnosis and treatment of ‘schizophrenia’ and hearing voices. These actions are connected to, and justified through, the theoretical frameworks which underlie the use of terms such as ‘mental illness’, ‘schizophrenia’, and ‘symptom’. In this chapter, in contrast to these kinds of practices, we will begin to see how alternative professional approaches critique psychiatry and attempt to deal with such tensions.¹ The literature can be broadly

¹ The professionals represented include psychiatrists, nurses, clinical psychologists, and academics. Alas, there is no space for a review of texts in a wider discussion of, for example, positions in the philosophy of mind and ‘mental illness’. For example, the position of Megone (1998), plus replies by Szasz and others
categorized into a number of different but sometimes overlapping perspectives on the phenomena in question, including critical analysis, psychiatric treatment in practice, and contextual, moral, existential, phenomenological, ethnomethodological, and voice hearer perspectives. Approaches which study talk and texts more directly are reserved mostly for Chapter 5.

Many of these works do not feature encapsulated representations of ‘mental illness’ and ‘schizophrenia’. Rather, they are characterized by a critique of the dominant psychiatric representation; and, thus, by what they do not engage in at least as much as what they do engage in. Some of these works, notably Leudar and Thomas (2000) and the various publications which have connections to the Hearing Voices Network, even aim to minimize the imposition of extrinsic, professional representations of the phenomena in question.

When is an alternative not an alternative? Some approaches, which are not included in this review but are at least in part presented as ‘alternative’, predict or provide supposedly different ways of dealing with ‘schizophrenia’ and ‘mental illness’ without including actual alternatives to the constructs which are central to a biomedically dominated approach. Thus, challenging the dominant model head-on may be avoided, whilst still benefiting from being ‘alternative’. Overall, CBT may be understood as an example of this, as described in the previous chapter. In practice, biopsychiatry and ‘schizophrenia’ may be merely augmented by ‘alternative’ approaches or perhaps even replaced with something into which the ‘alternative’ has been assimilated. However, despite this ‘change’, the social functions of diagnosis and treatment may be more or less unchanged and, through this ‘change’, biopsychiatry may remain dominant, even stronger and more pervasive.

in the same issue of Philosophy, Psychiatry, & Psychology, and the continuing discussion in 2000 (vol. 7, 1), would otherwise be pertinent here.
In contrast to pseudo-alternatives, this chapter is mostly taken up with the kind of approaches which act towards radically changing and even banishing ‘schizophrenia’, ‘mental illness’, and related approaches to distress. I suggest that it is likely to take the persistent application of these kinds of approach, in concert, to sufficiently challenge medical psychiatry and work towards professional and (inter)personal equity in ‘mental health’.

What challenges a biopsychiatric view? A number of researchers have pointed out that constructions of madness - including ‘schizophrenia’ and ‘severe mental illness’ - are socially and culturally contingent. For example, following Foucault (1971), Boyle (2002b) and Georgaca (2001) critically review what they identify as the discontinuous historical process from which the current, dominant view of ‘mental illness’ has arisen. They show that constructs which currently are taken to be objective facts about ‘mental illness’ have, instead, varied depending on prevailing social, cultural, and political influences. These changes include the use of moral treatment in the late 18th century, the development of Victorian asylums, the advent of new physical treatments, and the move to general hospitals and community care. Rather than tending to lead the way (as is often assumed in orthodox accounts), representations of ‘mental illness’ have varied in line with such changes.

Besides a critical analysis of the historical development of ‘schizophrenia’, Boyle (2002b) provides a thorough-going critique of ‘schizophrenia’ in its own terms, as a would-be medico-scientific concept. Boyle uproots ‘schizophrenia’ and systematically subjects every aspect of it, from the ground up, to unremitting scrutiny, demonstrating that every branch is fundamentally flawed. That is, despite its scientific veneer, from its very origins and in so many other important ways, ‘schizophrenia’ is untenable as a scientific concept.
At the core of Boyle’s approach is the contention that ‘schizophrenia’ does not meet medical science’s own basic standards as a hypothetical concept. From the pioneering work of Kraepelin, Bleuler, and Schneider onwards, ‘schizophrenia’ has never been shown to be a valid cluster of ‘symptoms’. Without this crucial step, no attempt to refine the ‘concept’ - whether through supposed improvements in diagnosis, the discovery of supposed causes, and/or the treatment of supposed symptoms - can be seen as progress, in a scientific as opposed to rhetorical sense. Boyle subjects historical events leading up to ‘schizophrenia’, the ‘concept’ of ‘schizophrenia’ itself, the diagnostic criteria for inferring ‘schizophrenia’, and genetic research, to unrelenting critical analysis.

Furthermore, on top of this primary and principal error, psychiatry’s ‘schizophrenia’ is shown to be an elaborate construction of self-interested representations and misrepresentations. Boyle lays bare many of the discursive practices which are used to maintain ‘schizophrenia’. It is not that any human endeavour can be done without representation and the occasional, arguable misrepresentation, but that ‘schizophrenia’ is systematically supported through such practices in ways which, with or without intention, conceal the invalidity of the construct (Boyle, 2002a & b).

Boyle (2002b) also considers the advantages and challenges of moving beyond ‘schizophrenia’. In her summing-up, she highlights the continuing need to unearth restrictive assumptive practices; to foster a more relational approach to the issues behind ‘schizophrenia’, so as not to repeat previous errors:

There is, first, a striking lack of a reflexive approach to the production of knowledge about psychotic behaviour and experience. It is still implicitly and at times explicitly assumed that knowledge will automatically accrue through the ever more precise efforts of objective researchers. ...[T]he extent of overlap between the assumptive frameworks of psychology (from where a good deal of the ‘alternatives’ have come) and those of medicine and psychiatry has been obscured. ...[T]here is still a reluctance to consider
fully the idea that psychotic behaviours and experiences are relational, that they arise in social and interpersonal contexts, that their form and content are given meaning by those contexts and that such behaviours are officially transformed to ‘pathology’ only through a relationship of unequal power...

Finally, there is a danger that we will seek an alternative account of ‘schizophrenic’ behaviours and experiences which will (seem) to do all of the administrative, social and moral work we have required of ‘schizophrenia’...

(Boyle, 2002b: 316-317; original emphasis)

Underlying much of Boyle’s approach is the contextual perspective of Sarbin. This is shown in his potent criticism of the DSMs (eg, 1997 on DSM-IV) (see also Boyle, 2002b, Crowe, 2000a & b, and Georgaca, 2001, for other DSM critiques). Sarbin argues for the return of personal agency. From Sarbin’s social perspective, ‘mental illness’ is better seen as unwanted conduct rather than pathology; as ‘doings’ rather than ‘happenings’. He lays bare the diagnostic labelling of ‘mental’ distress as a “distinct ideology”, rather than the outcome of mechanistic science (1997: 233) (see also Sarbin & Mancuso, 1980).

Sarbin outlines the social manoeuvres, the compromises, and the “unarticulated ideology that guided the [APA DSM] task forces, committees, and experts in their work” (Sarbin, 1997: 234). He also describes the staggering number of additions of diagnostic categories and criteria; all in a futile search for precision, for making sense of what can only ever be a “heap” (Coulter, 1991). Sarbin argues that “heap” is a more apt metaphor than “molecule” and other biological approaches to “sorting people” (p. 237). Kirk and Kutchins (1992) have also documented how each edition of the DSM was supposed to offer a solution to the unreliability of psychiatric diagnoses (ie, inconsistency across time and conditions); a problem which has not been solved to-date. Beneath it all, the DSMs are a social construction; an exercise in the factual rhetoric of science and technology. And, continuing Sarbin’s exposing of this obvious but largely
unacknowledged duplicity, “constructing a diagnosis is still a predominantly subjective enterprise” (p. 235). How else does one decide, for example, on how often is “often” enough for criteria such as “often has difficulty organizing tasks and activities” (p. 235)? How else does one follow the guidelines of practicing clinical judgement and to also take cultural and subcultural behaviours into account? Thus, partly as a result of such marked subjectivity, in practice, there are only tenuous links between diagnoses, type of treatment, and outcome.

Then there is the problem of validity. In contrast to reliability, validity receives little explicit attention in the DSMs. Rather, there is the apparent reliance on the validity of claims being self-evident and on vague references to such ‘things’ as a “chemical imbalance”. Such practices appear to be loosely based on the doctrine of Kraepelinian nosology; Kraepelin’s mechanistic framework for classifying ‘mental disease’. Sarbin notes that when psychodynamic theories were most popular in psychiatry then “the arcane language of mentalism” was instead used. Again, this shows how the construction of diagnostic criteria changes with the times and with prevailing social requirements. In the DSMs, both the macro-social and the micro-social are largely unacknowledged:

...efforts to understand unwanted conduct have, in the past, focused mainly upon idiographic “flawed minds” or upon mechanically connected intrapersonal antecedents, concomitantly neglecting social processes by which people assign a negative evaluation to an act, and also ignoring issues of role definition and role assignment. The neglect of social processes helps maintain the position that unwanted behaviors are problems of the individual and are to be explained in terms of how those behaviors are mechanically “caused” within the individual.

(Sarbin & Mancuso, 1980: 208; original emphasis)

Thus, Sarbin proposes the use of a contextualist approach to “the societal problem of sorting people into categories” (1997: 237). Rather than considering people’s actions as
“happenings” they can be seen as “doings”; as having “reasons” rather than “causes”; as “strategies” rather than rationalities. This, then, focuses on the

...agential, intentional, purposeful action of persons attempting to enact a drama based on their self-defining narratives. Striking an adversary, seeking a religious experience, bolting the doors and windows, and declaring that one is a host to multiple personalities are examples of doings, of actions.

(Sarbin, 1997: 237)

This does not pertain to medical symptoms and their causal happenings as indices of illness. It ought not to pertain to the unwanted conduct which is most typically referred to as a psychiatric ‘symptom’ of one kind or another. But, within the frame of biopsychiatry, it does. Biopsychiatry’s misapplication of the medical model reduces unwanted human behaviour, quite simply, to aberrant happenings in the brain. This is taken for granted - it is presented as a simple, objective truth - despite or because of all the technology which is marshalled for the cause.

The following serves as a summary of Sarbin’s contextualist proposal, for the promotion of personal agency in the psychiatric clinic:

The contextualist model sensitizes the clinician to focus on the master question: “What is the client or patient trying to do?” Answers to this question will inevitably be in the form of a narrative that includes the parts played by other actors in the client’s drama. The constructed narrative will provide clues for a diagnosis in terms of the class of strategic actions employed. The clinician’s answer to the master question satisfies the original purpose of diagnosis - namely, to guide the therapist and the client in developing a treatment plan. Classification for its own sake has no place in this construction.

(1997: 238; original emphasis)
Unlike in the medical model, the moral judgment - of behaviour being wanted or unwanted by the self and/or others - is explicitly acknowledged. Here is a description of the contextualist model in relation to ‘dysphoria’:

Clinicians who subscribe to the medical model regard dysphoric complaints as symptomatic of a bodily dysfunction. It has become common practice among physicians to prescribe medications to alter the body chemistry. A radically different approach would be taken by contextualist clinicians who are sensitive to the notion that distress follows from the failure of strategic actions to deal with problems of living. The self-reports of distress that are expressed in language of “feelings” are construed as the patient’s efforts to make sense of proprioceptive and interoceptive changes that accompany failed strategies to solve existential or identity problems. The clinician would direct his or her attention to the reasons for the unresolved strain-in-knowing rather than to reports of “feelings” that are adjuncts to personal problem solving. The focus would be on the antecedents of strain-in-knowing, on expanding the library of plots for interpreting distress, and on the exploration of alternative problem-solving strategies.

(Sarbin, 1997: 241; original emphasis)

This contextualist, narrative-based approach radically challenges dominant diagnostic practices which promote the medicalization of human distress. (For another narrative approach to ‘psychosis’, see White, 1995: chap. 5). Sarbin’s overhaul, however, does not suggest that clients should never be categorized for ‘diagnosis’ or treatment; there is no suggestion that clinicians are redundant. Although Sarbin does not directly address the issue of professional-client power asymmetries, he does propose that clinical activities be so altered as to acknowledge the central roles of agential acts, morality, and responsibility in the categorizing and treatment of unwanted conduct.

Sarbin has also applied the contextualist approach to ‘hallucinations’ (Sarbin & Juhasz, 1978). The phenomena in question are seen as reported imaginings (ie, doings)
rather than merely intrapsychic events (ie, mentalistic happenings, within an individual). As doings, we must consider the roles of the imaginer and the roles of the other/s; the potential patient and the diagnostician. These roles are reciprocal: each actor requires the other. Furthermore, “hallucinations yoke together two processes, a self report or other conduct on the part of one person, and the moral judging of that behaviour by another” (p. 122).

‘Hallucinations’ are, thus, “one of a family of interpersonal events where the actions and/or experience of one person is discounted by another”. For example, compare the statements ‘A: I am dreaming’ vs ‘B: I am awake’. Similarly, there is ‘A: I am hallucinating’ vs ‘B: I am perceiving’. In each case, Statement A is self-contradictory because a person who is dreaming or ‘hallucinating’ is not in a position to claim legitimacy as a speaker who is telling the truth; another person is required.\(^2\) The Statement Bs are not self-contradictory. As soon as we transpose the Statement As into the second person the statements lose their oddness: ‘You are dreaming’, ‘You are hallucinating’. When we become even further removed from the person in question, with a third person statement such as ‘He/she is hallucinating’, the impression is one of even greater objectivity (just as in professional psychiatric reports). Thus, an impression can be given in which the judgment has no apparent effect on the person being diagnosed; it is passed off as a simple truth. But what else do these actions conceal?

\(^2\) It is interesting to note that, thus far, in terms of provability, dreams are just as problematic as ‘hallucinations’. The authors’ other examples, such as lies, insanity, and not making sense, all fall into this category. Later in the paper, a host of other imaginings are mentioned (eg, ‘An artist says that he is painting from a picture in his mind’), all of which are equally self-contradictory when taken as intrapsychic events. Thinking and remembering are also discussed in this light. The doings of thinking and remembering, however, do not necessarily carry such negative evaluations (of the actor and the act) as ‘hallucinations’, lies, insanity, and not making sense.
Sarbin and Juhasz demonstrate, from what amounts to a social constructionist position, that we use the word and concept of ‘real’ to indicate a preference for (to privilege) one “fictive perspective” (construction) over another. Thus, someone can be rendered as being ‘out of touch with reality’. As an action, ‘reality’ status can be bestowed on either version, depending on prevailing social contingencies:

When a patient says, “I see pink elephants,” the psychiatrist declares, “Since there are no real pink elephants in my office, the patient is hallucinating.” To use our analysis, to say “no real pink elephants,” is only to direct one’s attention to the fact that the patient is referring to imaginary pink elephants. Imaginary pink elephants are as “real” as any other elephants. Note the following examples:

...[i.] This is a real circus elephant here in my office, not a mere imaginary elephant.

...[ii.] This is a real imaginary elephant here in my office, not a mere circus elephant.

The context of say “a real imaginary elephant here in my office” is the psychotherapist’s use of guided fantasy to treat a patient with pachyderm phobia. The psychotherapist is no more or less out of touch with reality than the spectator at the circus.

To say the hallucinator is out of touch with reality is to say no more than the hallucinator is not looking at phenomena from the same perspective as is the listener.

(Sarbin & Juhasz, 1978: 124; original emphasis)

This is the case, regardless of the degree of (inescapably represented) vividness of the perception, imagining, etc. And, in this privileging of one frame of reference over another, the role of the other (“the hallucinogenic other”, p. 127) is just as important in the construction of a ‘hallucination’ as is the reported imaginer: “it is the value judgment of the more powerful role partner which turns the reported imagining into a hallucination” (p. 127; original emphasis). Through this second person, the ‘reporter’s imaginings of...’ become content-free ‘hallucinations’. As a whole, with both actions,
“they are mutually excluding one another from their respective frames of reference” (p. 128).

Sarbin and Juhasz go on to describe the various functions which these roles can perform, for each actor. Using various psychiatric and non-psychiatric examples, they also discuss the circumstances under which the “transvaluation of social identity” (p. 129) can occur. There are, for example, “achieved roles (roles which are chosen by the actors)” and there are “ascribed roles (roles which are chosen for rather than chosen by the actors)” (p. 129; original emphases). Here is a summary of the key result and the key antecedent:

The result of the transvaluation is the assignment of the actor to a non-person status, variably labelled mental illness, insanity, or madness, or possible mental illness, insanity, or madness. If such assignment to non-person status has not been made, the reported imaginings will be classified as fantasy, pre-occupation, meditation, play, religious exercise, idiosyncratic conduct, comedy, creative achievement, or any one of a number of other excuses for lapses of attention to the requirements of social role enactment.

(Sarbin & Juhasz, 1978: 133)

The key result, then, is the assignment of non-person status and the key antecedent is the violation of social norms. That is, diagnostic labels come after the person has been otherwise ear-marked due to non-conformity. Otherwise, the reported imagining could just as readily be taken as a metaphor. Appeals to the logical equality of imaginings and metaphor can be used to attest to the nonsense of claiming that diagnostic criteria can be applied without considering the contents of the ‘hallucinations’ and without first morally judging the patient’s conduct.

Besides Sarbin and Juhasz’s argument that there is “a negative valuation on the reported imaging and, by extension, on the imaginer” (p. 129), their discussion of some of the degradations which occur with ‘the transvaluation of social identity’, their
mentioning of the “warehousing or rehabilitating [of] those whose humanity has lapsed” (p. 131), and their brief stating of “the non human role of mental patient” (p. 139), Sarbin and Juhasz do not, as far as I am aware, further justify their use of such a strong term as ‘non-person’. Perhaps chapters 6 and 7 of this dissertation go some way further towards substantiating the degree to which psychiatric patients may be made questionable as (rational) human beings.

What implications does this kind of representation of ‘hallucinations’ have for treatment? Due to the generality and other limits of social communication, reported imaginings - translations from the ‘imaginal mode’ to figures of speech - are readily open to misinterpretation. In psychiatry, “[t]he diagnostician who labels another as hallucinator fails to recognize that the actor is attempting to translate his imaginings from a special perspective” (p. 139; original emphasis). To use a diagnostic label such as ‘hallucinating’ or ‘deluded’³ constructs the phenomena as being both intrapsychic and pathological. A more respectful and useful approach would be to confer legitimacy on the person and their reported imaging. Through a willingness to consider the other person’s perspective, the role relation does not come under (further) strain: “The “cure” would not consist of convincing the woman to overcome her “delusion” but rather of helping the two actors establish new role relations which would be compatible with their presently existing statuses” (p. 139). Thus, taking on the role of ‘spirit guide’ or ‘medicine man’ may be more appropriate than ‘psychiatrist’ or ‘psychologist’. Such roles, as part of the proper occasions for “rites du passage” (and the new perspectives which are explored therein) may assist rather than freeze or demolish the person’s ability to shift to using more socially acceptable perspectives.

In sum, whilst it retains a role for some kind of professional expert, and whilst some people (on either side of the biopsychiatry debate) may take issue with equating voices
and ‘delusions’ to reported imaginings, the contextualist approach of Sarbin and colleagues has many merits, not the least of which is that it demonstrates respect for the views of the person in question.

Two renowned arguments which also strongly criticize ‘schizophrenia’ for the way in which it is a vehicle of social control are Szasz’s moral perspective and Laing’s existentialist perspective. There are many dissimilarities between these approaches, however. We shall begin with Szasz, who has considered both ‘mental illness’ generally (1961/1962) and ‘schizophrenia’ specifically (1976/1979). I shall focus on his work on ‘schizophrenia’, although the basic arguments - from whichever position, within the moral perspective Szasz adopted at the time - can be applied to ‘mental illness’ more generally.

Beginning with Kraepelin and Bleuler, Szasz argues that these clinicians did not discover the diseases for which they are famous; rather, they invented them. With a sleight of hand, these eminent clinicians turned away from seeking evidence in histopathology (the study of abnormal bodily structure) to finding it in psychopathology (the study of abnormal behaviour). To uphold this move one must believe in the sacred symbol of schizophrenia; one must believe in the supposed link, in ‘schizophrenia’, between certain behaviours and disease; one must not examine the evidence too closely. ‘Mental illness’, too, is a ‘sacred symbol’ and hospitalization and medical treatment of ‘mental illness’ are ‘ritual ceremonies’, for the same kind of sleight of hand is there also. In all of this, it is psychiatrists who occupy the position of priests. If one were to strip away the metaphoric and mythological character of ‘mental illness’ then the behaviours and misbehaviours of psychiatrists and patients would remain, but as economic, moral, political, and personal problems, rather than issues under psychiatric control.

3 Here, in their ordinariness and social-ness, ‘delusions’ are also reported imaginings.
Indeed, Szasz argues that the anti-psychiatry of Laing and Cooper merely replaces the metaphor of disease with a journey metaphor, which they use to justify their ‘treatment’ of ‘schizophrenics’, even though they also claim that ‘schizophrenia’ does not exist (1976: 74). That is: “Psychiatrists insist on seeing all schizophrenics, regardless of what they say or do, as sick and needing treatment for madness; anti-psychiatrists insist on seeing all schizophrenics, regardless of what they say or do, as tourists needing a journey through madness” (Szasz, 1976: 78). But is it not that Szasz also applies his approach (one that, ironically, has varied over the years) to all ‘schizophrenics’, so as to include them in the general population? All people are tarred with the same moral brush, as it were. But are there no other relevant categories to apply to people; special ones, for ‘mental illnesses’ (whatever they may be)? Szasz’s moral perspective does at least afford all ‘schizophrenics’ the right to free choice; for medical psychiatry if they desire it, for other ‘therapy’, or for no ‘treatment’. However, one of the most challenging aspects of Szasz’s civil libertarian approach is that it extends to the right to die, if someone so chooses. With this approach, a person can also be morally judged for all of their actions: ‘diagnosis’ is an irrelevancy.

If psychiatrists are ‘priests’ then what does Szasz propose to be the position of patients and their needs?:

Actually, in so far as the term “schizophrenia” designates some “problem” that an ostensible “patient” has, it refers usually to the fact that the “patient’s” life is disordered - that it is, or the “patient” thinks it is, aimless and useless. If so, it can no more be “cured” by journey than by drugs. Chaos, suffering, and turmoil can be remedied only by the subject putting his or her life in order. Whatever helps a person to achieve that goal will be “therapeutic”.

(1976: 74)
But Szasz does not only consider psychiatrists as if they are priests and he does not only consider patients to be people in disarray; he also sees them as if they are husband and wife, in holy matrimony:

The greatest symbolic and social power of “schizophrenia” lies precisely in its being inextricably tied to the idea of disease and the institution of medicine. Thus, an effort to offer a nonmedical model for schizophrenia is about as feasible, and futile, as would be the effort to offer a nontheological model for the Eucharist...

If we take the truly human, totally nonmedical, perspective on so-called schizophrenia seriously, it follows that what we need is not a model of the “patient” at all - whether of his brain, mind, or behavior. Instead, what we need is a model of the whole social situation or drama of which the relationship between the “schizophrenic patient” and his “significant others” is a part, and in which “schizophrenia” is somehow generated. We do not have to look far for such a model. I shall try to show that marriage - especially of the traditional, arranged sort - supplies us with a powerful paradigm for interpreting the psychiatrist-patient relationship. In this scheme we shall view the psychiatrist as the husband, the psychotic as the wife, and schizophrenia as the diagnosis/child...

(Szasz, 1976: 141-143)

Indeed, Szasz goes on to argue that, just as mating is both the cause and consequence of marriage, so is ‘schizophrenia’ the cause and consequence of psychiatrists and their patients. It is not that ‘schizophrenics’ are a problem for psychiatrists to solve; they are both part of the complex; both part of the problem of social control. Unless one wants the sociocultural complex of psychiatrists, patients, and their ‘mental illnesses’ - for social control - then none of them need exist. Remove one and you remove them all. It

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4 Perhaps this is similar to the symbiotic relationship which I propose to exist between ‘normal’ and ‘abnormal’ (conceptually and in the data-at-hand) and between therapist and patient.
is not that those people who would otherwise be diagnosed suddenly have no problems, just that they were never of (purely) physical origin. No lesion has been discovered for ‘schizophrenia’, nor for any other ‘mental illness’, because such ‘illnesses’ are not of (purely) physical origin; they are not illnesses, they are metaphorical maladies of the mind; not disease(s) of the brain. These are entirely moral issues, and not the rightful province of medicine. According to Szasz, in psychiatry, especially when treatment is in any way coerced, medical treatments are a tool for social control. Furthermore, they are the wrong tools for any of the jobs which ought to be done concerning behavioural issues. If people want to sort out their lives then they can seek and receive help for that. If people have personal differences then they can be dealt with in the usual way for resolving disputes. If a crime is committed then that is a legal issue (/complex).

One of the most common criticisms of Szasz is that he presents a black-and-white, unsympathetic version of ‘mental illness’. Along with this conclusion, whilst acknowledging that ‘schizophrenia’ may be best understood, for some people, as a problem with social relationships, Gosden (2001) suggests a renewed understanding that most ‘schizophrenic’ people are experiencing a spiritual/mystical emergency. He holds that Szasz’s arguments undermine the experiences of people in a mystical emergency by maintaining that all ‘schizophrenics’ are simply cultural outsiders (ie, people without other problems except not quite fitting into cultural norms), scapegoats (ie, those who are culturally ‘normal’ but in a stressed group of people), or role-players (those who simulate ‘schizophrenia’). However, I take it that the notion that a person’s deviance

Note that the bracketed insertions of the term ‘purely’ are my own. They may be straying a little from Szasz’s black-and-white approach. However, I add them to future-proof his arguments against some kind of anatomical or biochemical ‘discovery’ which could be claimed to ‘cause’ a ‘mental illness’. What I am saying is that, regardless of any ‘discovery’ of the (holy) lesion, ‘mental illness’ can never be demonstrated to be of purely physical origin; it is a complex, through and through.
from social norms and role-playing can lead to a psychiatric diagnosis would also apply to those with the added difficulty of a spiritual crisis and/or psychobiological ‘issues’.

Bentall also concludes that Szasz’s position is oversimplistic, but from a more mainstream, cognitive point of view. For example, Bentall and Pilgrim (1993) argue that it may be perfectly valid to consider an impairment of psychological function to be ‘illness’, without evidence of physical dysfunction. They also criticize Szasz for an implicit dualism; for distinguishing too sharply between the physical and the mental; and for not recognizing that the psychological can affect the physical and vice versa. Surely though, like ‘schizophrenia’, this psychological ‘illness’ can only ever be a metaphor - whether or not Bentall and Pilgrim care to make it explicit and whether or not they hold realist views concerning ‘things’ like cognitions. That is, Szasz’s position on ‘mental illness’ being only ever a metaphor still holds.

Bentall and Pilgrim’s other criticism of Szasz’s approach is that psychiatry should not be singled-out as being value-laden, since all judgements of pathology have moral and social aspects, as do all judgements of positive changes in the mind/body, even judgements of happiness. Coulter (1979: 143) also points to illness being a “culturally-relative state”; that “deviation from a physical norm ‘is in itself neither a necessary nor sufficient condition of being ill’” (citing Moore, 1975). He also distinguishes between disease and illness. But we may see that physical medicine is not so value-laden that inter-personal factors are able to typically conceal the absence of biological signs of disease for a given diagnosis. And, in the case of ‘psychological impairments’, who is to judge which aspects of being are impairments and how? Applying the same considerations to physical illness and ‘mental illness’, we find that both have psychological, social, and moral aspects, but that, to-date, there is only firm evidence of a marked physical impairment in physical illness. Hence, I do not use inverted commas when it comes to physical illness. Why then should we consider ‘mental illness’ to be,
above all, an illness? Is it not, as Szasz maintains, merely the application of a powerful, carefully hidden, and unsubstantiated illness metaphor? Even if this is only partly the case, and even if we do not subscribe fully to Szasz’s libertarian position, then shouldn’t we consider the phenomena in question to be rather different from, simply, ‘mental illness’?

Laing’s existentialist perspective is one which also targets ‘schizophrenia’ as being a matter of social control, but in quite a different way to Szasz. For example, according to Laing (1967), ours is a society in which we are increasingly alienated, from one another and from ‘true’ experience. This is supposedly ‘normal’. But social adaptation to a dysfunctional, pseudo-sane existence in a ‘sick’ society and its maladaptive families is dangerous. Rather than fitting in with the dysfunction, people who are labelled and ‘treated’ as ‘schizophrenics’ are on the margins of society.

Instead of such madness, according to Laing, these people should be assisted from their alienation, so that they can complete their existential journey from ‘objective’ outer reality into ‘subjective’ inner reality; to return with enlightenment. ‘Schizophrenic’ people are exceptional for having undertaken such a voyage, which, if successful, can bring resolution. Their journey is the potential solution, not the problem. But, according to Laing, it is not a journey which must be done with kicking and screaming, with distress, for anyone involved. This natural process need not be a struggle, it need not be so incomprehensibly ‘mad’, so frustrated by ‘treatment’. With appropriate help - not medical psychiatry - there is a better way.

In this (version of) anti-psychiatry, then, it is society which is ‘sick’, not ‘schizophrenics’. How does this compare with that other psychiatrist, Szasz? Both

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6 Szasz himself rejected the term ‘anti-psychiatry’ as part of his criticism of Laing’s approach (1976: chap. 2). Many a commentary, however, links the two approaches under the heading of ‘anti-psychiatry’.
approaches hold ‘schizophrenia’ to be a product of social control. Both argue that ‘schizophrenia’ should not be treated like an illness of physical origin. But there are major differences. Szasz’s approach maintains that - on social, moral, and libertarian grounds - people who would otherwise be psychiatric patients had better be left to live their lives as they see fit, because they are just like anyone else. That is, ‘schizophrenic’ is not a valid category, whatever name it is given and whatever theoretical framework is used to support its delineation. In contrast, Laing argues that - on social-phenomenological and moral grounds - ‘schizophrenics’ are an exceptional group of people who are undertaking a special process which should be helped. Indeed, Laing and his colleagues set up refuges/asylums/communities in which to guide people through their journey. Thus, with Laing, although ‘schizophrenia’ has been re-evaluated - some would say romanticized - as (potentially) positive, it still exists as a category, although it has a different theoretical framework to biopsychiatry. And these ‘schizophrenics’ require a ‘treatment’ of sorts, in an institution of sorts. With Szasz’s libertarian approach, people who would otherwise be diagnosed but are not a danger to others are more or less left to fend for themselves, along with the rest of society. There is little or no assistance from the State for anyone who experiences hard times. Laing, on the other hand, advocates that ‘schizophrenics’ should be helped through what he takes to be their existential journey; in the best interests of the patients and society.

Both of these approaches have been strongly criticized as idiosyncratic and extreme. Perhaps, though, it would be a mistake to discard the work of Laing and Szasz simply because of their 1960s veneer. Both stances offer valid and powerful critiques of medical psychiatry and they both (more or less) offer something to go, or not go, in its

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7 I appreciate that Laing’s position changed somewhat over the course of his career but my summary review turns to Laing (1967) to compile a broad overview of his approach.
place. (See also Parker et al., 1995, Gosden, 2001, and Georgaca, 2001, for discussions of anti-psychiatry).

This is certainly not a position adopted by Coulter (1973, 1979). Coulter’s (1979) chapter on ‘The metaphysics of mental illness’, is offered by him as a sifting of the (metaphysical) chaff from the (social practices) wheat of arguments on ‘mental illness’. He describes how, with his line of ethnomethodological inquiry, “the pit-falls of mentalist metaphysics and psychologism are avoided” (p. 153) and the incontrovertible conceptual problems of Szasz’s and Laing’s arguments are made clear.

On the one hand, Coulter’s version of conceptual-ethnomethodological inquiry should be applauded for its focus on, professional and lay, ordinary action concerning ‘mental illness’. With this, comes an appreciation of especially mundane forms of diversity (p. 148). Nevertheless, Coulter can be criticized for his failure to acknowledge the analytic relevance of what might be taken as a wider social and cultural context. That is, with its particular kind of interest in non-mental accounts of ‘mental’ phenomena (see also Coulter, 1999; Potter & Edwards, 2003), Coulter’s brand of ‘pure’ ethnomethodology entails a somewhat abstract, head-in-the-sand approach to ‘mental illness’.

For Coulter, positions which ‘assume’ psychiatrists to be taking literally a metaphor of ‘mental illness’, invoking a hypothetical disease, and/or invoking an actual disease concept (the general positions of Szasz, Scheff, Binswanger, Laing; and Sarbin; respectively) are all assigned to the category of being “polarized”, “unproductive”, and “confusing” in our making sense of ‘mental illness’ (p. 140). Instead, Coulter’s focus is on “the practical, daily work of psychiatric diagnosis as a part of the organized systems of psychiatric work” (p. 144). In this consideration, he makes various distinctions between uses of the terms, ‘illness’ and ‘disease’, and argues that ‘the concept of ‘illness’ does not entail any reference to a biological or physiological state, but rather
operates as a signal for states of personal incapacity which **might have** some biological foundation” (p. 143; original italics; my emboldening). But is not Coulter building on orthodox assumptions concerning the existence and nature of “states of personal incapacity”? To what ‘incapacities’ does Coulter refer, and might not “personal incapacities” represent an individualism which is imposed onto those who have the least social power? Furthermore:

...it is useful to bear in mind the fact that mental-illness determinations do not invariably require any esoteric knowledge or equipment... We can thereby see how strange it is to propose that ‘there is no such thing’, or that we should ‘alter our ways of talking’. We can often see mental illness, sickness or disorder without special training and certainly without making biological commitments either to aetiology or therapy. ...We need to take full social responsibility for the state of our psychiatry because the art of diagnosis is an art of cultural and civic competence which we share and make possible.

(Coulter, 1979: 150-151; original emphasis)

The implication, here, is that so long as there is a sufficient psychiatric, civic, and cultural *consensus* about the moral practice of diagnosing ‘personal incapacities’ and/or ‘deviant’ behaviour (the latter being a more socially-orientated term), then such practices should be sanctioned. It is ‘okay because we all do it’, as it were. But is that always a satisfactory and logically defensible state of affairs? And, leaving aside the earlier issue of metaphorical interpretations of ‘mental illness’, what, I wonder, should we make of the situated trade which is so often made from references (taken as implicit and/or explicit) in psychiatric discourse to **actual** medical illness and **actual** medical disease, which have a proven biological foundation? Would Coulter deem such questions to be realist and irrelevant to his ethnomethodological program? And can/should invocations of ‘mental illness’ as illness be sufficiently understood without linking them, *in the analysis*, to wider social discourses and wider social consequences?
There are, for example, the conceptual analyses and discussions of Boyle (2002a, 2002b) and the situated data-based analyses and discussions of this dissertation, which include criticism of psychiatric practices which present ‘mental illness’ as being related to physical illness. There need be no analytic realist assumptions in these lines of critique but Coulter’s arguments could be wrongly applied to undermine them also. Surely such analyses and discussions are relevant to a purely non-mentalist account of ‘mental illness’? Coulter (1979) renders psychiatric diagnostic practices as being understandable as social action. I agree, in so far as that goes. However, by *not* including wider cultural considerations *in the analyses*, Coulter does not go far enough, and, by implying that *all* critical references to ‘mental illness’ are unproductive and confusing, he goes too far.

Let us look at some more of Coulter’s contributions. With his main argument, he effectively claims to dismiss the foundational positions of Szasz, Laing, and Sarbin, as we shall soon see. In this, with the under-representation of the positions which Coulter seeks to undermine and the privileging of his own position, he goes too far. Having successfully argued that ‘mental illness’ is based on context-dependent judgements about conduct, Coulter holds that it is illogical to then conclude that ‘mental illness’ does not exist: “the phenomena of intelligence and mental illness are not *ostensively* definable like stones and tables; but only by reifying the notion of ‘phenomenon’ could we arrive at a position which argued for their non-existence” (p. 147; original emphasis). Nevertheless, I suggest that, in line with Boyle, it is logically defensible, without relying on realist assumptions about the existence or non-existence of *mental illness*, to criticize accounts of ‘mental illness’ which imply that the ‘phenomena’ in question have a primarily *physical* basis but where no such physical basis has been demonstrated. Furthermore, arguments which are compatible with social control representations of ‘mental illness’ need not promote the reification of ‘illness’. For
example, in an extension of Boyle’s (2002b) arguments about ‘schizophrenia’, one can apply to all ‘functional mental illnesses’ (ie, where there is no biological sign of pathology) the same criteria which medicine applies to the concept of physical illness, and find ‘mental illness’, as an illness, to be wanting. This can be done whilst maintaining a position that both kinds of ‘illness’ are constructions, but that physical illness is the more defensible as a scientific concept in terms of inferring an instance of ‘it’ (as a construct, note) from an evidenced biological dysfunction.

Coulter’s arguments, however, even go some way towards justifying psychiatric diagnosis; as a situated social action, but justification no less: “does the absence of generalized, context-independent criteria for mental illness (of the ‘functional’ kind) signify that psychiatric diagnoses are predicated upon an unjustifiable subjectivity?” (p. 144; my emphasis). It is true that Coulter cannot be accused of in any way concealing the evaluative, normative, moral work which all diagnoses perform (pp. 145 & 152). Coulter, in his discussion, also takes note of the questionable practices of Soviet Union psychiatrists (p. 151) and in various arenas of Western psychiatric practice. Nevertheless, my point is that, since Coulter’s arguments summate to answering his question (about objectivity and subjectivity) in the negative; since he does nothing in his analyses to render psychiatric diagnoses, per se, as being questionable; and since he does not include any critical analyses of actual data of diagnostic procedures, then psychiatric diagnoses are provided with some justification.

Coulter (1979) argues that “[p]sychiatric diagnoses are not poor cousins of physical diagnoses, for they do not belong to that family of practices, however ‘medical’ are some of the consequences. Rather, they are members of that cluster of ascriptive practices in which assessments of conduct and beliefs are made” (p. 149). In its social constructionist stance I see nothing wrong with this. However, there is an act omission, here. Coulter does not highlight the fact that it is very often a Members’ concern (and
not just a critical researchers’ concern) to invoke the medical model-proper in connection to ‘mental illness’. It is, thus, Members who have taken ‘mental illness’ into the family of practices which make up physical medicine. Is it illogical to judge those who invoke ‘mental illness’ on that basis, as Sarbin and Boyle do? But Coulter does not criticize, either conceptually or through interactional data, the practices of those who claim or imply that psychiatric diagnoses stand alongside physical diagnoses. Nor does he criticize the concomitant social evaluations of psychiatric patients which are warranted through such practices. Plus, there is another act of commission with which I take issue: in not being “poor cousins”, the implication is that psychiatric diagnoses are not poor at all. That is, Coulter’s actions, on the whole, amount to justifying ‘mental illness’. Thus, “the art of diagnosis is an art of cultural and civic competence which we share and make possible” (p. 151).

In sum, the implication of Coulter’s consideration of ‘mental illness’, as it is presented in practice, is that he has successfully dismissed Szasz, Laing, and Sarbin’s entire approaches; that only those matters which Coulter goes on to consider to be ethnomethodological ‘wheat’ rather than metaphysical ‘chaff’ are relevant to a logical consideration of psychiatric diagnostic practices; and that morality is not an issue to be successfully intertwined with analytic methodology. However, Coulter fails to mention that there can be valid, critical, discursive analyses of accounts about ‘mental illness’, hypothetical diseases, and actual disease concepts, which do not entail analytic recourse to metaphysics. Coulter isolates his analyses from issues of social justice, and - paradoxically given his stated aims - in some ways he favours conceptual issues over issues of practice. I regard these as noticeable and notable failures, and this dissertation hopes to contribute towards their rectification.

Another alternative way of representing ‘schizophrenia’ is the phenomenological perspective. Sass (1992) likens what he takes to be the experiences of ‘schizophrenia’ to
the works of various modernist and postmodernist artists and writers. Sass (1994) likens ‘schizophrenia’ to the kind of solipsism of which the philosopher Wittgenstein critically wrote. Wittgenstein is also highly critical of philosophical abstraction (Sass, 1994: 8-10, 34; Coulter, 1979). Indeed, Wittgenstein likened such metaphysical conjectures to madness. Thus, Sass considers a “solipsistic interpretation of schizophrenic experience” (1994: 51); “the inner world of insanity” (p. 2); “phenomenological peculiarities” (p. 12); and some of the behaviours which ‘follow’. The classic ‘schizophrenic’ case from which Sass extensively draws is that of Daniel Paul Schreber:

I argue that, despite the great importance he attributes to them, Schreber does not generally experience his delusions as being literally true but, rather, as having a certain “subjectivized” quality - that is, as being in some sense the product of his own consciousness rather than as enjoying an independent or objective existence (as the poor reality-testing formula implies). His mode of experience is in fact strikingly reminiscent of the philosophical doctrine of solipsism, according to which the whole of reality, including the external world and other persons, is but a representation appearing to a single, individual self, namely, the self of the philosopher who holds the doctrine (claiming, for example, that only his or her own feelings and perceptions are real).

(1994: 8)

Sass’s approach departs from orthodox psychiatry in his focus on what he takes to be the psycho-philosophical abnormalities which apparently underlie ‘delusions’. This opens the door for a greater, arguably empathic, understanding of patients’ experiences than psychiatry, which gives little heed to ‘content’. Sass’s proposal also departs from the reality-testing theories of mainstream abnormal psychology (psychoanalytic or cognitive). However, in contrast to the ‘normalizing’ aspects of Sass’s approach - in so far as he proposes a theory for understanding the experience of ‘schizophrenics’ - the underlying approach is founded on what I take to be a phenomenological de facto diagnosis of the ‘problem’: “the delusions and hallucinations recognized as being the
most characteristic of actual schizophrenics do not simply exaggerate but fundamentally distort, contradict, or call into question the normal human form of life” (p. 22).

Rather than typically confusing the real and the imaginary, as psychiatry would have it, Sass (1994: 21) argues that ‘schizophrenic’ patients operate a system of double bookkeeping: on the one hand, they have a set of ‘normal’, consensual, rational, reality-testing procedures for the objective world, whereas, on the other hand, those criteria are not applied to the imaginary world. That is, ‘delusional’ people do not generally mistake the content of their delusions for objective reality. But, according to Sass, they are abnormal: “In my view, the experience of many schizophrenic patients involves not an overwhelming by but a detachment from normal forms of emotion and desire, not a loss but an exacerbation of various forms of self-conscious awareness” (p. 12). Thus, people with ‘schizophrenia’ are afflicted with a kind of hyperrationality; “a state of passive hyperconcentration” (p. 39); an “epistemological centrality” (p. 123).

There are differences, here, compared to accounts of mundane reality testing which imply quite the reverse of Sass’ position on ‘delusions’ and hearing voices and yet still present the person in question as ordinary (see Chapter 5 of this dissertation, on Leudar and Thomas, 2000). The following extract from Sass can also be considered in this light:

Bearing this felt innerness in mind, one can understand why auditory hallucinations often have more the quality of something thought than of something heard. And one can comprehend how patients could “hear” the voices of absent people without finding the phenomenon strange.

(1994: 43; my emphasis)

In contrast to Sass, Leudar and colleagues’ empirical studies of reports of hearing voices experiences, in both the diagnosed and the non-diagnosed, point to the perplexing character of voices for most voice hearers (see Leudar and Thomas, 2000).
Sass attributes the ambivalence in ‘schizophrenia’ - between, say, the incorrigibility of delusions and the acceptance that they are not real - to a self-refuting paradox which plagues solipsism and ‘schizophrenic’ quasi-solipsism, where “everything can be both ‘real’ and ‘unreal’, both ‘inner’ and ‘outer’, both ‘subjective’ and ‘objective’”, an “impossible universe, where everything is felt to belong to the self, yet where there may be no self to possess it” (1994: 52). Given this paradox, one apparently internally consistent solution is to bracket the real; to accept that no solipsistic view can be proven, with internal consistency, to another (person) (p. 53). However, the philosophical problem does not go away, such is the paradoxical plight of a subjective vision which is experienced as the origin of all ‘things’: “The solipsist - to borrow one of Wittgenstein’s many metaphors for the futility of such metaphysical claims - is like someone who tries to measure his own height not by using an independent reference system but by placing his own hand on top of his head” (p. 56). An unholy equivocation between the subjective and the objective is the inevitable result.

Besides the fascination which comes with Sass’ approach, it remains, paradoxically, a phenomenological abstraction. It is, after all, professional psycho-philosophical conjecture about the experience of ‘schizophrenia’, rather than there being a focus ‘from the point of view of’, or even about, the actual reports of those who experience the phenomena in question. Furthermore, despite (or perhaps because of, given the paradox) Wittgenstein’s contention that solipsism is a key example of a “metaphysical or philosophical disease, a disease born not out of ignorance or carelessness but of abstraction, self-consciousness, and disengagement from practical and social activity” (Sass, 1994: 8-9), Sass’s approach takes no account of social interactional factors in the (co-)construction of reports about psychiatric ‘symptoms’. There is also the common

8 There are the practical tensions which ‘delusional’ people have in presenting themselves as rational so as to undermine (potential) negative social evaluation. See Chapter 5, on Harper (1999).
charge of ‘Where is all this supposed understanding taking us?’ What are the current and potential outcomes of such a psycho-philosophical enterprise? The following, though, seems clear. Although Sass locates the problems of ‘schizophrenics’ in phenomenology, the issues of ‘normality’ and ‘abnormality’ are no less problematic than in orthodox psychiatry. And, in connection to this conundrum, with the furtherance of Sass’ perspective, there would always be the continuing need for dominant professionals.

Johnstone (eg, 2000) provides us with a consideration of psychiatry in practice. To be more precise, the approach relies on Johnstone’s accounts of psychiatric practices and patient cases. This includes a detailed, functional-systemic consideration of the roles which patients and staff adopt within psychiatry; the role which psychiatry plays within society; and the influence that families, relationships, and wider social factors have on (potential) patients. With this “whole-person, whole-system” approach, Johnstone makes extensive use of real-life examples to illustrate ‘mental’ distress and responses to distress from a psychosocial rather than a medical point of view.

In an introduction to what I take to be the question ‘what is the problem?’, Johnstone describes six different (but not mutually exclusive) groups of patients. The groups are delineated according to the way in which they use services and the way in which services typically respond:

1. There is a group of people who are asking for help with problems that are really relationship and family issues...

2. There are people who ask for help with problems which, while still involving those around them, are not primarily to do with current partners or family relationships.

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9 This is my term, here. There is no recourse to any formal systems theory, as Johnstone keeps practice firmly in her sights.
An example might be someone who has been bereaved, or who is a victim of rape or sexual abuse, or who has had an accumulation of stressful life events.

3 There are other people who, usually for lack of alternative options or more appropriate forms of help, opt for the career of psychiatric patient as the only escape from painful situations in their lives.

4 There are those who use the hospital or out-patient services mainly to meet social or economic needs, perhaps because they are lonely and isolated or have no suitable place to live. Hospitals may also be used for what is often called ‘time out’, or respite. For example, an exhausted mother might come in for a break, or a disturbed adolescent might be admitted for a week mainly to relieve his parents. However, pressure on beds means that such admissions are far less frequent than they used to be.

5 There is a group of people who are suffering from conditions of definite physical origin, such as senile dementia, Huntingdon’s Chorea and severe head injury.

6 Finally, there are more extreme examples of the first category, where family relationships are so intense and entangled that one person in the system breaks down very severely.

(Johnstone, 2000: 19)

A diagnosis of ‘schizophrenia’ is often used to describe people who are in the sixth group. Johnstone considers these groups in detail, from a functional-systemic point of view. She repeatedly points to ways in which medico-psychiatric responses to largely psychosocial problems tend to result in exacerbation rather than remedy. Although the patients, families, psychiatric staff, and society, all have certain needs met through the application of the medical model, important psychosocial factors are not being addressed in psychiatry.

The Rescue Game (from the Transactional Analysis school of therapy) illustrates the kinds of problematic roles adopted by some psychiatric staff and patients:
In psychiatry, the switch from Rescuer to Persecutor, from ‘this patient is mad’ to ‘this patient is bad’ is seen all the time. Some people present themselves as Victims at first assessment. Some are pushed into the Victim role by the process of medicalising their problems and gradually become more helpless and dependent on the psychiatric system, which in turn gradually becomes more Persecutory as harsher remedies are tried out.

(2000: 25)

Typically, at almost every step, this medicalizing of the ‘problem’ results in the patients taking, and being afforded the agency to take, less and less responsibility for their actions and recovery. An external solution is privileged but it is seldom actually forthcoming, in practice. The person is described as going deeper into an institutionalized Victim role, which merely elicits further medical treatment or a denial of services. Such institutionalization renders the person less able to live in the wider ‘community’. Thus, once such ‘sick role’ patterns become entrenched, the prospect of recovery slips further and further away. And throughout all of this, emotional and relationship problems remain and are even reinforced. We may see that parts of this understanding are not dissimilar to aspects of Szasz’s moral approach.

Family management and cognitive approaches are seen by Johnstone as partly challenging and partly complementary approaches to medical psychiatry. Crisis intervention is an alternative that is conducted within the psychiatric system and the hearing voices movement is an alternative in which users and ex-users challenge psychiatry from outside the system.

In a continuing shift towards what I take to be the question of ‘why is there (still) a problem?’, Johnstone also considers the role of gender in psychiatry, the impact of the way in which the various psychiatric professionals are trained and positioned, the official and unofficial history of psychiatry, and the interests behind the pharmaceutical industry and other physical treatments such as ECT. She concludes that the status of ‘mental illness’, as an illness, is unsupported by the evidence. Current physical
treatments in psychiatry represent qualified advances over those of the 19th century, in theory, but not in practice. Drugs can play a useful role in treating ‘mental illness’ but they should not be allowed to dominate our response to ‘mental’ distress. Some of the limitations of psychopharmacological treatments are their limited positive main effects, their negative main effects/side effects, and the fact that they do not address underlying psychosocial issues.

The other two pieces in this consideration of ‘why is there (still) a problem?’ are resistance to change in the system and the relationship between psychiatry and society. In this whole-person, whole-system approach, such considerations allow further appreciation of the issues surrounding the question of ‘what is the problem?’: there is no clear distinction between the ‘whats’ and the ‘whys’. We can now perhaps recognize more of what various parties stand to lose if ‘mental’ distress ceases to be presented as ‘mental illness’. Psychiatrists and their professional supporters stand to lose credibility and social power over patients and other staff. Families and society also stand to lose the medical psychiatric methods of social control over patients. And patients lose the limited-responsibility role to which they have become accustomed and which at least afforded them some kind of assistance. All of these factors contribute to inertia rather than progress.

Johnstone notes that, to counter such resistance, there are examples of patients who, after some time, dramatically ‘improve’ following their reintroduction to personal and social responsibility. In particular, there are the patients of Foudraine (1974), in the US. In line with such underrated psychosocially orientated approaches, there are also the successful examples of crisis management by Scott in the UK; the well-documented but largely ignored successes of Mosher’s Soteria Project and the other Soteria-type “healing social environment[s]” in the US (1999) (see also Mosher & Burti, 1994, and Mosher, 1996); and the evidenced but ignored psychotherapeutic approaches which
have been successfully trialled in several Scandinavian countries (eg, Alanen, Lehtinen, & Aaltonen, 1991). All too often, such projects are run by what amount to lone voices; voices who are eventually replaced by the orthodox servants of psychiatry and society. Along with these challenges to psychiatry, there is also feminist psychotherapy and the hearing voices movement.

Johnstone makes it clear that she is not stating that there is no such thing as (severe) ‘mental’ distress, that families have good reason to be concerned, that psychiatric staff are not wicked, that psychiatric treatments can be beneficial, and that patients are not simply and solely the victims of labelling, scapegoating, and political oppression. She does however hold that

...social and political factors are a crucial component of mental distress... [that] the maintaining of society’s status quo by labelling dissent as illness, is actually the major function that wider society, consciously or unconsciously, expects and demands that psychiatry should fulfil... [and that] the principal mechanism by which psychiatry performs its function of social control is the use of the medical model...

(Johnstone, 2000: 222; original italics)

With the use of the medical model in psychiatry, we do not need to look to history or to oppressive political regimes for cases of abuse: there is clear evidence of social control - for example, of women, ‘schizophrenics’, black people and other ethnic groups, and the working class - in contemporary Western society.

With regards to what Johnstone advocates as an alternative to medical treatments in psychiatry, she at least recognizes that psychotherapeutic approaches can also be used for social control. Formal counselling is not for everyone and (inter)personal support can be provided in a variety of different ways, such as self-help groups and/or the ‘simple’ process of respectful, compassionate listening. However, Johnstone suggests that talking therapy can help shift the focus from ‘mental illness’ to psychosocial
concerns and macro social change, especially if there is a political awareness and professional assumptions are made explicit.

Finally, Johnstone considers a wider range of emerging psychosocial ‘treatment’ options and alternatives, which have already been tried and tested (some formally). There is, for example, the Soteria Project, the Northern Birmingham Home Treatment Service under the guidance of Sashidharan (Muijen, Marks, Connolly, & Audini, 1992), the Nafsiyat Inter-cultural Therapy Centre (Acharya, Moorhouse, Kareem, & Littlewood, 1989), community psychology (Melluish, 1998), and various groups and activities within the service user movement (eg, the Mental Health Task Force User Group, 1994; the Hearing Voices Network; Survivors Speak Out; the United Kingdom Advocacy Network; ECT Anonymous; and the National Self-Harm Network). All of these offer alternatives to a medically dominated approach to psychiatry. (See also parts 3 and 4 of Newnes, Holmes, & Dunn, 1999, for discussions of the service user movement and (other) beyond (biological) psychiatry approaches, respectively). Each of these projects is largely in accordance with Mosher’s philosophy of “de-medicalising, de-hospitalising, de-psychopharmacologising and de-professionalising” our helping of those in distress (Johnstone, 2000: 258). It is important that, at the very least, medical management is not always the first and overriding choice.

It remains a matter of much debate as to whether changes will be better performed from within or without existing mental health services and whether changes should be led by service users or professionals. Johnstone herself advocates a psychosocial focus, with an emphasis on psychotherapy and user-led initiatives, in preference to medication. Perhaps also, changes in the way we deal with ‘mental illness’ can be part of a wider social change in conjunction with other disadvantaged groups. Johnstone’s functional-systemic approach is surely a step in the right direction. Although not based on data-at-hand, the “whole-person, whole-system” approach to ‘mental illness’ and mental health
services provides a comprehensive critique of psychiatry as it is considered to occur in practice rather than in theory.

As we have seen already, in contrast to the perpetuation of normality-abnormality divides, some approaches advocate a greater emphasis on voice hearer perspectives and, thus, anticipate the end of professional dominance in constructing such experiences. In support of these approaches, it is important for professionals, patients, and the public to understand that reports of voice hearing do not necessarily reflect pathology, as a number of studies have made clear. For example: (a) hearing voices is not uncommon in the ‘normal’ population, with ranges of between 3 and 37% reporting experiencing the phenomenon at some time in their lives (Posey & Losch, 1983); (b) hearing voices may be a positive rather than a deeply distressing experience and it has been estimated that as many as 45% of voice hearers never come to the attention of psychiatrists (Tien, 1991; Barrett & Etheridge, 1992; Romme et al., 1992; Romme & Escher, 1993); and (c) there appear to be essentially no differences between the voices heard by ‘schizophrenics’ and ‘normals’ (Leudar, Thomas, McNally, & Glnski, 1997).

We are also beginning to learn more about the reported experience itself, from the perspective of voice hearers - with the acknowledgement that no experience can be separated from representational practices. For example, from Leudar et al. (1997) and Leudar and Thomas (2000): (a) voices are overwhelmingy not experienced by hearers as ‘real’, and hearers establish this through mundane reasoning strategies; (b) a consideration of the pragmatic properties of voices shows that they most often make mundane comments and regulate the hearer’s conduct; (c) voice-talk is not fundamentally senseless and is often clearly orientated to the immediate physical and social environment of the voice hearer; and (d) voices are rarely described as ‘irresistible’, but rather their influence is mediated by moral considerations on the part
of the voice hearer. I discuss further the work of Leudar and colleagues, presently, and in Chapter 5.

Coleman and Smith’s (1997) workbook is a practical example of adopting a voice hearer perspective. It comes from a collaboration between a voice hearer and ‘recovered’ psychiatric patient (Coleman) and someone with a background in mental health nursing (Smith). Theirs is a practical guide which is mostly made up of questions for the voice hearer to answer, with assistance from a chosen helper, as required. This encourages the voice hearer to learn to accept their experience of hearing voices and to learn effective ways of dealing with and using those experiences; ways which function within frames of reference other than the medical model. Thus, the aim is to become emancipated from relating voices to distress; from seeing voices as a pathology to be suffered.

Coleman and Smith’s (1997) work is born out of experience rather than research evidence. It is an example of the kind of approach which is taken by members of the Hearing Voices Network. The network comprises ‘support’ groups which are run for voice hearers and by voice hearers. Originating in the Netherlands, from the ideas of psychiatrist, Marius Romme, and voice hearer, Patsy Hage, there are now a number of groups in the UK. Both of these developments - the workbook and the HVN - represent significant progress in the re-humanization of voice hearers, with voice hearers firmly at the helm. Thus, hearing voices may be constructed in many different ways, to effect either the promotion of, or challenges to, the subjugation of voice hearers. The Hearing Voices Network and medical psychiatry offer markedly different approaches. The HVN

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10 As a representation of Hearing Voices Network practices the workbook is but one version. Indeed, this especially would be the case for any representation of such a user-group, which has distributed representations of experience across people, by definition. See also Coleman (1999), Blackman (2000), and Georgaca (2001).
promotes personal meaning and agency, along with the prospect of ‘recovery’ from, or the prevention of, a ‘psychiatric career’.

Romme and Escher were instrumental in establishing the HVN (eg, 1993). As well as working with service users, they also aim to enable professionals to assist voice hearers in accepting their voices and to develop an account of distressing voices which is grounded in the voice hearer’s life-experiences and personal philosophy, rather than psychopathology (eg, Romme & Escher, 2000). The voice hearer’s perspective is approached in terms of social psychiatry. There is a grounding in research concerning the problems that arise when one pathologizes voices and the benefits of uncovering the relationship between personal history and hearing voices. In short, it is proposed that the majority of voice hearers report having experienced traumatic life-events; voices and even ‘schizophrenia’ can function as a way of dealing with those experiences; and patients can benefit from the formulation of this connection between their voices and their life experiences and from having this link recognized - some even ‘recover’. As part of this, Romme and Escher favour a process diagnosis: a diagnostic procedure which establishes the order of events and their functional relationships, rather than the cross-sectional establishment of symptoms. This all seeks to place voices within an inter-personal context:

Psychiatry has followed the wrong line of reasoning when it conceptualised people’s reactions to certain problems as specific diseases. Psychiatry started to study ‘disease’ itself, instead of the spectrum of different reactions people may have to events that make them feel disempowered.

...Biological research can, indeed, play a part in all this. However, it will have to be a role very different from the one currently played by research institutes and the pharmaceutical industry. The focus of their enquiries would have to move to examining how the brain reacts to emotions and the processes which occur in parallel to the emotional reactions themselves and which may possibly fixate those reactions.
Romme and Escher suggest various procedures for diagnosis and for analyzing voices. The focus is on the voice hearer’s own account of their experiences, although these are gained through a semi-structured interview, compiled into a structured report, and developed into what Romme and Escher call a ‘construct’. The construct is a distillation of reported material, in the furtherance of, at an appropriate time, making sense of the voices by understanding their relationship to life experiences. Central concerns are: ‘Whom do the voices represent?’ and ‘What problems do the voices represent?’

The link between trauma and voices is, however, as Romme and Escher acknowledge, a largely psychological interpretation which may not appeal to everyone.

The process of intervention, as described by Romme and Escher, involves categorizing the experience of voices into three phases. The startling phase (sic) is when the person is still overwhelmed by the strange, new experience of hearing voices. The person needs to gain control over their voices and be more distanced from them. Anxiety management, coping/dealing with voices strategies, education about voices and ‘mental health’, trying medication, and support for the person and their family are all important here. This is suggested as a good time to do the interview.

The intervention focus is different for the second phase of dealing with voices. In this phase, the person is more used to their voices and they can be more experimental with how they handle them. This is suggested as a good time to discuss the report and to consider ideas for the construct; to explore the personal meaning of the voices. Besides the social-psychiatric perspective, Romme and Escher (2000) include relatively mainstream psychological approaches as examples of mid-term intervention strategies: decatastrophization and normalization (Kingdon & Turkington, 1994, 1996), focusing

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11 Thus, we have the job of how to represent voices so as to seek a better understanding of how the voices represent reported experiences and problems in the person’s life.
(Haddock, Bentall, & Slade, 1996), influencing beliefs (Chadwick & Birchwood, 1996), coping-strategy enhancement (Yusupoff & Tarrier, 1996), and re-authoring lives (e.g., White, 1995). Romme and Escher recognize that interventions involve pathological explanations of voices (pp. 98 & 107). Self-help groups are promoted in addition to “individual therapy and guidance” (p. 61). That is, in this professional approach, voice hearer’s theories, alternative therapies, and self-help, are used to complement or even supplant dominant psychiatric and psychological versions of events, depending on the voice hearer.

By the third phase, according to Romme and Escher, the voice hearer has built up a more balanced relationship with their voices; they can agree or disagree with what the voices say. Here, emphasis is placed on the need for a more stable sense of identity, which can be helped by negotiating a suitable construct. The importance of recognizing social disempowerment and assisting with developing the person’s social network and independence is also stressed.

This approach represents a remarkable, interwoven achievement: an approach which is inspired by the perspective of voice hearers, is written by psychiatric professionals for psychiatric professionals, and is about working with voice hearers and their voices from a research-based social-psychiatric approach. It includes other (close to dominant) psyche discipline approaches, and, above all, it seeks to respect the reported viewpoints of voice hearers themselves. Furthermore, as Romme and Escher put it in their call for a widespread “paradigm shift” re ‘psychosis’ (2000: 127), “there is no reason why we should not use this approach with other serious mental health problems”.

The pragmatic and dialogical approach of Leudar and colleagues complements the work of Romme and Escher and emphasizes how historically, culturally, and interpersonally, hearing voices experiences may be constructed as many different things (see Leudar and Thomas, 2000). These researchers provide an illuminating perspective
on hearing voices through the ages and by people in the present who do not necessarily find their experiences distressing. As with the latter two reviewed approaches, the focus is on voice hearers’ own accounts of their voices, in contrast to an *a priori* pathological approach.

What emerges from this perspective is an understanding that hearing voices phenomena can be many different things to voice hearers and that, currently at least, people who do not hear voices tend to describe them as pathological and dangerous. Voice hearers themselves may describe their voices as, for example, benevolent or malevolent; objective, subjective, or spiritual; a hallmark of madness or a guiding voice from the gods. Leudar and colleagues’ approach is pragmatic in that, rather than trying to establish an objective truth, it considers aspects of how various accounts can constitute hearing voices experiences differently and, thus, achieve different outcomes for voice hearers (and others).

Currently, dominant theories in psychology favour more or less pathologizing explanations in terms of failures in certain kinds of reality testing. This misses the fact that most voice hearers do not have problems with distinguishing between people speaking and hearing voices. Leudar and colleagues, instead, consider whether hearing voices may be a variety of the ordinary experience of inner speech.\(^\text{12}\)

Peg is a voice hearer who, with the help of dialogue with a mental health worker (Thomas) about how voices related to her life experiences, came to develop a more ‘integrated’ account of the voices in her life (Davies, Thomas, & Leudar, 1999) (see also Leudar & Thomas, 2000). Peg’s voices were worked with rather than on. The dialogical and pragmatic properties of the voices were explored along the way. Peg also began to hear a benevolent voice which assisted her with distressing voices. It is

\(^{12}\) Note that an explanation in terms of ‘inner speech’ can be constructed as pathologizing, ordinary, or a mixture of the two.
important to note that the dialogue with Peg is described as not being therapy, as it is commonly understood. It was not institutionally systematic, besides being somewhat conversational. Moreover, it was not done by someone to someone.

Leudar and colleagues have also given detailed consideration to the wider study of the contemporary, local, pragmatics of voices. This was first reported by Leudar et al. (1997) (see also Leudar & Thomas, 2000). Questions include ‘What are the features of voices and what they can they do with words?’ and ‘What do voice hearers say to voices?’. Some of the voice hearers had been diagnosed; others had never come into contact with psychiatric services. Results are largely consistent with an inner speech theory and with the notion that human experience (the self) is, more or less, dialogically organized (see Bakhtin, 1981, 1988; cited by Leudar & Thomas, 2000: 174).

We see more of Leudar and colleagues in the next chapter. However, perhaps the central message of this approach is that, whatever similarities there may be across voice hearer accounts, the very act of producing professional accounts of those voices takes the focus away from the personal and the interpersonal, away from context-contingent reports of the voice hearers themselves.

In conclusion, unless alternative approaches are given a hearing, the current biopsychiatric status quo will continue to dominate professional and lay accounts of distress and distressing behaviours, to the detriment of the broadness of human experience. With the exception of Coulter, each of these reviewed approaches challenge the current psychiatric hegemony, adding to the case that ‘schizophrenia’ is untenable as an illness/disease. Some of the arguments focus specifically on hearing voices or ‘schizophrenia’. However, it is also concluded that the medical model is far too excluding of important inter-personal factors for all so-called ‘mental illnesses’.

Despite such findings, however, presumptively pathologizing constructions of ‘mental illness’ and ‘schizophrenia’ continue to dominate professional and
commonsense views of the phenomena in question. The current hegemony is
maintained through systematic fact constructions in the preservation of social control,
professional power, and commercial gain. To counter this, a “paradigm shift” is
required (Romme & Escher, 2000: 27), to recognize the validity of critical and voice
hearer perspectives, to render them more widely as ‘respectable’ and no longer merely
‘alternative’. As we have seen, a number of critical researchers remain open as to
whether the medical model can operate as an as-needed, secondary measure, after more
psychosocial and less professional steps are first tried for most, if not all, cases.
Resolving the incompatibilities between medical and social approaches will, however,
not be easy, if at all possible. If our present understandings of the differences between
the psychosocial and biomedical approaches are anything to go by then notable tensions
are likely to remain.

The above challenges to ‘schizophrenia’ and ‘mental illness’ do not represent an
‘anything goes’ free-for-all. All of these approaches either have been, or have the
potential to be, validated empirically. Also, categorizations of the phenomena and even
the people in question are not entirely side-stepped. Sarbin and Juhasz, and Romme and
Escher, each make what might be taken to be socio-clinical judgements and each offer
alternatives to biopsychiatric diagnoses which are nonetheless still categorizations.
There are also the categorizations which Johnstone makes in terms of the ways people
use services and the ways in which services tend to respond. What, therefore,
characterizes the above critical approaches as being different from current, mainstream
professional approaches? It is important to recognize with these critical approaches to
the phenomena in question that the actions of professionals and services are just as
much if not more in question than the people who experience the phenomena. That is,
these critical approaches are not individualistic and they do not presume any kind
pathology (with the exception of Sass).
A recurring theme in many of these alternative approaches, not unrelated to my last point, is that the medical model tends to reduce personal agency. Another recurring theme is the importance of considering inter-personal context. This is perhaps most clearly stated in the contextual and voice hearer perspectives. However, the need to consider inter-personal context - to consider behaviour as social action rather than ‘symptom’, and to consider personal perspectives - is a feature of almost all of these approaches. These researchers, with the possible exception of Sass and Coulter, also promote personal agency. Both agency and a discovery of inter-personal context may be promoted through dialogue; dialogue between patients and professionals and between professionals. Through co-equal exchange, we can better learn about personal experiences and frames of reference other than our own.

As this chapter demonstrates and as is shown throughout this dissertation, there are many valid criticisms of medical psychiatry. However, the accounts reviewed here represent various emphases, varying degrees of respect and sympathy towards service users, and varying degrees of alternatives offered (compared to criticism alone). It is also abundantly clear that to search for a static, ‘winning’ representation of the phenomena in question would be a divisive and futile enterprise, given the variations in perspectives and reported experiences. Many people are not well served by current mental health systems, but there is no single or simple answer for how best to represent and deal with ‘mental illness’ and ‘schizophrenia’, besides the resounding need to consider personal perspectives and the need to consider behaviour as social action rather than ‘pathology’. It is clear that matters such as dialogue, macro- and micro-social context, and the perspectives of those who are most experienced with the phenomena in question are of much greater importance than is recognized by orthodox psychiatry and psychology. In the following chapter, our consideration of alternative representations of
psychiatric practices is extended to the literature on the discursive analysis of *actual* interaction which relates to people with ‘severe mental illness’.

Discursive approaches, with their focus on social action, can play a major role in exploring the empirical distinctions between accounts of ‘normality’ and ‘abnormality’ and between dialogue and ‘therapeutic’ practices. As this review has shown, it *stands to reason* that psychiatric practices are used for social control and that constructive practices are an inseparable part of that. It *stands to reason* that dialogue *between* co-equals contrasts with talking therapy interventions which are done by professionals to clients, given that psychiatry regards its patients as ‘mentally ill’. Thus, various kinds of interactional asymmetry *may* be taken to be privilege- and discrimination-in-action in connection to the pathology/sanity status of participants. Besides being less than respectful and perhaps not optimally helpful, the gross privileging of professional accounts *may* also contribute to wider damaging effects and the deleterious normative social control of the lives of those in question. The above alternatives to ‘schizophrenia’ have gone a long way towards arguing these points, as did my discursive analyses of *actual* professional texts in the previous chapters. However, the approaches in this chapter rely on the *conceptual analysis* of generalized professional accounts or professionally-rendered ‘cases’ of the phenomena in question. As such, the findings are somewhat distant from the actual data, if any, to which they refer. Can such findings be substantiated through the close analysis of *actual interactional data* concerning the phenomena in question? In the following chapter, we begin to address this issue by considering empirical evidence from *discursive studies* of ‘mental illness’, ‘delusions’, and hearing voices.
PART 2. THE PRODUCTION OF INSANITY: STUDIES OF PSYCHOTIC TALK

The language-game of reporting can be given such a turn that a report is not meant to inform the hearer about its subject matter but about the person making the report.

CHAPTER 5. INTRODUCTION TO DISCURSIVE STUDIES OF MADNESS

Here, I consider a selection of studies which focus on ‘severe mental illness’ as it is constituted in talk. My interest is in the various constructions of ‘mental illness’ and hearing voices which emerge from the participants’ and analysts’ accounts. Researchers such as Rapley, Antaki, and McHoul have begun to investigate interactions between professionals and people with intellectual disabilities (Antaki & Rapley, 1996; McHoul & Rapley, 2002; Rapley, 2004). However, there have, as yet, been very few discursive studies of interactions with that other highly marginalized group in Western society, with people who are typically described as ‘mentally ill’. Such approaches to studying ‘mental illness’ are characterized (with the arguable exception of Palmer; see below) as being distinct from studies which assume the presence of a ‘mentally ill’ person on the basis of ‘knowing’ who was in the room during the interaction. Similarly, discursive studies are also generally distinct from those which presume to know something about ‘mental illness’ on the basis of theories or facts which are externally imposed on the interactional data. However, none of the studies in this review are of actual clinical encounters between professionals and people who are diagnosed as ‘psychotic’, something which the following chapters aim to address.

One approach to studying ‘mental illness’ in talk is to analyze talk about ‘mental illness’. In such studies, the person in question need not be directly involved. A classic example of this is Smith (1978). Smith’s analysis turns on how an interviewee, Angela, constructs her friend, K, as having a ‘mental illness’ through a process of ‘cutting-out’
K from their social group.\(^1\) Through the analysis of interview transcripts, the interviewee is shown to explicitly categorize K as being ‘mentally ill’ and to present K’s behaviour as being ‘objectively anomalous’ as opposed to being ‘deviant’.\(^2\) One of Smith’s concerns is how the account is structured so as to direct hearers in what to believe, even before the presentation of evidence. Thus, *authorization rules*, “instructions about how the... [account]... is to be read”, render the interviewee’s account as “authorized as *that* version which can be treated by others as *what had happened*” (Smith, 1978: 32; original emphases). The account is constructed as the one and only factual version of events; a process which begins before what may be considered the account-proper has even begun.

Much work is done by Angela in the continuation of this effect, using various devices to lead the hearer away from more standard or default interpretations such as K having ‘rational’ reasons to act as she did (ie, a reasoning which is in touch with ‘reality’), towards an individualistic ‘mental illness’ interpretation. Various types of *contrast structures* (c-structures) are delineated by Smith in this regard. Additional witnesses are also recruited by the interviewee to these ends, and constructed as independent.

Below is a summary of one of Smith’s analyses of contrast structures. The extract from the interview transcript has already been split into two parts:

\[^1\] Of the studies I review, Smith (1978) is the only one in which the phenomena in question are not identified by the author as being to do with ‘delusions’ or hearing voices.

\[^2\] Note that this meaning of ‘deviant’ may be contrasted with that which Hester (1998) describes (see Chapter 2 of this dissertation). The ‘deviance’ described by Smith (1978) entails a common rationality with ‘mentally well’ people (ie, it is still within ‘normal’ parameters, in terms of ‘mental health’). However, although framed in terms of educational psychology rather than ‘mental health’, the ‘deviance’ in Hester (1998) is constructed as being ‘abnormal’. That is, the ‘deviance’ described by Hester may be taken, by implication and in ‘extreme cases’, to potentially include ‘mental illness’.
(i) It was obvious that she was terrified of anyone getting too near to her, especially men.

(ii) And yet she used to pretend to us (and obviously to herself too) that she had this and that guy really keen on her (43-5).

(Smith, 1978: 40)

These two statements (i, a disposition, and ii, an example of typical behaviour) are described as being packaged in a c-structure. That is, the two statements are linked by ‘It was obvious... and yet...’. But to what effect? Smith considers how such structures produces K as ‘pretending’. Smith looks at two ‘proper’ kinds of interpretation of pretence, under different belief conditions of pretending, compared to the paradoxical interpretation which hearers are left to resolve in this instance:

Either:
K believes that others know \(abc\)
Therefore [she] does not believe that she can conceal it from them. [Option 1]
Or:
K believes that others do not know \(abc\)
Therefore [she] believes that she can conceal it from them. [Option 2]
But... in fact we have:
K believes that others know \(abc\)
Therefore she believes that she can conceal it from them. [Option 3]

(1978: 41; original emphasis)

If K were ‘in touch with reality’ then she would be aware that \(abc\) was ‘obvious’ and understand, therefore, that it cannot be concealed (Option 1). Option 2 is not available since \(abc\) is ‘obvious’, so it would be known by others. However, given that she is pretending, despite the obvious (rather than K herself being completely unaware), then hearers are left with the paradoxical Option 3. Hearers are, therefore, led to resolve this
paradox by concluding that K is not seeing what is obvious to everyone else; she is cut-out from ‘reality’.³

Thus, Smith demonstrates how K is systematically and additively excluded from those who know what is; she is excluded from those who know how to relate ‘rationally’ with the ‘real’ world. There is a ‘cutting-out’ of K’s behaviour, away from an adherence to relevant social norms, rules, and sense-making, so that her friends are presented as naturally and correctly concluding that K is ‘mentally ill’. Hearers are set to follow suit in constituting K as an anomaly, as qualitatively different from ‘normal’; as not ‘mentally well’, not like us.

More recently, Harper, Georgaca, and Palmer have each examined ‘psychotic symptoms’ in studies which include the analysis of talk-in-interaction with actual patients. As such, these are groundbreaking contributions to our understanding of ‘mental illness’ in talk. In the main examples from these authors below, the patient talk was gained from researcher interviews. In Part two of this dissertation, however, the talk is from ‘naturally’ occurring ‘clinical’ interaction.

³ We may see that there is at least one other culturally available, paradoxical belief condition of pretending which is consistent with the interviewee’s account, made relevant by the description that K is obviously also pretending to herself:

K believes, on one (mental) level, that others know abc

but, on another level, K is unaware of abc.

Therefore, on one level, K believes that she can conceal abc from them,

whilst, on another level, she believes that there is no pretence.

Indeed, this kind of mentalistic interpretation of events, based on currently dominant psychological notions of intentionality, is potentially recursive and hence potentially infinite. However, any such interpretation also has the effect of cutting K out from ‘normality’; on this occasion due to the invocation of ‘mental conflict’ or some such construct.
A substantial proportion of Harper’s (1999) PhD dissertation is devoted to the discourse analysis of interviews with nine patients, plus a number of their psychiatrists, general practitioners, and nurses, on the topic of the patients’ ‘paranoid delusions’. Harper’s analysis of these interviews draws on the discourse analysis of “structured texts in the public domain”, from earlier in his dissertation; social constructionist literature; and commonsense understandings of ‘paranoid delusions’. The author takes a social constructionist, deconstructionist stance, in line with Parker, Georgaca, Harper, McLaughlin, and Stowell-Smith (1995) and Parker (1999) (ie, the critical approach of the ‘Manchester school’). I focus on a summary of Harper’s approach to some of the interview material, from Part 2 of his dissertation. His analyses favour scope rather than fine detail, as can be seen from the broadness of coverage and from the relatively simple transcription conventions, compared to EM/CA. Here is an account by Harper of his aims in interviewing patients and their treating professionals:

...to get multiple perspectives on the ‘same’ situations. The idea was that the potentially contradictory accounts might speak of influences like power and so on. Here, then, there was a micro rather than a macro focus - looking at how paranoia was used in everyday clinical practice situations and looking at the detail of how wider discourses and positions were effected in less structured situations. I was also interested in whether unexpected things would emerge from the twists and turns of the detailed analysis of specific instances.

(Harper, 1999: part 2 opening)

In this extract, Harper compares his present study to his earlier studies of interview materials. As I have already flagged, Harper’s analytic approach is not ‘micro’ in comparison to CA. We consider this further later. We consider also whether the interviews in question concern “everyday clinical practice situations” (see above extract), as we will consider Georgaca’s and Palmer’s work on this issue.
Harper’s (1999) study of interviews looks at three major discourse analytic themes: (1) how talk of emotion (especially distress) was related to accounts of ‘paranoia’, belief, and action; (2) how people rhetorically established plausibility and implausibility and how these relate to issues such as culture, race, gender, and class; and (3) how people constructed medication and other treatments.

A recurring feature of Harper’s dissertation (after Parker, 1992; Davies & Harré, 1990), is the identification of a number of oppositions which arguably operate ‘within’ the discourse. For example, Harper describes this approach, thus:

I will describe how paranoia can be seen as structured around a number of implicit dualities or oppositions. In this chapter I examine the place of ‘paranoia’ in contemporary Western culture and will, to some extent, [develop] ...the concepts of dualism and opposition to show how the ‘paranoid’ position itself is constructed in two main ways: by being construed as either an individualistic (and intra-psychic) or as a societal phenomenon (what might be termed an individual/social opposition); and by being seen as either an illegitimate and unwarranted manifestation of paranoia or as an example of a legitimate and warranted albeit conspiratorial theory (what might be termed a normal/pathological opposition). ...The rhetorical strategies used to construct these respective positions and the different discursive effects of these positions will be discussed.

(Harper, 1999: section 2.1; original emphases)

Harper examines what he takes to be the operation of such discursive features in publicly available texts. He then draws on those analyses, in addition to selectively reviewing social constructionist work on his topics of interest, to inform his analysis of interview materials. Below, we see specific examples of what Harper takes to be ‘oppositions’, as located in his analysis of interviews.
To touch upon some of Harper’s considerations in connection to his first major analytic theme, the construction of distress in paranoia, we turn initially to a service-user, Sharon, talking about her ‘paranoia’:

Extract 5.1 (from Harper, 1999: section 4.3.1) 

Sharon: Well, <pause> in the past I have been paranoid quite a lot really, quite a lot of my life but erm <pause> I didn't take it as seriously as I do now. It seems to have got worse, I don't know why. I think it's because I'm, it might be because I'm doing nothing all day, because I'm unemployed, well on the sick and erm I've got nothing else to think about all day so my imagination runs a bit wild really, that might be why it is <pause>. And I do feel like frightened, sometimes I'm frightened of going outside, I get a bit agoraphobic as well. <Dave: Right> 'cos I think these people are going to be saying something <Dave: Right, right> and I just can't relax and I feel like I'm setting myself up because I can't relax and everything and that's, it gives people something to say about me.

The analyst begins by noting a ‘moral positioning’ in line 2. Sharon’s statement that she did not used to take paranoia seriously implies that this is no longer the case, something which may be taken by staff as current motivation and insight; a positive development.

Sharon’s explanation of why her ‘paranoia’ became worse (lines 3-5) is taken as an account of ‘paranoia’ filling a lack in her life (due her being unemployed, “having nothing else to think about all day”, and the fact that her “imagination runs a bit wild”). Harper notes, in connection to this account, that thoughts and feelings are not ‘disembodied’ but constructed in a (social) reality where class, employment status, and gender are a powerful influence. We may note that, in connection to issues of participant concern, gender does not appear in this extract, for the participant. In a personal communication, however, Harper (2003) argues that agoraphobia is a gender-related issue. Harper (1999) also argues that Sharon “draws on notions of control here” and “the oppositions both of mind/body and thought/feeling”, in connection to her

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4 My version of Harper’s (1999) dissertation does not include accurate page numbers, nor does it include line numbers for the data. I have therefore added my own line numbers. Harper’s data extracts have no coded titles.
unemployment. Thus, the mind is presented as having power over the emotions and actions (“I’m frightened of going outside”; my emphases, regarding emotions and actions, respectively) and of not operating within a social vacuum. Harper argues that this “draws on the oppositions both of mind/body and thought/feeling”. Sharon’s saying that she “can’t relax” receives the same kind of analytic reading: “in placing agency outside of herself as a moral subject, Sharon is thus able to justify her difficulties and thus deflect perceived criticism of her”. We can see this as an example of Harper’s linking of ‘oppositions’ in theory to discursive moves in the data-at-hand. In the next section, Harper clarifies that he is not making claims about the intentionality or otherwise of the respondent, but about the functional potentialities of such accounts.

So what else might make sense of Sharon’s account? One of the other views which Harper presents as a possibility is that Sharon’s account could be due to her ‘illness’. For example, from an interview with Sharon’s psychiatrist:

Extract 5.2 (from Harper, 1999: section 4.3.1.3)
Dr Smith: /Yes, never fully co-operated with treatment. <Dave: Right> Erm <coughs> <pause> erm she’s erm rather insecure erm has got a very poor sort of erm self-image.

Another view developed by Harper is that a person who is positioned as ‘paranoid’ must manage a difficult three-way tension. Here, I take Harper to be drawing on the literature, his analyses of systematic texts, and the patient and professional interviews. According to Harper, first, there is the need to justify behaviour which others deem to be unacceptable. Invoking ‘mental illness’ is one way of handling this, since responsibility may then be attributed to the ‘illness’. Second, Harper points to a moral ambivalence, where psychiatric patients are not held to be responsible for their actions but they may be criticized for being ‘resistant’ and ‘manipulative’. Nevertheless, there is the requirement of being a ‘good’, compliant patient, which involves, to a certain degree, a patient’s responsibility for their own actions. Third, there is the need to
counter the Western view of psychiatric patients being out of control - out of touch with reality, and therefore dangerous - by presenting oneself as being rational and ordinary. Thus, according to Harper:

> It is obvious that these three imperatives pull in different directions and have contradictory effects. Some of the comments in this account could be seen as attempted discursive solutions to these problems but of course, a solution to one of these dilemmas may construct another problem. Such an analysis illustrates why a moral theme may run through this extract in that Sharon is attempting to negotiate her identity through these three poles.

(1999: section 4.3.1.3)

Harper then argues that one aspect of the management of these tensions is whether ‘paranoia’ is positioned as being inside or outside of the personal. For example, in line 1 of the extract immediately above, Sharon speaks of having “been paranoid”, which Harper takes as constructing the ‘paranoia’ as a part of her character (ie, dispositional, within the self, personal). Whereas, in line 2, ‘paranoia’ is described as “it”, in the kind of way one might describe a medical condition (“it seems to have got worse”). Thus, here, ‘paranoia’ is constructed as being outside of the personal. In the former construction, agency and control over paranoia is within the person, whereas in the latter construction, the implication is that the person does not have agency in relation to their ‘paranoia’.

Harper holds that this ambiguity in the construction of agency “does the job of negotiating two potentially contradictory imperatives. It also mirrors the ambiguity in much of the cognitive-psychiatric literature” (section 4.3.1.5). That is, cognitive-psychiatry views patients as not being responsible for ‘their symptoms’, whilst also requiring them to ‘cope’ better through the use of ‘cognitive coping strategies’. The same ambivalence is noted to occur in family management models of ‘schizophrenia’,

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which suggest that family behaviour can lead to relapse in the individual, requiring families to intervene in the way they relate to each other. In section 5.6.1, Harper describes a related contradictory position such that service users may be caught in a rationality trap. This trap is described as having the following characteristics: (1) patients who try to prove their rationality highlight the fact that their sanity is in question; (2) patients find themselves adopting a standard of rationality which is beyond the reach of ‘normal’ people, including professionals; and (3) rationality is not necessarily a major influence on professional judgements of ‘psychosis’.

Returning to Harper’s consideration of agency, in particular, he notes that one of the implications of agency being constructed as outside the person is that an external solution is required. He argues that Sharon’s use of technical terms, such as “a bit agoraphobic” (line 7) heightens this effect and goes towards warranting professional intervention. In commenting on a different extract, Harper discusses how an alternative view to constructing ‘paranoia’ as an external and powerful agent in relation to the person...
there are still options for ‘professionals’ to be less professionally institutional (for example, in the way that they privilege certain orthodox points of view) than is typical amongst orthodox clinicians and even postmodern therapists.

In sum, Harper describes a number of different features of ‘psychotic’ discourse. However, I suggest that Harper’s approach, as shown by his analytic use of ‘oppositions’, illustrates a potential danger of the analyst reading too much into, and away from, the data-at-hand: he tends towards explanation rather than explication. For example, some of the ‘oppositions’ may be more the analyst’s concern than participants’. Thus, they may be little more than analyst-identified contrasts between positions that are held, by the analyst, to generally oppose each other in such discourse, or perhaps in an additive fashion with data extracts which were not shown for reasons of space. The relatively small amount of data included does not very often allow for the checking of such matters in or between local, occasioned talk. The challenge is for analyses to remain grounded in the data-at-hand (see Antaki, Billig, Edwards, & Potter, 2003). In a personal communication with Harper (2003), he pointed out, concerning the notion of oppositions, that he “would not want to reify these too much or give them causal power” and that they are his “reading of the interview extracts and the professional literature”. In the same communication, Harper (2003) noted that he does not claim to represent participants’ concerns, and that he variously moves between a close, but not CA close, view of the data and wider discourses. Harper cited Burman’s (forthcoming) commentary on Antaki et al. (2003), comparing different forms of DA, in this regard. As we saw in Chapter 2, matters such as these, concerning methodological choice, rigour, and suitability are hotly contested in DA and CA circles.

Georgaca has also analyzed transcripts of interviews with ‘delusional’ patients; blending the Loughborough and Manchester school approaches. This analytic blend is to the fore in at least two of Georgaca’s recent papers (2000, in press). Her critical
analysis of the category of delusions (2000) begins with a consideration of the four main diagnostic criteria for ‘delusions’. Two of these criteria relate to apparent falsity of content: implausibility (the belief is impossible, implausible, or bizarre) and idiosyncrasy (the belief is not shared by others of the same culture or subculture). Georgaca notes that definitions which focus on ‘delusional content’ hold that “a belief is diagnosed if it is false. The process of diagnosis, therefore, involves a comparison between the delusional statement and reality” (p. 228). The other two criteria relate to apparent abnormality of form: conviction (beliefs are held with absolute certainty; ie, abnormality of form) and incorrigibility (beliefs are not open to change through compelling argument or proof; ie, abnormality of form). Accordingly, definitions which focus on ‘delusional form’ hold that “a belief is diagnosed as delusional if it is arrived at through abnormal thought processes. This involves scrutinizing the process by which the individual arrived at that belief and the way the belief is expressed, and judging its normality or deviation from normal thought processes” (pp. 228-229).

I consider Georgaca’s (2000) application of the diagnostic criteria to actual ‘delusional’ talk (ie, her analysis of interviews), rather than her theoretical critical analysis of the diagnostic criteria. However, Georgaca’s analysis of talk turns on a theoretical and practical consideration of reality testing. Briefly, according to Georgaca, current psychiatric discourse is dominated by theories which centralize the supposed failures of the ‘delusional’ individual to adequately reflect Reality, through failures in reality testing. That is, although there has been progress in recent cognitive approaches towards the normalization and contextualization of ‘delusions’, professionals remain focused on the (ir)rationality of the individual. In contrast to the dominant psychiatric view, Georgaca describes an alternative, social constructionist, view of how versions of reality are constructed in and through social action and how participants (themselves mundane reasoners in-action) presuppose a shared mundane reality and mundane
reasoning in their discourse with others. Following Pollner (1975) and Coulter (1975), Georgaca argues that conforming to the rules of mundane reason is a key aspect of any participant’s credibility, in practice. Under these norms, reality disjunctures (discrepancies between participants regarding the nature of any general or particular aspect of Reality) are attributed to the (subjective) participants rather than to (objective) Reality. Rather than judging what reality ‘really’ is, Georgaca’s ensuing analyses examine “the internal logic of mundane reason and its practical use in interactions” (2000: 231).

Georgaca (2000) analyzes four data extracts from her interviews, two from each patient, Patrick and Ahmed. Georgaca then considers how the criteria of implausibility, conviction, and incorrigibility might be applied to each extract. Idiosyncrasy is not addressed in any of the discursive analyses because “although extensively used in clinical practice, it is rarely mentioned in psychiatric research” (p. 232).

We begin with Patrick, an African-Caribbean man who is diagnosed as ‘suffering from bipolar affective disorder’. In the first extract, Patrick tells of the spirits which have been following him and making him sick. The interviewer (Georgaca) questions him about evidence for the existence of the spirits:

Extract 5.3 (from Georgaca, 2000: 233)
I: So did, did something specific happen yesterday that made you feel so bad?
P: Yeah.
I: What was it?
P: Those spirits. Spirits have been following me, spirits that, you know, they are coming up, they are coming out.
[...]
I: Yeah. So what type, I mean, what type of spirit is it?
P: I would say a mind spirit.
I: Yeah, yeah, I mean, obviously that’s, I mean, you haven’t seen it or heard it or anything, you just...
P: I feel it.
I: Yeah, you’re just feeling it. So how do you know it’s a spirit then?
P: The world made up of, the world made up of body I just think it’s spirit.
I: Hmm mm, but it doesn’t do anything else to you, does it?
P: That it made me sick, it makes me sick.
Georgaca’s analysis describes how Patrick draws a contrast between two competing interpretive frameworks; a materialist and a spiritualist discourse. He accounts for his claims by invoking the spiritual world; a framework in which proof-by-perception does not apply. His spiritual explanation is of a kind which is socially acceptable in the Afro-Caribbean community and within other groups in the West. Georgaca argues that conviction and incorrigibility cannot be considered problematic in this case “because Patrick constructs himself as a competent social actor willing to negotiate his views and to follow the conversational requirements of answering challenges and providing evidence” (p. 234). With regards to the criterion of implausibility, “[b]oth the claims under negotiation and the form of negotiation are such that the veracity or falsity of Patrick’s claims are impossible to definitely resolve”. In the second extract from the interview with Patrick, he also competently negotiates his appeal to the domain of personal, subjective experience, such that the three diagnostic criteria again do not apply.

Georgaca describes some of the statements of the other interviewee, Ahmed, as “extreme claims on external reality, identity and perception, which are difficult to conversationally sustain” (p. 235). For example: “A: ...she’s saying to me now ‘my name is Raquel Welch and I am fifty-four years of age’ and she’s speaking to me and to everyone else” (p. 237). However, Georgaca also argues that “the lack of common ground [with the interviewer and with readers] is the result, not of Ahmed’s claims having been proven false, but of the impossibility of definitely settling disputes over reality” (p. 235). This statement requires some qualification, which we arrive at shortly.

Ahmed is of Asian origin; he is diagnosed with ‘schizoaffective disorder’, with ‘grandiose delusions’ and ‘auditory hallucinations’. The first extract of Ahmed’s interview involves a dispute over the colour of his parents’ skin. At one point, in what Georgaca takes to be an apparent shift away from colour perception as in discourses of
racial skin colours, Ahmed persistently claims that his own skin is red. He soon elaborates this to “red and white sort of like, not so white as you, I’m not like that but...” (p. 236). Since, there is no longer a mutual interpretive framework within which to negotiate, the interviewer laughs and asks Ahmed if he wants to stop the interview.\(^5\) Georgaca argues that, because Ahmed did not provide a framework within which to understand his statements, they could not be conversationally proved or disproved through mundane reasoning, not without “undermining the status of one of the participants” (p. 237). Thus, under the local conditions, issues of truth and falsity (implausibility) simply cannot be negotiated: according to Georgaca, they are not locally relevant criteria. Note that Georgaca might not have arrived at this finding had she not considered the patient’s concerns as much as the professional’s, an issue which we will revisit when reviewing Palmer’s approach.

The following extract from Georgaca’s interview with Ahmed also involves a dispute about perception, this time about hearing voices:

**Extract 5.4 (from Georgaca, 2000: 237)**

\(I:\) So what do they say to you?

\(A:\) They just say, you know, they say, they talk to me.

\(I:\) Hmm.

\(A:\) This is, my mum speaking to me, and is sort of saying ‘my name is Raquel Welch and here is my son’, she’s talking to me.

\(I:\) Mm hmm.

\(A:\) Other people can hear her voice at the same time. And they, and she, she’s saying to me now ‘my name is Raquel Welch and I am forty-four years of age’ and she’s speaking to me and to everyone else.

\(I:\) Now, at this moment?

\(A:\) Yeah.

[...]

\(A:\) And they’re speaking outside, speaking through me.

\(I:\) Mm hmm. So do you think that I could, I can hear her now?

\(A:\) Yeah, you can hear her as well, but you don’t want to admit it.

\(I:\) [laughter]

\(A:\) You don’t want to admit that I can hear her.

\(I:\) No, I can’t hear her.

\(^5\) Even though a metaphorical framework of being simply human (flesh and blood) might perhaps apply, this would be an imposition upon the interaction. This point was noted by Georgaca in a personal communication (2003) in which she clarified for me the lack of grounds, in the data, for a metaphorical reading.
A: That’s the way things have been, you see, and people don’t like to admit it.

Unlike Patrick’s spirits, which were presented as a *subjective experience*, Ahmed constructs the voice of his mother as something which can be *objectively perceived*. Georgaca points out that, within this understanding, given the reality disjuncture which develops (the interviewer stating that she cannot hear the voice that Ahmed can hear), the only resolution is to posit a bias or defect in one of the hearers, in order to maintain the public nature of Reality. Ahmed skilfully manages this disjuncture by “attributing interest in presenting a false account” (p. 238) (his final 3 turns). Indeed, we can see that the interviewer’s very first turn, “So what do they say to you?”, is noncommittal about the objectivity of the voice. On the one hand, it may be taken as either contributing to the co-construction of the voice as external and yet it is also not inconsistent with a formulation of the voice as being located within Ahmed. Even the utterance, “So do you think that I could, I can hear her now?” is equivocal in its challenge to Ahmed as to whether the event is objectively, mutually perceivable. Something like, ‘Well I can’t hear it, how can that be?’, would be a more direct challenge. It is not until the interviewer’s final utterance, “No, I can’t hear her”, that this is clearly stated; only then are her own perceptual cards about the voice finally put on the table, as it were. It might be fair to say that the interviewer ‘played’ within Ahmed’s perceptual framework, only to pull the rug out from under it at the end (her side of the rug, at any rate). Ahmed, however, skilfully and diplomatically manages to maintain the consistency of his account about the objectivity of the voice with an explanation of the behaviour of others (changing from “You don’t want to admit that I can hear her” to the more general “people don’t like to admit it”, after the interviewer’s statement that she cannot hear the voice herself). It can also be said, as Georgaca implies, that Ahmed finishes by using recurring circumstances as a causal explanation for the reality disjuncture (“That’s the
way things *have been*”; my emphasis) and that he reduces immediate confrontation by finishing with an explanation in terms of people in general rather than the interviewer in particular (“people don’t like to admit it”).

Georgaca argues that Ahmed “claims that there is an external perceivable entity located in the objective realm. He *observes the rule* that disagreements in perception have to be accounted for and attributes my claims to not perceive it in terms of my motivation” (p. 238; my emphasis). Ahmed is competently within the bounds of mundane reason and the criteria of conviction and incorrigibility are not applicable. Regarding implausibility, Georgaca states that, given the perceptual framework and the reality disjuncture, the existence or non-existence of the voice does not seem to be able to be established conversationally, without “engaging in mutual accusations about the capacities, integrity and motivation of either of us”. According to Georgaca’s analysis, if either participant were to pursue the dispute about where the voice originates further then it would be one person’s word against another, with each participant, the interviewer and Ahmed, constructing their accounts and themselves as objective. There would come a point when the matter could only be settled by attributing a lower status to one of the participants. Thus, correspondingly, one of the participants can then “be assumed *a priori* to serve as the norm against which others’ claims can be tested, which might be the position clinicians assume in the process of diagnosis” (Georgaca, 2000: 238). We may suppose that, even if a third person were present, appealing to the applicability of a consensus decision (which goes hand-in-hand with proving idiosyncrasy), it cannot but serve to lower the status of the person whose claims are disqualified. Furthermore, by logical extension, if the professional is taken to be the *a priori* norm then, to some extent, the patient is presumed to be *abnormal*.

In conclusion for this study linking micro-analytic findings with wider concerns, Georgaca argues that the patients’ claims cannot be considered pathological in relation
to the diagnostic criteria of conviction and incorrigibility. Rather, “while maintaining their claims, [they] did conduct themselves as competent social actors, were willing to discuss their views, account for them and respond to challenges, following conversational rules” (p. 238). Their talk was also in accordance with mundane reason. Furthermore, within the described confines of mundane reason and conversational conventions, the truth or falsity of claims about ‘reality’ (i.e., im-plausability) could not be incontrovertibly settled.

It is worth noting that my own, brief added analysis - focusing on the interviewer (see above) - would not have been possible without Georgaca’s inclusion of sufficiently long extracts which included the interviewer’s turn. The author herself also, to some extent, includes a consideration of the interviewer’s turns in her analyses. Accordingly, in Georgaca (2003), with different data, the author focuses mainly on the interviewer’s part in jointly constructing accounts of a patient’s psychotic experiences.

On the basis of her analyses, Georgaca (2000) suggests that it is debatable whether decisions on a belief being delusional or not are ultimately sustainable by clinicians in talk. (Note that the need to lower the social status of the person being diagnosed is not mentioned by Georgaca in such proximity with ‘clinicians’). In this light, Georgaca suggests that the diagnostic role may be less neutral (i.e., less objective) than it is commonly presented to be. Georgaca then contrasts diagnosis with that other clinical pursuit, therapy, proposing that, in therapy, concerns about truth and falsity may be both irrelevant and unhelpful. We may note that this is in line with Leudar and Thomas (2000) and their descriptions of non-therapy dialogue with Peg.

Palmer has conducted micro-analytic studies of interview data regarding ‘delusions’ (1997, 2000) and ‘hallucinations’ (unpublished). Criticisms aside, it should be recognized that, along with Georgaca (2000), Palmer’s work is groundbreaking in its close discursive analysis of ‘psychotic’ talk. Such studies have the potential to challenge
many of the assumptions of orthodox psychiatry; to open up the debate into a greater consideration of social factors. For his paper on ‘delusions’ (2000), Palmer focused on one of the three ‘delusional’ patients whose transcribed interviews were studied in his 1997 thesis. Palmer does not state it in his paper but he appears to be the interviewer. Furthermore, Palmer, like Georgaca, assumes that the interviews may be taken as involving much the same processes as formal diagnostic interviews. In this, he may be right. However, Palmer falls short of the potential of CA to analyze psychiatric practice by choosing politic over principle and evidence. In this critical review of Palmer’s approach, I try to show that he becomes rather too familiar, as it were, with psychiatry; a stance which dominates over important aspects of CA methodology.

Palmer (2000) describes how his approach can change psychiatry by “explicating the material workings of psychiatry in their own terms”. Thus, social interaction is to be made relevant to psychiatrists. But what does that mean, in Palmer’s work, in practice? I shall begin by considering further this issue of changing psychiatry, in terms of what Palmer describes in his accounts and in terms of how he describes it (a content vs function distinction, if you will). Palmer effectively claims that his approach has the potential to recognize symptoms, “within psychiatry” (my emphasis), and I shall argue that his approach does de facto diagnostic work for psychiatry:

In recent years biological concepts have begun to strengthen their hold on psychiatry. ...A practical consequence of this new knowledge is that sociological themes and concepts are becoming marginal to the field. In short, as knowledge of ‘natural’ factors advances, so the need for ‘social’ factors seems to retreat. However, regardless of this biological ascendency, there is a way in which sociology has an undiminished and central role to play within psychiatry. This is not in the area of explanation (i.e. aetiology) but in that of symptom recognition (i.e. psychopathology).

(2000: 661-662; my emphases)
That is, “regardless of this biological ascendency”, through “symptom recognition” rather than “explanation”, Palmer holds that his approach can operate in parallel with biological psychiatry. I discuss the issue of ‘symptom recognition’ further below and, for now, continue to focus on Palmer’s proposed role of microsociology in psychiatry:

My argument so far is that the foundations of psychiatry - i.e. how disorders are recognised - are the specialist province not of psychiatry but of microsociology. As a result, it is reasonable to expect that microsociological work on how conduct acquires a symptomatic significance would influence psychiatric practice.

[Social constructionist] criticisms have gained currency within microsociology but have made little impact on the very field they intended to criticise. It is this paradoxical state of affairs which the present paper seeks to account for and move beyond. ...I report the results of a study into how delusions are recognised and use these to move beyond the paradox outlined above. This involves outlining a method of study which both produces a foundational criticism of psychiatry whilst retaining relevance for that discipline.

(2000: 663; my emphasis)

Palmer, thus, claims to highlight the role of social practice in psychiatry; to balance explicating psychiatric practices from within, and being critical of, psychiatry. Indeed, he goes so far as to describe his approach as being a part of the creation of a “hybrid discipline”, a “clinical sociology”:

In my usage, clinical sociology does not add sociological knowledge to psychiatry but takes the more ethnomethodological path of explicating the immanent sociology of practice (Garfinkel 1967: vii). In other words instead of preserving sociology’s independence a hybrid discipline is developed (see Lynch 1993: 274) which explicates psychiatry’s internal sociology. It is this hybrid which offers the prospect of producing effective criticisms which are finally capable of changing psychiatry itself.

(Palmer, 2000: 676; my emphases)
But why is there a need for such a “hybrid discipline”? Is such hybridization a matter of rhetoric, to aid in the socialization of psychiatry? And does hybridization in practice adversely affect the practice of ethnomethodology? Palmer claims that his approach shows how “disorder” (p. 668) is “identified” and how delusions are “recognized”. Hallucinations are considered from a similar standpoint. Palmer claims to be analyzing the recognition of “disorderly conduct” (see below), something which might be taken as having an entirely social orientation. However, his consideration of the social interaction in question rests, paradoxically, on the one-sided psychiatric presumption that people who report ‘delusions’ are disordered, a priori, as individuals. That is, although Palmer does not reify ‘delusions’ in terms of biology, he reifies such reported phenomena in terms of individualistic ‘social’ ‘disorder’. In this way, Palmer starts from largely realist, orthodox psychiatric assumptions about the nature of ‘delusions’ and ‘hallucinations’.6 Here, is an example of such reification, which, in this instance, comes before his analysis of the interactional material. Palmer appears to reify the psychiatric notion of hallucination and delusion, as ‘symptoms’ of “insanity”, as being distinct from “perception”, “belief”, and “sanity”, respectively:

So, the foundational issue is not to explain disorder but to describe how it is identified. That is, to specify how sanity is distinguished from insanity, perception from hallucination and belief from delusion. It is the question of how disorderly conduct can be recognised that will be addressed in this paper.

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6 In a personal communication from Palmer (2003), he states that I have misunderstood his ethnomethodological intentions of ‘indifference’ (citing Garfinkel & Sacks, 1970). However, it is not his intentions with which I am concerned but his actions. I acknowledge that my own work risks sacrificing being methodologically indifferent (or unmotivated, to use another term) but this is on the grounds of taking the side of the ‘patient’, to help redress professional dominance. I do not see any such morally defensible benefits in Palmer’s favouring of an orthodox psychiatric position.
Similarly, he discusses how a belief ‘being true’ does not prevent it from being diagnosed as delusional:

This clearly demonstrates that crucial skills involved in the recognitional process are not captured by the definitional criterion of falsity. As a result, the key task facing microsociological studies in this area is to develop an analysis of the tacit skills which underpin the recognitional process but which are not captured by the diagnostic criteria.

(Palmer, 2000: 667; my emphases)

Presently, I will try to demonstrate how Palmer’s adoption of psychiatric concerns over those of the patient influences his analysis, in a way which I take to be unhelpful for both the patient and CA. What Palmer considers to be “recognitional skills” might otherwise be considered to be assumptive prejudice-in-action, in favour of the dominant party in the diagnostic interview. But for these pervasive reifications of psychiatric constructs (based on assumptions that ‘delusions’, etc, are something to recognize and that psychiatric workers have the necessary skills to recognize/diagnose them accurately), these are potentially valuable ethnomethodological pursuits. Indeed, I agree that “[t]he very symptoms which psychiatry deals with are the products of shared, tacit skills” (Palmer, 2000: 676). These are the practices which should be Palmer’s analytic target, in explicating the ‘skills’ involved in the social co-construction of ‘symptoms’. Instead, we have “psychotic symptoms [which] are qualitatively different from neurotic ones”, which apparently require only the “tacit skills” of the psychiatric professional in their recognition of ‘disorder’, and the ethnomethodologist in their explication of that recognition:

[My study] will break new topical ground by analysing the psychotic symptom of delusion. As psychotic symptoms are qualitatively different from neurotic ones the tacit skills involved will be very different... [My study] focuses on actual cases of delusion
rather than reporting or reconstructions. In this way, direct, material access is provided to the tacit skills which underpin the recognition of delusion and which constitute the workings of psychiatry.

(Palmer, 2000: 668; my emphases)

Palmer claims to be analyzing the procedures of psychiatric diagnosis by working, as an ethnomethodologist, from psychiatry’s own points of view-in-practice. His stance contrasts with Georgaca (2000), who is critical of the psychiatric category of ‘delusions’ and the criteria which are supposedly used in its diagnosis. But how can Palmer be dealing with anything other than reports (Sarbin & Mancuso, 1980)? Furthermore, in order to explicate and perhaps even help change psychiatric practices, one does not need to adopt uncritically any of the tenets of orthodox psychiatry, as it appears Palmer does. One might argue that there are benefits in adopting something of the position which one is trying to understand and change. For one thing, regarding change, a reliance on shared assumptions can enhance recipient design. The adoption of aspects of another’s position might also allow the promotion of an ‘evolution from within’ rather than a resisted ‘revolution from without’. Palmer argues that it is useful to adopt the assumptions of orthodox psychiatry in order to gain an initial understanding and eventually effect change. However, assimilation looms when one starts to ‘become’ too much like what one is seeking to change, especially when it has as much social power as psychiatry. As I hope to show, with Palmer’s focusing mainly on what he describes as shortcomings in a patient’s social abilities (but he treats largely as individual shortcomings), he gives insufficient weight to the patient’s concerns in interaction and too much to the psychiatric view. Thus, Palmer’s approach is severely restricted in its social context; it represents a type of individual diagnosis on purportedly social grounds.
Let us consider the data in Palmer’s paper on delusions. It comes from an interview with a psychiatric patient. The patient, R, tells the interviewer, C, that he has seen a god who calls himself Thor. R’s talk is identified by Palmer as “diagnosed as delusional”, in close proximity to the transcript (2000: 669), adding to the construction of R’s talk as ‘delusional’. Also, there is no information provided about the professional credentials of the interviewer, although it is apparently Palmer himself: this is not an actual psychiatric interview.

Extract 5.5 (from Palmer, 2000: 669-670)

1  C: So you believe there's an afterlife then?
2     (.)
3  R: Ye:s I do no:w. No:w I've seen a god as
4     well you know. Well he doesn't call himself
5  God he calls himself Thor.
6     (0.8)
7  C: Ye:ah.
8  R: I saw him on a f:- (. I've se:en him a couple of
9  times on a field up in Leicestershire I saw him
10  once.
11  C: Right. ((questioning tone))
12  R: Right out in the countryside where I was work:ing.
13     (.)
14  C: Yeah.
15  R: I had a job as a gamekeeper there for Mr. Burnett
16     the animal food manuf:acter.
17  C: Uh huh.
18     (0.5)
19  R: And e:r he visited me while I was up th:ere.
20     (.)
21  C: For some re:ason.
22  R: Wuh-What kind of thing does
23     What did Floor-Thor look like?
24     (0.8)
25  R: Well he's uh quite looks quite impres:sive
26     he's gotta .hhh gotta catsuit on.
27  C: Right.
28  R: With an orange flas:h down the front
29     like a: flash of Li:ghtning would look
30     like sometimes.
31     ***Lines omitted about what Thor created***
32  C: Is he kind of hue:ge.
33     (0.4)
34  R: A big bloke or?
35  C: No: he's not hue:ge he's a biggi:sh looking
36     bloke though.
37  R: Right.
38     (0.7)
39  C: A bih- ter: (: .) not biiger than (0.5) no:rmal
40     big men:but (: .) big you know.
41  C: Right. Couldn't he:- (1.0) pahh! I don't want
42     to sound s (h) keptical but- couldn't he have just
43     beenas jo:gger or something like that?
Palmer barely considers lines 1 to 21: “For present purposes the crucial parts of #1 are lines 22 to 58. However, to contextualise the analysis I shall make some brief comments about lines 1 to 21” (p. 670). Indeed, Palmer simply quotes lines from the transcript to summarize the fact that C asks whether R believes in the afterlife (line 1) and that R initially responds in the affirmative (line 3). Palmer then states that “[o]n lines 8 to 21 R expands on this claim by reporting some details of an encounter he had with the god Thor”. In a personal communication (2003), Palmer explained that he barely considered the section from line 1 to 21, because “definitionally it has nothing to do with delusions! What R describes here is a visual sighting of Thor and thus is relevant to the recognition of hallucinations. Of course, your argument is [that] this section is interactionally germane...” (original emphases), an argument to be decided empirically.

Palmer’s main interest is in lines 22 to 55, as to how they demonstrate that R is delusional, in the sense of evidencing R’s ‘social disorder’. I shall summarize Palmer’s analysis proper (ie, concerning lines 22 to 58), presently. But it is from the outset, in connection to lines 1 to 21, where Palmer first introduces the notion that R is giving an account of a paranormal event:

In non-delusional accounts of paranormal activity such as those described by Wooffitt (1992) a central concern is to establish the occurrence of some supernatural happenings. In other words, descriptions of supernatural events routinely demonstrate that the event has paranormal properties. So, in this case, we might expect R to provide some evidence that he met the god of Thunder; for instance, he might have reported a characteristically god-like action performed by Thor such as controlling the weather. However, instead of providing this type of evidence R simply states that he met Thor.

(Palmer, 2000: 670)

Thus, Palmer constructs R’s account *a priori* as necessarily an account of a *paranormal event*. In my counter-analysis, however, I consider whether or not this is the way that R
constructs it. Palmer does not specifically mention it, but his citation of Wooffitt makes relevant Wooffitt’s ‘I was just doing X... when Y’ device (1991, 1992). This device is where the tellers of paranormal tales typically establish themselves as ‘normal’, credible witnesses, with ‘I was just doing something ordinary or otherwise grounded’ (X), before they describe the paranormal event (Y). Indeed, in contrast to a person’s presenting of themselves as being rational when reporting what they take to be paranormal phenomena, Palmer, following on from his analysis-proper, makes it clear that he holds that R’s responses are

[i]n strong contrast to the non-delusional accounts of paranormal activity that Wooffitt (1992) has studied. A theme which runs through his analysis is that people without delusions are concerned with the grounds on which their stories might be doubted and so attempt to undercut those grounds. Doing this involves substantial engagement with the other person and with their interactional concerns. It involves entering into debate with them and arguing your point of view. It is this ‘outward’-looking orientation which is absent from R’s talk and, as such, he appears disengaged from interactional concerns which constitute the normal social world.

(Palmer, 2000: 673)

But rather than considering R’s point of view and concluding that R’s account is not being presented as a paranormal tale, Palmer’s analysis sides with C’s concerns - a somewhat psychiatric position - and presumes that R is delusional; a most psychiatric outcome. R is not ‘diagnosed’ by Palmer for believing that events which could not have occurred actually did occur. Rather, according to Palmer, the problem (for which I described R as being ‘diagnosed’ by Palmer) is that R only reported ordinary events in support of a paranormal story which was doubted by C. That is, R did not produce his story in the way that Palmer deems to be socially correct because R did not provide evidence of the paranormal. Palmer takes it that a paranormal story is required of R on
the basis that R claims to have seen Thor and that such claims are doubted by C (in that they may have been ordinary events mistaken for the paranormal). On that basis, what Palmer takes to be R’s paranormal story is deemed to be socially inadequate:

In summary, from C’s point of view, there are two bases on which this story can be recognised as delusional. First, R’s account contravenes the logic of practical action. By this I mean that every social activity we perform has an internal logic to it. In this case, the logic is as simple as: ‘When describing a paranormal entity show that something paranormal happened’. Whilst R claims to have met a god he only describes Thor in ordinary ways: as a large man, in a tracksuit with an orange flash on it. As a result, R’s claims appear ungrounded and are systematically open to doubt that he mistook an ordinary phenomenon.

...With respect to the type of story examined above, its internal rationality is simply ‘when telling a paranormal story show that something paranormal happened’. As a result, paranormal stories can become inherently disordered and irrational if they only report ordinary events like seeing a tall man in a catsuit.

(Palmer, 2000: 674)

Palmer holds that R “clearly recognised that evidence of the paranormal was required [and that] he neither disputed this standard nor attempted to provide that sort of evidence” (p. 675). But to what extent does C explicitly state his doubts about R’s account and to what extent is the account a paranormal tale, for R? Below is a gloss of my counter-analysis to Palmer’s.

For reasons of space, I concentrate on lines 1 to 21, but contend that the same principles apply to the entire interaction. Unlike Palmer’s reading, I argue that R’s account is not presented by him as paranormal. Rather, what R is actually doing is describing his grounds for believing in the afterlife - which is considered a perfectly reasonable belief in some circles - in response to C’s question, “So you believe there’s an afterlife then?” (line 1). R’s initial response attests to the intersubjectivity with C of
his report: “Ye:s I do no:w. No:w I've seen a god as well you know.” (lines 3 & 4). Indeed, we may take it that, at this stage in the interaction, R’s problem is not that he is reporting to have witnessed evidence of the afterlife but that the god that he has seen is Thor and not a figure which is more acceptable in contemporary Western religions: he continues, “Well he doesn't call himself God he calls himself Thor.” (lines 4 & 5). At the outset, then, this concern in the afterlife is framed by both C and then R as a socially acceptable concern. However, R must now substantiate his account of Thor, as a factual report and not as a paranormal account. Otherwise, given that his report of having seen Thor (and not, say, Jesus Christ) is not typical amongst contemporary accounts of the afterlife, he runs the risk of being considered by C to be insane. Thus, despite it being an account of seeing Thor, the events are presented as being really quite ordinary; perfectly ‘normal’. The circumstances were ordinary (line 9, “on a field up in Leicestershire”) and the main event was quite ordinary (eg, in lines 4-5, the matter-of-fact way in which R talks of how the god prefers to call himself Thor; lines 8-9, “I've seen him a couple of times”; line 19, “he visited me while I was up thegre”). Indeed, lines 8 to 21 all attest to R’s rationality, in that they provide him with rational reasons for being where he was and affirm that he was doing rational things when Thor visited. Thus, lines 8 to 21 might represent the ‘X’ part of an ‘I was just doing X... when Y’ tale of the paranormal. However, if R’s report required an ‘X when Y’ account, as C and Palmer apparently have it, then there is a problem in that what might be taken as the ‘Y’ part (the paranormal events part) is described before the obvious ‘X’ part (when R describes his reasons for being where he was).

But, to complicate matters still further, the first part of R’s report is not actually presented by R as involving paranormal events. Rather, Thor is quite ordinary, even though he is a god. Thus, it would be more accurate, from R’s point of view, to describe this as a doubly ordinary ‘I was just doing X... when X’ account rather than one of
Wooffitt’s ‘I was just doing X... when Y’ tales of paranormal events. That is, for R, this is not an ‘X when Y’ account. Rather than follow this line, it appears that Palmer’s analysis rests on a presumptive ‘diagnosis’ that R’s account is problematic, disordered, delusional. If one assumes, like Palmer, that Thor is paranormal, then one might expect a rational person’s talk of meeting the Norse god to obey the rules of paranormal talk. And, if those rules were not obeyed, then one might have moral grounds for taking this lack as evidence of a delusional disorder, a kind of social disorder. This would be a matter of morality because there are no absolute rights or wrongs when it comes to social rules (Sacks, 1992) (or anything else for that matter).

We may now see that R is diagnosed in Palmer’s analysis and discussion with ‘social dysfunction’ for not conforming, for not producing a paranormal tale when C and Palmer deem that he should have conformed. This is despite the fact that R presents himself as a mundane reasoner (line 3, ‘Ye:s I do no:w’, implying that he would not have believed in the afterlife if he had not seen Thor with his own eyes), and even though he abides by numerous rules of social interaction (such as turn-taking and providing answers to questions), and negotiates between his ordinary position and C’s pseudo requests for paranormal evidence. For example, in these ‘opening’ lines, R begins to warrant his credentials with his working there (line 12) and, more specifically, being a gamekeeper (line 15) only after C’s matter-of-fact responses (lines 7, 11, 14, 17). My point here might seem paradoxical but I suggest that C’s responses are unusually subdued in the face of R’s description of seeing a god (especially a Norse god in contemporary Western society). In such circumstances, one might expect C to indicate great surprise and considerable doubt, perhaps even more so with R’s description being presented in such an unmarked, matter-of-fact manner. Thus, it may be partly in response to C’s non-uptake (the ‘yeahs’), combined with the other elements of his largely implicit doubting of R and R’s report (the most explicit being the
questioning “Ri:ght” in line 11, and the almost questioning for paranormal evidence in lines 23 and 47), that R builds up the ordinariness of the account still further and warrants his own credentials for being able to rationally say that it really happened as he says it did. That is, with C’s non-uptake of R’s topic, with neither clear affirmation nor great doubt from C, he shapes R’s talk into being even more matter-of-fact about the events (events which both C and the analyst deem to be, perhaps, ordinary occurrences which were incorrectly considered by R to be paranormal, hence they hold that R should provide evidence of the paranormal, and not the ordinary, if he is to be considered sane). To employ two unmatched metaphors, C is on a ‘fishing expedition’ for delusions-in-action and R is given ‘enough rope to hang himself’ in that regard. In my alternative reading to Palmer’s, however, it is C’s talk which is problematic, not R’s. By including more of C’s talk in the analysis than Palmer did, it can be suggested that C demonstrates what amounts to prejudice-in-action towards R. To put it mildly, the patient is not being treated like an ordinary conversationalist.

Furthermore, and returning to R’s part in this, recall Harper’s (1999) discussion of the rationality trap, where psychiatric patients present themselves as being more rational than people usually are, to offset their questionable social position as ‘mental patients’, thereby highlighting the very ‘thing’ which they are moving to minimize? Presenting oneself as dealing with a bizarre situation in an ordinary and calm way, could be equated to presenting oneself as rational. Such a consideration of social action and positions can provide hearers with a context for R’s actions; a context which undermines any kind of psychiatric or ‘social’ diagnosis because it includes R’s reasons for reporting as he did. Thus, R affirms that his is rational/understandable, after all.

Sacks’ work on doing ‘being ordinary’ may also be pertinent here:
...Whatever we may think about what it is to be an ordinary person in the world, an initial shift is not to think of an ‘ordinary person’ as some person, but as a somebody having as their job, as their constant preoccupation, doing ‘being ordinary’.

...Your business in life is only to see and report the usual aspects of any possibly usual scene. That is to say, what you look for is to see how any scene you’re in can be made an ordinary scene, and that’s what it is.

...Reports of the most seemingly outrageous experiences, for which you’d figure you’d be at a loss for words, or would have available extraordinary details of what happened, turn out to present them in a fashion that has them come off as utterly unexceptional.


One interpretation of Palmer’s (2000) data, then, is that R is doing ‘being ordinary’ in the face of (repeated) bizarre experiences. Another explanation is that the experiences simply were ordinary for R. With the data that we have, who can ‘know’ and who should judge R, either way? And, regardless of any such judgments by a hearer, R’s job as an ordinary person is to bring off his account in as ordinary a way as possible. In line with Georgaca’s (2000) consideration of interpretive frameworks, one can suppose that some people might achieve ordinariness by invoking ‘mental illness’ as an interpretive framework, by attributing their experience to a ‘symptom’. Others sometimes rely on spiritual discourse to achieve ordinariness. Nevertheless, according to Sacks’ notion, in ordinary conversation - regardless of the interpretive framework employed, and unless one is telling a tale of the extraordinary, which is also constructed in such a way as to present the teller as ordinary and rational - then the teller’s responsibility is for the entire event, and the teller themselves, to be presented as ordinary, rational, and ‘not-mad’. Furthermore, as I have already argued, the social asymmetries which are operative between C and R (some of which are evidenced, interactionally, in the transcript) may also contribute to R’s telling of what might be considered extraordinary
and/or ‘delusional’ in a most ordinary way. In this regard, the ‘QA QA QA A’ distribution of turns should be noted. This is not the dialogical “debate” or “sharing a social world” which Palmer claims (2000: 675). C asks a question, R provides an answer (three times), until C provides his own, delicately phrased position (lines 56-58) on the overall question/s of did R really see a god / is there an afterlife / is R delusional?. Also, C’s tiptoeing around making an explicit statement of his opinion of R’s sanity never fully moves beyond withholding, even in the proposal that R’s eyes have deceived him (lines 56-58). Even when C, finally, explicitly reports doubt in the form of an alternative account to R’s, it is hardly the forthright kind of ‘You must be joking!’ or ‘You must be crazy!’ response which would, paradoxically, convey respect between co-equals, by not shying away from and/or concealing the implicit evaluations which have been and still are being performed, by omission.7

To summarize, in R’s account, and C’s, there are interactionally manifest reasons for R saying what he said and for presenting the events and himself as he did. And some of those reasons - including what may be taken as amounting to negative social evaluations of R by the interviewer - are evidenced in the interaction (eg, the non-uptake and the largely implicit but nevertheless consequential doubting). Indeed, R

7 Palmer, in a personal communication (2003), argues that my approach to his work has a “tendency to overlook ordinary interactional structures in favour of some sinister practises revealed by a hermeneutics of suspicion”. For example, he points out that one ordinary explanation of C’s withholding is that doubting is a disaffiliative, dispreferred action because it presents R as incompetent (Pomerantz, 1984). Thus, C is being extremely respectful to R, by providing him with face saving opportunities (Lerner, 1996). Palmer notes that he can imagine few things more disrespectful in this context than my suggestion that C explicitly questions R’s sanity with ‘You must be crazy!’. I however, hold that C is doing just that, but implicitly and psychiatrically. If C were to call R ‘crazy’, in the psychiatric sense, then at least it would be more ‘open’. Furthermore, here, Palmer fails to acknowledge that the term ‘crazy’ may be used in a more ordinary sense than those which reify ‘insanity’.
himself attests to his own reasoning when he describes Thor as visiting him “[f]or some reason” (line 21). R presents Thor’s reasons, even if they are unknown, as being relevant information, thereby demonstrating R’s mundane reasoning.⁸⁹

Palmer’s first main analytic consideration does not actually arise until he looks at lines 22 to 58:

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Extract 5.6 (from Palmer, 2000: 669-670)

19  R:  And e:r he visited me while I was up the:re.
20   (.)
21  R:  For some re:ason.
22  C:  Wuh-What kind of thing does
23  What did Floor-Thor look like?
24   (0.8)
25  R:  Well he’s uh quite looks quite impressive
26  he’s gotta .hhh gotta catsuit on.
27  C:  Right.
28  R:  With an orange flash down the front
29  like a: flash of light:ning would look
30  like sometimes.
***Lines omitted about what Thor created***
37  C:  Is he kind of hu:ge.
38   (0.4)
39  C:  A big bloke or?
40  R:  No: he's not hu:ge he's a biggis:h looking
41  bloke though.
42  C:  Right.
43   (0.7)
44  R:  A bih- ter: (. ) not bigger than (0.5) no:rmal
45  big men but (. ) big you know.
46  C:  RIght. Couldn’t he:- (1.0) pahh! I don’t want
47  to sound s (h) keptical but- couldn't he have just
48  beena jo:gger or something like that?

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Palmer points out that, in lines 22-23, C is withholding acceptance of R’s account.

Palmer’s analysis (which is more far detailed than presented here) takes R’s account about Thor to be a disputable claim and not, as I have, what at least begins as a

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⁸ Unfortunately, readers of the paper are not in a position to check lines 31 to 46 for any more detail on R’s presented reasons for Thor’s visit because those lines are not provided in the published paper.

⁹ That is not to say that someone working from an orthodox psychiatric position, or from Palmer’s position for that matter, would not ‘diagnose’ R (or someone deemed ‘like’ him) as ‘delusional’ under different interactional circumstances to those in Palmer’s data. But what I am saying is that the bases for such ‘diagnoses’ are moral and questionable, even against their own criteria. Further studies are, of course, required on the explication of such practices.
straightforward report. C might otherwise have responded with, say, ‘Wow weren’t you frightened?’, were he not looking to find evidence of delusions. Instead, however, in terms of R’s talk and perhaps even C’s (even though I, on the face of it like C and Palmer, also consider the talk to be about a bizarre topic), there is nothing inherently problematic in R presenting the event as ordinary. The events are perfectly understandable from R’s point of view.

Palmer takes R as providing only ordinary details about Thor (the catsuit, etc), in response to C’s implicit request for evidence about the paranormal. This is in line with Palmer’s assumption that R is describing a paranormal event as a paranormal tale. Thus, R is negatively evaluated for being out of touch with the social world; for not telling a paranormal story as one is supposed to. Palmer forgets that conversational rules are not to be followed ‘slavishly’ (Sacks, 1992). For Palmer, this is the first of R’s major shortcomings.

In another reading, however, R is merely managing the social tensions which bear on C’s questioning of R’s rationality, whilst at the same time providing some evidence on C’s terms. R, though, is not fully conforming to the social norms, and Palmer’s criteria, of how one should report what some might take to be an extremely extraordinary series of events. In my reading, R can be said to be displaying considerable social skills, including the ability to manage the tension, from a position of less social power (given that he is the ‘patient’ being doubted), between his ordinary report and trying to respond adequately to C’s requests and C’s largely implicit but not ineffectual doubt-in-action.

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10 I acknowledge that this is, in part, a moral judgement but, after Boyle (2002b: 248), I use ‘bizarre’ in the social sense of the phenomena being incomprehensible, as Thor, to me: it is not necessarily incomprehensible to everyone and certainly not to R.
Consider also substituting in the transcript the word ‘Thor’ and that character’s Thor-like accoutrements with a more obviously ordinary or otherwise acceptable identity and his or her characteristic accoutrements (eg, a jogger in a tracksuit, or Jesus Christ). Does one not find, leaving the rest intact, that R’s is an ordinary tale which had better be taken as such, on its contents, actions, and on R’s own terms? In the extract below, I have replaced ‘Thor’ with ‘Jesus’:

Extract 5.7 (modified from Palmer, 2000: 669)
1  C: So you believe there's an afterlife then?
2    (.)
3  R: Yes I do now. Now I've seen a god as
4    well you know. Well he doesn't call himself
5    God he calls himself Je:sus.
6    (0.8)
7  C: Ye:ah.
8  R: I saw him on a f:- (.) I've se:en him a couple of
9    ti:mes on a fi:eld up in Leicestershire I saw him
10   once.

In some social circles, such as amongst particular branches of Christianity, a person who describes having experienced this kind of visitation may be deemed ‘normal’ (as opposed to ‘insane’) and even considered to be privileged. That is, depending on cultural factors, such a report may produce an increase, not a reduction, in social status. Nor is it generally considered to be a mark of ‘schizophrenia’ for those who believe in such matters to attempt to proselytise unbelievers. With R’s account of the afterlife - a topic which is set up by C, as at least a potential believer - why then should we privilege C’s position and a psychiatric position (which, as I have argued, somewhat coincide)? Why should R be ‘diagnosed’ a priori, simply for reporting idiosyncratic experiences and beliefs? As in Harper’s (1999) rationality trap, after C’s and Palmer’s a priori ‘diagnosis’ of R, whatever work R does to establish himself as an ordinary, rational, mundane reasoner merely tightens the ‘diagnostic trap’ still further. With such dominating institutional practices in place, as long as R holds to any vestige of his version of his account, then he may be deemed delusional, no matter much he
demonstrates that he is rational. It is as simple, as far-reaching, and as power-laden as that.

In contrast, Palmer has it that R is not socially ‘outward-looking’ and does not provide the kind of evidence which is required to quell C’s doubt: “It is this ‘outward’-looking orientation which is absent from R’s talk and, as such, he appears disengaged from interactional concerns which constitute the normal social world” (p. 673). For Palmer, this is R’s second major shortcoming. It is on the basis of these two shortcomings that Palmer suggests a social diagnosis of ‘delusion’ could/should be made.11 The rest of the analysis and the discussion section of the ‘delusions’ paper turns on much the same issues I have already described, as does Palmer’s approach to ‘hallucinations’: the patient is found to be ‘socially disordered’ in that they do not fully report questionable phenomena in the way that Palmer deems to be socially appropriate, according to his psychiatrically skewed view of the ‘interaction’. Through his analyses, Palmer has it that the patients have “irrationally constructed descriptions of experience” (from the unpublished hallucinations paper) and I take it that the patients are deemed to be irrational because they do not fully conform to the interviewer’s and the analyst’s social rules; rules which are in fact normative, and not absolute as Palmer would have them.

In conclusion concerning Palmer’s approach, the moral basis of his de facto ‘social’ diagnostic procedure is not made explicit by the author. The author also gives little or

11 In a personal communication from Palmer (2003), he points out that, here, I omit to mention his empirical grounding of his claim that R recognizes, but does not respond to, local interactional concerns: “By contrast, in its original context, this claim is grounded on an interactional analysis of lines 47-55 that uses four pieces of evidence. These are the sequential location of C’s turn, the details of its design (‘Is he kind of huge?’ versus ‘How large was he?’), R’s lexical choice in his reply and the precise prosody of his turn (i.e. the contrastive stress on ‘no normal’).”
no analytic attention to important issues of privilege and prejudice which are enacted both within and without the data. This is, after all, a social scientific interview where C is in charge (something which may well be an approximation of an actual psychiatric interview and of the kind of mundane practices which probably also occur in ‘normal’ conversation when one of the participants is deemed by the other to be delusional). These shortcomings are despite Palmer’s sound, general introductory discussions of matters such as social power. In a number of keys ways, it appears that Palmer’s approach to being understanding of psychiatry’s methods has supplanted his regard for the concerns of those who are reporting the experiences in question.

We now consider hearing voices, in particular, but not in terms of Palmer’s approach. Rather, we return to Leudar, Thomas, and colleagues’ inter-personal approach to studying hearing voices; research which does not supplant voice hearer accounts. For example, Leudar, Thomas, McNally, and Glinski (1997) (see also Leudar & Thomas, 2000) used interview data to study voice pragmatics. Due to the nature of voices, this could not be research on the ‘direct’ interaction between voice hearers and voices. Instead, it is a discursive study of the functional relationship between voice hearers and voices, according to voice hearer accounts. If voices are a kind of inner speech (see McGuire et al., 1996, who construe voices as abnormal), then what kind of speech is it? What do voices and voice hearers ‘do with words’, in relation to each other? Note that these are question which can be posed regardless of whether voices are considered ‘normal’ or ‘abnormal’.

The 1997 study used a semi-structured interview to gain information about the respondents’ voices. The participants were all voice hearers. Less than half had at some time been diagnosed with ‘schizophrenia’; others had never come into contact with psychiatric services. Leudar et al. (1997) found differences in voices, between reports
from respondents who were diagnosed with ‘schizophrenia’ and those who were not, to be best summarized as quantitative rather than qualitative.

To what extent were voices describable as speech? Most respondents described their voices as something which is spoken, that they can hear; something with auditory and verbal qualities. However, there are ways in which such talk is not like the ‘everyday’ variety. For example, none of the respondents reported that their voices come from people’s mouths. Some respondents’ voices were described as coming from within their own heads and yet occupying a particular spatial position (left or right). Of those who reported hearing voices through their ears, some of them heard them from a fixed spatial position in relation to their body (e.g., always from behind and on the left). Thus, unlike ordinary speech, voices were typically tied, in one way or another, to the voice hearer’s body. Also, some respondents described perceiving their voices in other sensory modalities, such as the physical sensation of a voice’s breath, even in the absence of its speech. Some voices were described as being unclear or even ‘silent’; some as being a chorus of voices, saying the same thing.

How are voices personified? Each voice hearer experienced an average of two or three recurring voices. Voices were identified through a variety of phenomenological characteristics, such as voice quality, age, gender, displayed knowledge, and typical verbal behaviour. Characteristics tended to remain the same across occasions. Most voice hearers reported experiencing voices which were aligned to a particular person: they were the voices, or like the voices, of people who they knew or had known (living or dead) and had some personal significance for the voice hearer. Most voices were aligned with ordinary characters. Several of the voices were said to be just like the respondent’s own voice, and yet they were somehow ‘other’ than the respondent. Although some voices were identified as famous people or supernatural beings, this was not typical; nor was bizarreness.
Leudar and Thomas (2000) note that Chadwick and Birchwood (1994) state that the voices of most hearers ‘with schizophrenia’ are attributed to the supernatural and are therefore ‘delusional’. However, Leudar and colleagues’ respondents mostly reported that their voices were aligned to ordinary people. Also, Leudar and Thomas show that their respondent, TK, below, does not unequivocally report a supernatural origin, even though the voice is clearly aligned with a supernatural identity:

Extract 5.8 (from Leudar & Thomas, 2000: 186, Code DM and TK)
58. TK: and it’s put me in a psychosis, I’ve walked around (0.62) I’d used to think it was God, you know what I mean, I was really ill (1.3), I’ve walked around hospital (1.0) fearing people can hear me me voices, you know what I mean, I’ve I’ve been in a psychosis,[sic] you know what I mean [Debs?]
59. DM: [Yeah. (0.71) So: do they um (1.28) kind of (0.65) where do you hear them? (0.35)
60. TK: In me left-side of me head. (0.52)
61. DM: Right.=
62. TK: =The left-hand side (0.78) and it’s funny, ‘cos sometimes God speaks to me right-hand side. I don’t know whether it’s God or just meself, y’know. (99) [sic] I’ve not sorted that one out yet. I’ve not come to terms with that yet.
63. DM: So, right, is the voice you, there’s a voice that you sometimes think is God?
64. TK: Yeah.

We can perhaps begin to see how a voice hearer describing a supernatural character *in connection to* a voice might be misconstrued as being a *clear statement* of belief that the voice *is* the actual voice of that supernatural character. This is ironic, in that people who are deemed to be mad are not supposed to make sense, and are therefore, typically, not supposed to be capable of making clear statements, by definition. To reiterate, though, most voices are aligned to ordinary people and they are said to be *like* someone, rather than usually being thought as actually coming *from* that someone. Also, the way in which the voice is described varies according to the ongoing interaction in the interview. With this in mind, we may compare the use of “God” in turn 58, above, with the second use of “God”, in turn 62. The former is positioned in a ‘psychotic’ past in which TK thought it really was the voice of God, and the latter comes after a question which makes relevant a more individualized, rational account of the voice. Note also
that the first use of God in turn 62 could be taken to be referring to the ‘actual God Almighty’ or to a voice that TK calls ‘God’ because it in some way resembles ‘God Almighty’. Leudar and Thomas make a particular point, here, about not interpreting voice identities and other meanings; of not privileging their own categories over those of the voice hearers. Thus, we may conclude that analysts using ‘other meanings’, such as metaphor, or like Palmer, taking all accounts as literal, should be mindful of the benefits of maintaining a grounding of their conclusions in the interaction.

In what ways are voices dialogically positioned? This refers to the matter of whose message the voice is conveying and to whom. If voices are a kind of inner speech then one would expect them to be focused, dialogically, on the activities of voice hearers. Conversely, it would be unlikely for the voice hearer to be positioned as an eavesdropper; for the voices to address another person or to address themselves without the voice hearer as a targeted audience. In line with this theory, most respondents’ voices were dialogically positioned to directly address the voice hearer and not anyone else. This was typically the case even for reports of several voices talking at once. Also, rather than being completely removed from social interaction with other people, some voices were reported to comment on what other people said or what the voice hearer said to other people. Thus, the voices, and not the voice hearers, tended to be in the dialogical position of overhearers.

Another participant position concerns whether the voice hearers speak to other people about their voices. This was rare. In line with the dominant, contemporary view of voices in Western society, the respondent, TK, said that he did not want others to feel bad about him when he was feeling ‘paranoid’. He also said that he did not want others to feel what he was feeling under such circumstances. However, we can note that, as the study found that most voice-talk was a commentary on voice hearer’s everyday actions, topical (ir)relevance and mundaneness may be other reasons for why the experience is not
often shared with others. The emphasis which DSM-IV places on the loosely specified criterion of “a voice keeping up a running commentary on the person’s behaviour or thoughts” (APA, 2000: 312) as a prime indication of ‘active-phase schizophrenia’ is alarming, given the commonality of often mundane comments by voices about a voice hearer’s thoughts and actions. Bear in mind that many of the respondents in Leudar and colleagues’ interview study were from a non-psychiatric population of university undergraduates. This may be taken as a problem with the construct of ‘schizophrenia’ rather than an indication that many people in the ‘normal’ population have ‘psychotic tendencies’ or undiagnosed ‘schizophrenia’.

Leudar and colleagues also consider some of the sequential properties of voice-talk. For example, they describe how Socrates’ daemon was characterized by asymmetrical forbid-obey adjacency pairs, initiated by the ‘voice’. Indeed, most of the interview respondents in the 1997 study reported that their voices ordered them to do things; mostly mundane activities, but sometimes to injure themselves or others. In line with this, voice hearers rarely reported that a voice had access to knowledge which was beyond the voice hearer. And although typically mundane, voices usually had a moral imperative. For example, about half of the respondents reported being judged by voices, with roughly half of them being positive judgements and half negative. The following extract concerns a report of the latter:

Extract 5.9 (from Leudar & Thomas, 2000: 198, Code PT and NJ)
54. PT: So what what sort of things would would he say to you (1.34) [in those circumstances?
55. NJ: [((cough))  
56. erm  
57. I’ve got to think of an instance (0.40) uhm I can remember (0.26) there was quite some occasion I wasn’t sleeping very well (0.46) and I would start (0.25) missing him and thinking of him (0.56) and (0.52) remembering occasions where we were happy together (0.30) looking for comfort from him (0.38). But he would come and he would say ‘you’re being stupid, it never was like that’ (0.53) ‘you’re being’ erm (0.33) ‘you’re not being a proper mother’ (0.28) ‘you’re neglecting things’ (0.35) erm ‘you’re a mess’. It would be very derogatory to [me
58. PT: [(right]
It is important to note, however, that voice hearers typically did not agree with the voices’ judgements or obey their voices’ orders, mundane or otherwise. This, like the ordinariness of most voice content, is contrary to dominant media and psychiatric representations of voices and voice hearers. Interestingly though, although the most common voice hearer reaction to a voice was to tell it to go away, it was rarely effective. That is, voices regulate the actions of voice hearers more than the other way around.

Leudar and Thomas (2000) discuss how voice hearers frequently display mundane reality testing in their accounts about voices. They note that this is a problem for psychoanalytic theories which posit poor reality testing through a regression into fantasy (citing Sass’, 1992: 273, consideration of this problem) and for cognitive theories which posit a reduced tendency or deficient capacity to perform reality monitoring/testing through pre-conscious, meta-cognitive processes (citing Bentall, 1990b, and Bentall, Baker, & Havers, 1991). It is a problem for these psychological accounts to explain, then, how respondents generally reported not having difficulty in distinguishing between the objective and the subjective, and between perception and fantasy; in knowing the difference, say, between a voice and the person to which the voice is aligned. And yet, despite such insights, the respondents continued to hear voices. Why, then, should mentalist explanations be allowed to dominate over the empirical fact that voice hearers are generally ‘good’ mundane testers of ‘reality’, regardless of (or perhaps because of) some of the more bizarre constructions which may be enlisted to explain the often perplexing phenomena of hearing voices with no external source. Why, also, should hearing voices be crystallized as an error when many voice hearers do not negatively evaluate any or all of their voices?
Returning to Leudar et al.’s respondents, they described a range of mundane reality testing approaches, such as checking whether other people can hear the voice, or checking for external sources of the voice:

Extract 5.10 (from Leudar & Thomas, 2000: 204, Code PT and NC)

26. NC: ...the: second one that I heard recently "right" ((asp)) was my friend (2.4)
27. PT: ye your partner?
28. NC: Ye:h=
29. PT: =yeh
30. NC: it was ↑he:r↓
31. PT: "Right" (3.60) so, so you know very clearly that (0.67) em I mean that it’s: her voice, you can tell even if it [didn’t (unclear)]
32. NC: [Second one was ] yeah yeah it was if was definitely her because I even had asked if she’d come down to ma because I thought she might’ve come down to my door=

Here, the voice is enough like a perceptual experience and sufficiently like NC’s friend for her to go about the mundane reality test of later checking with her friend whether the friend had ‘really’ been calling from outside the door (turn 32). Note, however, that it is not until the phrase “because I even had asked if she’d come down” (turn 32), and PT’s question which preceded it, that it is clear that NC was reporting that the voice was merely like her friend and not actually from the friend. Thus, we may see this as another demonstration of the situatedness of reports about voices, in interaction, and the importance of not jumping to analytic conclusions. Leudar and Thomas (2000) also conclude that NC is distinguishing between the ‘real person’ and ‘the voice’ rather than between ‘internal’ and ‘external’. It is of note that CBT for ‘psychosis’ often focuses on promoting reports that a voice sounds like it is inside rather than outside a voice hearer’s head; a practice which might be to the exclusion of a person-voice distinction like NC’s. However, not every respondent reported always being able to clearly establish such matters:

Extract 5.11 (from Leudar & Thomas, 2000: 203, Code DM and TK)

56. TK: I don’t want people to (0.56) to feel anything off me, you know what I mean y’ don’t? (0.45) when you’re getting me scared of people feeling (0.41) bad about you, y’know what I mean y s you get paranol ah paranoid about, that’s why it’s called paranoid schizophrenia you know I mean I think (0.83) you’re just you’re scared of people witnessing what you’re going through, or hearing the voices. I’ve
been through psychosis (0.46), because I’ve been scared of people being able to hear me voices.

57. DM: Yeah.

Leudar and Thomas describe two questions which seem to vex voice hearers as they discursively deal with their voice-related experiences: (1) How can they hear a voice with no apparent external source - are they a visionary or are they mad? and (2) Why have they been singled out for such a bizarre experience? Despite the ordinariness of most voices, the experience remains a puzzling enigma, for voice hearers and non-voice hearers alike; for both lay people and professionals. Nevertheless, Leudar and colleagues have done a great deal towards elucidating the pragmatics of hearing voices, from a voice hearer’s point of view.

In conclusion, for this stage of our review, all of the above approaches have involved the study of what many would take to be ‘psychotic’ discourse from a more or less discursive point of view. Such detailed consideration of ‘psychotic’ talk is rare, especially if it comes without assumptions of pathology. This also contrasts with orthodox psychiatry, in which the content of ‘psychotic’ talk is of little or no interest. In Harper’s work there is a pronounced incorporation into analyses of beyond-the-data, macro-social issues such as gender and class. Such analytic practices have costs and benefits. That is not to say that Georgaca and Palmer did not include social justice (ie, macro-social) considerations in their discussions, but that they did not feature so strongly in their analyses, which, especially in the case of Palmer, were focused on fine-grained aspects of the data-at-hand. Nevertheless, Palmer’s analyses were, in practice, found to be influenced by macro-social factors, in favour of the dominant social position. This was not adequately acknowledged by Palmer. In contrast, Leudar and colleagues’ approach managed to minimize their assumptions by focusing on explicating the perspectives of voice hearers.
A small number of studies have applied discursive analysis to the talk of ‘psychotic’ patients and their treating professionals either in actual clinical encounters or talking about them. McCabe, Heath, Burns, and Priebe (2002) use a CA approach with consultations between psychiatrists and ‘psychotic’ patients. Following their analysis, the authors conclude that the patients tended to use various ways of opening up the topic of the content of their ‘symptoms’ but that the psychiatrists tended to use various ways of not taking it up. This non-uptake may be compared to my reading of Palmer’s (2000) data. In both of these studies, Palmer (2000) and McCabe et al. (2002), those who were not patients were characterized by their non-uptake of patient topics from the patients’ perspective. McCabe and colleagues, though, cautiously suggest that it might have been better had the non-patients (in their study, the psychiatrists) responded differently. Their paper is also notable for its being published in the influential *British Medical Journal*.

A study by Messari and Hallam (2003), published in the influential *British Journal of Clinical Psychology*, uses discourse analysis to investigate clients’ (and therapists’) interview talk concerning cognitive-behavioural therapy for psychosis. The following discourses are considered: ‘This is truly happening’ (ie, the construction of ‘psychotic’ experiences as real), ‘I am ill’, ‘CBT as an educational process’, ‘CBT as a respectful relationship between equals’, ‘CBT as a healing process’, and ‘CBT participation as compliance with the powerful medical establishment’. Most of the clients were inpatients.

Most of the clients and all of the therapists described therapy as a respectful, healing, and educative, collaboration. One of the clients (C2), however, made much use of ‘CBT participation as compliance with the powerful medical establishment’. This client’s account was “dominated” by “powerlessness and passive compliance” (Messari & Hallam, 2003). C2’s account also suggested that they were unsure about the purpose of therapy. We can see that both of these problems, ‘compliance/domination’ and
‘uncertainty about the purpose of therapy’, *may* be attributed, by some, to problems located within the patient. However: “C2’s lack of clarity about the purpose of therapy was mirrored by his therapist’s (Therapist 2) account of her reluctance to discuss openly with C2 about the purpose of therapy” (Messari & Hallam, 2003). This raises questions about causality. To whom might the problem be attributed and what about the influence of social interaction on both parties? Also, some of the clients switched often between the supposedly contradictory discourses of ‘This is truly happening’ and ‘I am ill’. This raises questions about the “double awareness of delusions” and whether such ‘beliefs’ can be reliably measured (Messari & Hallam, 2003, citing Chadwick, Birchwood, & Trower, 1996). Messari and Hallam suggest that a consideration of the demands of the social interaction and the wider social context may be important in understanding such matters.

The problems for Messari and Hallam’s (2003) approach, of their interviews about CBT not being ‘naturally’ occurring talk, and of their analysis having little detail and being insufficiently grounded in the interaction, should not be overlooked. However, the paper represents important progress, in the published application of discourse analysis to talk which directly involves ‘psychotic’ people, in general, and in client/patient talk about CBT for ‘psychosis’, in particular.

In conclusion, although the reviewed studies do not tend to include the professional representation of ‘mental illness’ (and ‘mental wellness’) as a topic in its own right, this review has shown that ‘clinical’ interactions such as diagnostic interviews and therapy sessions may be a key arena for Members’ concerns about such matters. And, when discursively studying professionals representations of ‘severe mental illness’ then what better place can there be to study such representations than in interaction with patients who are diagnosed with ‘severe mental illness’. The above studies, by considering practices and not just theoretical positions, have told us much about how professionals
and patients do, or may, represent ‘severe mental illness’ in ‘clinical’ interaction. Nevertheless, given the withholding of explicit professional opinion shown by the ‘diagnostic interview’ studies of Georgaca and of Palmer, and the fact that both of those approaches involved contrived situations, perhaps actual talking therapy sessions will be a better location for the investigation of such representations as they naturally occur.

In this chapter, we have considered a selection of discursive studies of talk by or about patients who have been diagnosed with ‘severe mental illness’. All of the discursive approaches reviewed (including the textual and extra-textual aspects of those approaches) stand in generally sharp contrast to dominant psychiatric practice in which the content of talk - except talk which espouses an orthodox psychiatric position - is considered to be largely meaningless. As such, the reviewed studies and their approaches offer important challenges to biomedical psychiatry. The studies also complement and confirm the ‘findings’ in this dissertation concerning the discursive representation of hearing voices within ‘mental illness’ and ‘schizophrenia’ and concerning privileges and prejudices-in-action which operate in such discourse.

Various cautions were noted, however, with Palmer’s psychiatrically skewed ‘social diagnoses’. Such cautions are mostly in connection to the analyst being swayed by extra-textual concerns, in that concerns of the ‘professional’ interactant and psychiatry were privileged over patient concerns. This was identified as both a methodological shortcoming - with Palmer’s version of EM/CA - and a problem in the actual and potential social ramifications of how the methodology was put to use, as what amounted to prejudice-in-action against the patients’ accounts. That is, such an approach tends to overshadow inter-personal accounts with professional accounts. Besides ‘academic’ pros and cons, there may be ‘practical’ negative social consequences for people who are already socially subordinate, as ‘patients’.
A related concern in this chapter has been whether discursive analyses, such as Harper’s, ought to make use of beyond-the-data, macro-social, cultural information in their analyses and discussions. If so, then there are the thorny questions of ‘How much?’ (local vs cultural), ‘Where?’ (analysis vs discussion), and ‘To what ends?’ (explication of data vs critique as addition to psychiatry vs critique for replacement of psychiatry). Overall, it appears to be a matter of matching the tool with the task to be performed.

It has been noted that none of the reviewed studies have concerned actual talking therapy encounters with people who are diagnosed as ‘psychotic’, as do the following chapters. However, I hope that, before we move on to the hearing voices group, this review of studies and stances on ‘mental illness’ has sufficiently described and given credit to the way in which the various discursive approaches have begun to explicate, challenge, and even potentially change socially restrictive psychiatric practices.

12 Of course, even a number of these bracketed distinctions are readily debatable.
CHAPTER 6. REALITY AS A NEGOTIABLE OBJECT

Everyday descriptions and psychological attributions, viewed in the context of their occurrence as discourse, perform normative, reality-defining, intersubjectively oriented work. That work includes the invocation of a range of psychological categories whose status is not so much definitive of the persons described, nor even of the person-perceptions of the describers, but, rather constitutive of the interpersonal actions performed using them.

(Edwards, 1997: 66)

SECTION 1. THE DATA CORPUS

This chapter and the next are based on transcribed ‘schizophrenic’ talk. Each chapter includes professional-led talk about the content of voices and ‘delusions’; contrary to the dogma of orthodox psychiatry. Perhaps, though, what is most striking - especially given the apparent bizarreness of the kind of experiences in question and given their psychiatric history - is the overall ordinariness of the speakers and much of their talk. This is in line with Leudar and colleagues’ interviews with voice hearers; those who had been diagnosed and those who had not.

But what of the other participants? We have already seen in this dissertation some of the ways in which clinical psychologists can claim to be more respectful of the views of

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1 A version of this chapter is under review for publication in Discourse & Society as “Hearing voices and cognitive-behavioural therapy: Competing accounts of ‘what really happened’ and ‘what really helps’”.

psychiatric patients, in comparison to orthodox psychiatry. Now we can see some clinical psychologists in action.

The transcribed data extracts, here, are from a corpus of audio recordings of group therapy sessions and interviews about hearing distressing voices. They do not focus on positive voices experiences. Also, only a small selection of materials from the 8, weekly, 1½ hour group sessions are included here. The transcripts are based on conventions developed by Jefferson (eg, Jefferson, 1985) (see Appendix A of this dissertation for a summary version).²

The recordings were collected in a regional mental health centre, in Perth, Western Australia. There were four patients and two therapists. Within this group of participants, numbers varied from week to week. These particular voice hearers all had well-established psychiatric careers. They were all psychiatric outpatients who had experienced at least one diagnosed ‘psychotic episode’ and who were referred by mental health workers to the hearing voices group for having ‘medication-resistant’, distressing ‘auditory hallucinations’, despite at least 12 months of routine medical treatment. In fact, the patients had all experienced distressing voices for many years. Three of the patients had a diagnosis of ‘chronic schizophrenia’. The other patient was diagnosed with ‘anxiety symptoms with agoraphobia’, ‘borderline psychotic symptoms’, and ‘dependent, histrionic, and borderline personality traits’. All of the patients were ‘well-known’ within the service.

² The titles of the extracts are in the following format: Extract # (HVG, S#, MW). The first number refers to the positioning of the extract in the chapter, in relation to the other extracts. ‘HVG’ stands for hearing voices group. The second number refers to the number of the group session from which the transcript extract was taken. ‘MW’ stands for Mike Wise, the transcriber. Some of the transcripts in these chapters also include the start and end time of the extract, in minutes and seconds, with 00:00 being the start of each group session.
The extracts in this chapter and the next include the following interactants: Belinda (B, a voice hearer); Mike (M, a psychologist, a trainee clinical psychologist, and the author of this dissertation); Richard (R, a senior clinical psychologist); and the voice hearers, Stuart (S), Tanya (T), and Walter (W). Across these two chapters, the males of the group (Stuart, Richard, Mike, and Walter) are most featured; a product, I suggest, of the fact that these interactants produced more talk than the females in the group. The extracts in these chapters were selected, quasi-randomly, on the basis of their relevance and perspicuity to the thesis question.\(^3\)

The group therapy protocol (Wise, 2000) was based on up-to-date cognitive-behavioural research. That is, it adopted a CBT approach, ostensibly to enhance the integration of experiences, to increase exposure to voices, and to develop effective coping skills. As we saw in Chapter 3, the proponents of CBT, as ‘scientist-practitioners’, claim an objective, intrapsychic understanding of behaviour and its causes in relation to cognitions. Furthermore, researchers and cognitive therapists claim to know what is normal and abnormal therein, and how to intervene to bring about something closer to normality within the client/patient. In CBT, then, despite (or because of) ‘normalization’ and supposedly non-leading Socratic questioning, the view of the professional is typically privileged over that of the client/patient.

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\(^3\) I thank Mary Boyle, who noted in a personal communication (2004) that there is a marked imbalance in the amount of male and female talk in this chapter and the next. The interactional basis and the implications for a therapy group of such gender imbalances in the amount and perhaps content of talk warrant further investigation.
SECTION 2. ‘WHAT REALLY HAPPENED’ AND ‘WHAT REALLY HELPS’

Introduction

Here, I consider further some of the background of why the analyses in Part 2 of this dissertation are of interest. As we saw in Part 1, the content of ‘psychotic’ talk is given little credence in biomedical psychiatry. Instead, patients’ reports of bizarre phenomena and the form of their talk are considered simply as ‘symptoms’ of ‘psychosis’. Irrationality is assumed. In those same chapters, we noted that, in CBT, patients’ talk and the personal meanings of their experiences are theoretically afforded more status. However, as was shown in the last chapter, the application of discursive analyses to ‘psychotic’ and ‘therapy’ talk lays bare actual clinical practices which may be at odds with these theoretical commitments. To date, though, such studies have relied on data from contrived interviews rather than naturally-occurring clinical encounters. To address these and other shortfalls, I apply a discursive analysis to talk from a CBT group for formally diagnosed ‘schizophrenic’ patients who hear distressing voices. To pre-empt our findings, in this chapter it is shown that, despite considerable evidence of patient capability in the group, their overall irrationality is assumed and the accounts of patients’ lived experience provided by treating professionals are privileged. That is, what is locally permitted to constitute both ‘help’ and ‘reality’ is at the expense of accounts from patients; those with, arguably, the most immediate expertise on the phenomena in question.

Current psychiatric and commonsense understandings of the experience of hearing voices and of the holding of ‘delusional’ beliefs are that these phenomena are pathological ‘symptoms’ of ‘severe mental illness’ (American Psychiatric Association, 1994; see British Psychological Society, 2000). In consequence, the recommendation of
orthodox psychiatry is to pay no heed, at a local interactional level, to the detail of actual patient talk about the phenomena in question. With its current biological focus (eg, Liddle, 2000; Cunningham Owens & Johnstone, 2000), the implication in psychiatry is that patients - especially those in ‘florid psychosis’ - are deemed to be, quite simply, out of touch with reality. Thus, any attempt to engage with a patient’s descriptions of bizarre phenomena is to collude with, and hence to reinforce and maintain, their madness. Therefore, like other ‘talking therapies’, CBT is typically reserved only for patients with ‘residual symptoms’; ‘symptoms’ which have not been alleviated by the primary and principal treatment of medication.

The contemporary posture of biopsychiatry belies the fact that, in practice, little is known about the phenomena in question (Boyle, 2002a & b). Despite occasional acknowledgments that hallucinations are not invariably associated with psychosis (eg, Johns, Nazroo, Bebbington, & Kuipers, 2002), as ‘symptoms’ of schizophrenia, voices (or ‘auditory hallucinations’), like ‘delusions’, are increasingly seen as the result of dysfunctional neurotransmitters or, if a psychological gloss is applied, as either a ‘sensory deception’ (Bentall and Slade, 1988) or other failure of reality-testing such as a misattribution of inner speech (cf. Bentall, 1990c; Bentall, 2003). Disruptions to automatic cognitive processes and maladaptive conscious appraisals - in the mind - are seen as leading to ‘psychotic symptoms’ (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Although (once a diagnosis has been established) the contents of delusions and voices are traditionally seen as irrelevant in medical psychiatry, they are increasingly seen as potentially fertile ground for cognitive-behavioural therapies (eg, Chadwick, Birchwood, & Trower, 1996), as an adjunct to pharmacological treatments. An approach which allows people to talk about their voices, and which apparently leads to a reduction in voices-related distress, would seem to be worthwhile and ‘empowering’. However, talking therapies such as CBT can also be highly restrictive
and prescriptive - starting as the approach does from the assumption that the client displays cognitive irrationalities which, for a therapeutic effect to be achieved, require replacement with therapist-endorsed adaptive cognitions. As such CBT has been criticized as a tool for the continuation of medico-professional domination (Cooke & Rapley, 2000) as the data in this chapter also demonstrate empirically. The medical model is not far below the surface in clinical psychology. Other social-therapeutic interventions - including, for example, educational or vocational activities - still tend to be seen as palliative, rather than curative or otherwise beneficial.

**The existing literature**

In this chapter and those that follow, I argue that psychiatric and psychological assumptions about hearing voices entail grossly pathologizing generalizations about complex issues which are, in practice, shaped by and produced in the interaction of therapists and patients. Earlier in the dissertation, we identified a number of criticisms of, and critical alternatives to, a biopsychiatric approach to the phenomena in question. From the review, it was concluded that discursive data and methods of analysis may provide support for the more theoretical/conceptual alternative approaches which have been adopted to date, including that of Boyle (2002b). However, a small corpus of work has begun to explore social-interactional aspects of what is commonly considered to be ‘severe mental illness’. For example, drawing on the work of Romme (eg, Romme & Escher, 1993, 1996, 2000), Leudar and colleagues have begun to use a pragmatic and dialogical approach, without the assumption of pathology, to unpick reports of voice hearing experiences (see Leudar & Thomas, 2000).

When considered from such a position, even distressing voices may be seen as perplexing, yet in some ways ordinary, experiences. We can then seek an understanding of these experiences in terms of personal and interpersonal meaning, rather than
viewing them as inherently meaningless symptoms of an individualized ‘mental illness’. Indeed, it is important for professionals and patients to understand that hearing voices may be positive rather than deeply distressing experiences and that hearing voices may occur without coming to the attention of psychiatrists (Tien, 1991; Barrett & Etheridge, 1992; Romme et al., 1992). It has been estimated that as many as 45% of voice hearers never come to the attention of psychiatric services (Romme & Escher, 1993) and that between 3 and 37% of the ‘normal’ population experience hearing voices at some time in their lives (Posey & Losch, 1983).

As we have seen, it has further been suggested within this approach that some voice hearers might develop a more integrated personal understanding of their voices through a dialogical exploration of the experience which relates voices to life experiences. Davies, Thomas, and Leudar (1999) describe the single case study of Peg, who seemed to benefit in this way. One key aspect of this approach was the exploratory, co-equal, dialogue between Peg and a mental health worker. This is taken by Davies and colleagues to stand in contrast to standard talking therapy interventions which are applied by a professional to a patient/client. It is my aim to provide a discursive, data-based complement to the work of Boyle on ‘schizophrenia’ and the work of Leudar and colleagues on hearing voices.

A small number of researchers have already applied the socially-orientated investigative tools of DA and CA to data involving spoken interaction with patients who are diagnosed as ‘delusional’. As we saw in my review, Harper (1999) used a critical form of DA to describe certain features of discourse concerning ‘paranoid delusions’. As a part of his study, Harper interviewed patients, plus a number of their treating professionals on the topic of the patients’ ‘paranoid delusions’. He also drew on his own discourse analysis of structured texts in the public domain, social constructionist literature, and commonsense understandings of ‘paranoid delusions’. One of the
features of ‘paranoia’ which Harper discusses is the necessity for a person who is
diagnosed as having ‘paranoid delusions’ to manage being assumed irrational. As such,
patients must grapple with what Harper termed the ‘rationality trap’. This double-bind
may be summarized as follows. Adopting the role of being ‘mentally ill’ to some extent
divests the patient of agency and responsibility, allowing them, instead, to settle for
being ‘good’ and compliant. But, in a bid to balance this presented and assumed
irrationality, patients also worked to present themselves as more than rational; a move
which can, paradoxically, have the effect of drawing attention to their supposed
irrationality. In this and the following chapters, we see the rationality trap operating,
through a close analysis of interactional data.

In Chapter 5, we also considered Georgaca (2000, 2003), who adopted a somewhat
close, CA, approach to her data but with some additional DA elements. This latter
aspect of Georgaca’s work is more in line with a discursive psychological approach than
CA in its most strict form (see Edwards, 1997; Edwards & Potter, 2002; Potter, 1996;
Rapley, 2004). To summarize, Georgaca (2000) interviewed patients who were
diagnosed as ‘delusional’. Analysis of the transcripts of interviews found that the
patients operated within the bounds of prevailing cultural norms: they evidenced
considerable social skills and practical reasoning in their management of actual or
potential disagreements concerning aspects of the ‘reality’ of their ‘delusions’. Furthermore, the diagnostic criteria of implausibility, conviction, and incorrigibility
were found to be severely lacking on a number of counts.

Finally, Palmer (1997, 2000) also studied ‘delusional’ talk, this time from a fine-
grained, CA perspective and, in an unpublished paper, applied the same approach to
‘auditory hallucinations’. Palmer argues that his patients evidenced social inadequacies, in
particular failings to address conventional requirements of the social interaction. To
summarize, Palmer (2000) focuses on an analysis of an interview with ‘delusional’
patients and like Georgaca, makes the assumption that the interviews may be taken as involving much the same processes as formal diagnostic interviews. However, unlike Georgaca, Palmer starts from an analytic position which accepts the psychiatric reification of constructs such as ‘delusions’ and ‘auditory hallucinations’ as pathological. He then goes on to find a matching type of ‘social’ pathology in the ‘delusional’ talk in his transcripts. But Palmer does this by largely overlooking the patients’ concerns; the patients’ point of view. Palmer’s *de facto* diagnoses therefore miss a large part of the social interaction.

One of the drawbacks of Harper’s, Geogaca’s, and Palmer’s studies is that they each used *interviews* with patients (with all of the inherent interactional asymmetry of the interview method: see Houtkoop-Steenstra, 2000) rather than ‘naturally’ occurring *clinical* interactions. This is another issue which I aim to address in this part of the dissertation.

**The present study**

This chapter takes as its analytic materials the transcript of a single cognitive behavioural group therapy session for people who hear distressing voices. This particular session, session six of eight, occurred towards the end of a manualized series (Wise, 2000). It is, however, in many ways not dissimilar to the other seven sessions. Accordingly, here we follow Billig (1989) who argues that a “single case study can be especially useful, for the detailed analysis of a particular phenomenon can enable the identification of basic features. Whilst no claims for sample representativeness can be made from a single case study ...in-depth analysis can reveal features and complexities, which have a wider generality” (p. 204). The official business of the session was to discuss and evaluate strategies for coping with, and otherwise managing, distressing voices. The therapy sessions of which this was a part were recorded in a regional mental
health centre, in Perth, Western Australia, in the course of a routine CBT group offered by the centre. The speakers in the transcript are Stuart (S, a voice hearer), Tanya (T, a voice hearer), Richard (R, a senior clinical psychologist), and Mike (M, a psychologist and author of this study). Stuart and Tanya had both been diagnosed with medication-resistant schizophrenia. Transcripts are based on the conventions developed by Jefferson (e.g., 1985).

In addition to the aims described above, the analysis presented in this study has two main aims. First, to investigate how the therapy involves negotiations about the veracity of established psychiatric knowledge, as compared to voice hearers’ personal experiences. This is the negotiation of ‘what really happened’ and ‘what really helps’. Second, to examine how talk about mundane (ordinary) topics may do the (institutional) work of therapy. The situated nature of what is describable as ‘institutional’ or ‘ordinary’ talk is shown in the interplay between constructions of ongoing talk as therapy or mundane conversation.

**Analysis**

In the analysis which follows, it is important to keep in mind the fact that the patient participants are formally-diagnosed, long-term users of psychiatric services. These speakers are, officially, schizophrenic. They are ‘sufferers’ from what is supposedly the most severe form of mental illness; an illness which, to boot, leaves its victims with severely reduced capacity for effective social interaction and for sharing the ‘real’ reality which is occupied by their ‘sane’ therapist interlocutors. That is, by virtue of their mental illness, Stuart and Tanya are, by definition - at least according to the canons of psychiatric practice - more or less lacking in insight, out of touch with the shared rationality of the rest of us, thought disordered, irrational, and socially incompetent (APA, 1994). It is also important to bear in mind the fact that the purpose of the therapy
group was, officially, not only to assist the participants to develop ‘healthier’ cognitive and behavioural strategies for dealing with hearing distressing voices, but also to provide a safe and supportive forum within which to learn more ‘adaptive’ strategies. To pre-empt the analysis somewhat perhaps, as we will see, much of the talk in these sessions is perhaps better understood not as a benignly therapeutic collaboration, but rather as an unequal conflict over what should count as ‘reality’.

1. A personal account: Medication and a doctor who knows

A noticeable feature of the data corpus is that disagreement with, criticism of, and the avowal of counter-positions to Richard and Mike’s talk by the patients are rare, subtle, and/or slow to arrive, particularly given the technically-mandated CBT requirement for the therapists to identify and deliberately ‘challenge’ their clients’ supposedly irrational cognitions and beliefs. Such interactional management suggests that the supposedly irrational patients are at least aware of the delicacy and precariousness of their position vis-à-vis their professional interlocutors. To see this more clearly, I begin with Stuart’s account of being given professional help for dealing with distressing voices in Queensland, where he previously lived; an account which soon becomes problematic. This interaction occurred in the course of a discussion about how Stuart dealt with hearing a voice the night before, and about what time he takes his medication. Note that Stuart takes care to preface his account with the provision of mundane, but factual, details of the name of his doctor, twice repeated, and of his specific location:

Extract 6.1 (HVG, S6, MW)

1  S: And erm: <Doctor: Brown> ↓ his name was. ↑ YEAH
2  Doctor Brown ↓ in (0.2) Townsville
3   (1.4)
4  S: [^t] ↑ He: u: m (.) he: put me o: nto um: (0.2)
5  ↓ clo: zapine
6   (1.4)
7  R: ((croaky)) Y: e[h.]
Stuart describes doctors in Queensland as having had a “good idea what was going o:n” (line 13 ff.) and reports their advice to remain on clozapine permanently as, again, being a matter of fact (line 8), a situation with which he describes himself as being “happy enough”. In the present context of a very different treatment modality (group therapy vs. pharmacotherapy), this account is hearable as a subtle criticism of the treatment he currently is receiving. This is, perhaps, a criticism of the current therapy group. However, despite this, neither Richard nor Mike pick up on what Stuart is saying about clozapine and previous medical care as being effective. It is noticeably not taken up as either a criticism or as a potential avenue for exploration of the group’s main aim of reducing distress from problematic voices. Stuart’s story then moves into contrasting Queenslanders, some Queensland therapy groups, and himself, as ‘feeling’ and ‘expressing’, in contrast perhaps to Western Australians and WA therapy groups (lines 19 to 32, below). Here, feeling’ and ‘expressing’ may be taken as another possible solution that Stuart is offering to the distressing experience of hearing voices. It is also perhaps another subtle criticism of the current therapy group. It is certainly to lay claim to expertise in the nuances of therapy across locations, and also to claim the ability to veridically experience and describe the ways that things stand in the world with respect to the very matters (his and others’ emotions and communicational capacity) that both his diagnosis and his presence in the group place in jeopardy.
In lines 40 to 42, Stuart effects a display of his social tact and delicacy via the contrast he constructs between group members and, for example, ‘people at school’. That is, in lines 19 to 42, Stuart works to display his social awareness and subtlety. He moves on to escalate his troubles telling and, with neither Richard nor Mike receiving Stuart’s troubles telling with sympathy but merely the minimalist acknowledgement tokens ‘mmm’, ‘ok’ and ‘right’ (lines 22, 26, 31, 38, 43), Stuart resorts to agreeing with himself (lines 45 and 49). This is not some form of ‘schizophrenic’ self-talk. Rather, it is a public display of capitulation to therapeutic disinterest, as indicated by the intonation contour of the “Yeh.” at line 49: following the soft and tentative elongated “Y:eh.” of line 45 - which is hearably a last invitation to Mike and Richard to take up
the topic - the “Yeh.” at line 49 is delivered in such a manner as to indicate the termination of Stuart’s turn and his handing over of the floor.

In this brief exchange, then, it would seem to be clear that neither therapist wishes to offer encouragement to Stuart to develop his account of the features of previous therapy groups which he has found helpful. Nor, it would appear, do the therapists have much interest in exploring the issue of Stuart’s claimed capacity to feel, to express himself, and to know his ‘real’ self. Nor indeed do the therapists comment one way or the other upon Stuart’s claimed experience of long-term belittlement. Indeed, by virtue of the non-uptake of Stuart’s material and an immediately following topic shift by Mike (as we see in the next extract) Stuart is, to all intents and purposes, told that his concerns are not therapeutically relevant. That is, we can see that Stuart is both persistent in his efforts to engage his therapists in his version of ‘what helps’, but also sufficiently socially aware to recognize that his efforts are ultimately doomed.

2. Professionalizing the patient’s account: Official coping

As we saw in Extract 6.2, by their failure to pursue the topic offered by Stuart, both Mike and Richard make it clear that Stuart’s offerings are of doubtful relevance to the therapeutic task of the group. Stuart’s acknowledgment that he has understood this (line 49) is then followed by a brief pause and a marked topic shift initiated by Mike immediately following Stuart’s ceding of the floor. With a dysfluent and self-repairing delivery, Mike rhetorically asks whether he can change the subject. The topic proposed then confirms the therapists’ estimation of Stuart’s prior talk (as therapeutically irrelevant) and, instead, proposes therapist-modified patient material as that which is really of local, therapeutic, relevance.

Extract 6.3 (HVG, S6, MW)

51 M: C- (0.2) c’n I j’st (0.5) <zoo:m ‘us \underline{↓}back to
52 (0.4) that situation la:st ni:[ght ]> (th’t-)
S: [YEH.]
(0.6)
M: Um
(1.0)
S: [Mm.]
M: ·hh ONE of the things th’t impressed me:
S: Mmm.=
M: =↓with: um (0.1) the: way: you described it
S: [Y]EH.
M: um (0.1) the: way: you described it
S: [Mm.]
M: ·hh (0.5) >U’m almost thinking it w’s– it w’s
S: [Y]EH.
M: kinda like a three stage process °with–°
(1.0)
M: ↓well (. ) more than that I spose ↑I’]
S: [R i: g ht]
M: could ((smiley voice)) >I could build in
(0.5)
M: lo[t[s of sta]ges ° couldn’t I– <·hh (((cough)))
S: [R i g ht.][↑Y E A H ]
M: could ((smiley voice)) >I could build in
(0.5)
M: ° couldn’t I– <·hh (((cough)))
S: [Y]EH.
M: =↓He[a r i n g– ]
M: (((finger clicking sound)))
S: =Yeh.
M: ((finger clicking sound))= ↓deciding whether or
S: Uh huh.
not it w’s a voice (0.2)
M: deci:ding whether it was true or not=
(0.5)
S: =Yeah.
M: and ↑then deciding what
M: [you’re gonna do: about it]
S: [As a voice yeah. ] >Ye:ah. °As a
M: voice [Mik–]<
S: [ o r ] what your re↑action ↓w’
M: gonna be.
S: [ Y e] ah (0.1) >that it’s gonna be.< (0.1)
M: ↑An[d]
S: [Y]eh.
M: s:- cs:- ↑it kinda sounds quite deliberate ↓the
way you descri:be it. (0.5) ↑More than just
↓lu:cky <th’t i’ did– n’> (0.2) sen:d you
cra:z[y ]
S: [CWA]ZY. [Yeh.]
M: [Bu– ] ↑bu’ (. ) th’t you wer[e–]
S: [Ye]h.
(0.3)
M: ↑It sounds like ↓you– (0.2) you were
(0.8)
M: · hhh
(1.2)
M: <↑i:n contro: l>
Mike’s extended pedagogic turn thus not only demonstrates a misalignment with Stuart’s troubles telling (Lee, 1995) by changing the topic towards a psycho-educational, teaching-as-therapy, service delivery instead of providing a sympathetic troubles receipt (line 51), but also demonstrates an orientation to locally operative structures of authority in the interaction in hand. That is, Mike, as therapist, has the authority to indicate that Stuart’s story - including his potential solutions, his appreciation of clozapine from doctors who have a good idea of what is going on and

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the expression of feelings - is not relevant for the ‘therapy’ talk he and Richard wish to pursue. Of particular note, given the diagnosis Stuart carries, is Stuart’s clear recognition of these conversational realities, and the perfectly competent manner in which he not only displays his awareness of these realities but also his readiness to accede to them. Mike changes topic accordingly and delivers a packaged professional treatment (line 51 ff.). In other words, according to Mike and Richard’s actions, Stuart’s story is not relevant (it is perhaps too mundane) for special ‘therapy’ talk and Stuart, obligingly, accedes.

Mike’s displayed hesitancy suggests an orientation towards his own misalignment to Stuart’s troubles. Nevertheless, it is Mike, as a therapist, who does a “zoom” back to “that situation last night” (line 51 ff.). The term “zoom”, and others such as “c’n” and “j’st” (line 51), are the first of many in this sequence which Mike uses to present himself as being both casual and ordinary, whilst at the same time ‘doing therapy’. This is a deliberately mundane presentation of what, by definition, cannot but be an extraordinary therapy topic. However, from line 130, it is Mike, not Stuart, who refers to that “which ↑I think we touched on >↓a couple a weeks ago<” in a previous therapy session. It is Mike who leads the lesson. This therapeutic account of “that situation last night” is clearly pedagogical, ‘institutional’ talk. This is, despite Mike’s softening devices, a formal learning environment (the salient identities here are clearly TEACHER + STUDENT), and it is clearly orientated to as such by both parties.

I shall now summarize the macro-structure of the sequence in Extract 6.3, before making some additional observations. Mike gives a pre-message evaluation of Stuart’s performance the night before (line 57 ff., above), followed by an initial delivery of the therapeutic message about what Stuart did (line 65 ff.). He then provides three re-deliveries of the repackaged message (from lines 93, 122, and 141). Interspersed with these re-deliveries are two further evaluations of Stuart’s performance (from lines 110
and 137). Throughout this sequence of (re)deliveries and (re)evaluations, Stuart responds as an able enough student with appropriate continuers/acknowledgement tokens (eg, lines 59 and 83). Stuart also demonstrates a more pronounced message uptake in the form of a collaborative reformulation (“As a voice yeah”, line 86) and repetition (“gonna be”, line 90, and “cwazy”, line 97). It is only at the end, with Stuart’s addition of “↑PI:LLS” to Mike’s message, that Stuart departs from being a deferential student/client and begins to undermine Mike’s version of events.

There is an apparent tension in what Mike says, between asserting a technical position (the topic) and delivering it in a ‘nice’ and ordinary way (which I shall call, here, the presentation). For example, Mike uses vague and mitigating terms such as, “>↑U’m almost thinking” (line 65), “I spose” (line 68), “↑It sounds like” (line 101), and “↑SOUNDS LIKE” (line 141). By using such devices to soften his message, Mike appears to be orientating to his part of the reality negotiation, to the privileging of his, rather than Stuart’s, version of Stuart’s experience. This may be taken as Mike not very successfully being a ‘nice guy’ (a NOT-THERAPIST) whilst at the same time, in and via this ‘cover identity’, actually doing therapy (see McHoul & Rapley, 2002). (We will see more on cover identities in a later chapter). Indeed, Mike’s evaluations of Stuart’s behaviour may be seen as attempts to bridge the gap between the ‘nice guy’ and the therapist (from lines 57, 110, and 137), but at the same time the very asymmetry of authority to confer praise in this interaction again renders it irredeemably institutional. Thus while Mike presents Stuart as a skilled voice hearer on the one hand, on the other hand he is actively engaged in reformulating Stuart’s version of ‘what really happened’. As the pedagogical sequence continues, as Mike continues to doggedly recycle and privilege his technical version of ‘what really happened’ and ‘what really helps’, his praise for Stuart becomes all the more fawning (eg, line 137 ff.).
Mike does not let go of the classroom pointer, even whilst mitigating his wielding of power in the ‘institutional’ asymmetry which he and Richard have jointly asserted, and to which Stuart has acceded. From line 65, he employs technical language “↑U’m almost thinking it w’s- it w’s kinda like a< ↑three stage process”, invoking his own expert knowledge in this area. In lines 68 to 71, whilst undermining the psychological knowledge which he is promoting by drawing attention to its tendency towards infinite regress, Mike maintains his control of that knowledge by using the term “I” in “I spose” and “I could build” (lines 68 and 70). Mike then moves on to the first presentation of his message in the form of a three-part list about the decisions which Stuart makes when he hears a voice (lines 78 to 85). Mike employs finger clicking to underscore his delivery. Subsequent re-deliveries of the repackaged and slightly elaborated message continue with Mike’s theme of Stuart taking deliberate, controlled, steps to deal with the voice (from lines 93, 122, & 141). What contributes to Mike’s part of his recognizably doing ‘therapy’? In lines 141 to 145, there appears to be a noticeable increase in the degree to which Mike is doing ‘therapy’ as ‘teaching’. This is brought about by his slower speech and marked shifts in pitch, which highlight the importance of his message and require an intensification of the receipt tokens that Stuart is, collaboratively, producing.

For his part - for the time being - Stuart appears to accede to Mike’s ‘therapeutic’ account. He presents himself as a fairly keen, able, but not gullible student, receiving the message with continuers/acknowledgement tokens. For example, when Mike projects the relevance of affiliation with an in-breath and a cough (line 71), Stuart gives it (line 72). Stuart also collaborates in the account’s construction (line 86) and shows affiliation and message uptake by repeating Mike’s words in lines 90 and 97 (see Rapley & Antaki, 1996, on repetition as affiliation). Despite the inclusion of affable features in Mike’s delivery, his multiple repackaging of much the same ‘therapeutic’ message, and his dogged resistance to the start of Stuart’s alternative account, present
him as more of a dogmatic pedagogue than a ‘nice guy’ (lines 146 to 151, below). Again, as earlier, Stuart’s concluding statement in Extract 6.3 about medication is not taken up by Mike or Richard as being a valuable contribution to the business-in-hand of the group.

As an alternative to non-uptake as a method of silencing ‘irrelevant’ material, more active therapeutic interventions may be deployed. In Extract 6.4, Stuart’s initial attempt at disagreement (line 146) (which is more clearly shown by the subsequent development of his alternative account to Mike’s) is met, in overlap, by Mike’s immediate re-affirmation of his professional version of events (line 147):

Extract 6.4 (HVG, S6, MW)

141 M:  
142 S:  
143 M:  
144 S:  
145 M:  
146 S:  
147 M:  
148 S:  
149 M:  
150 S:  
151 M:  
152 S:  
153 M:  
154 S:  
155 M:  
156 M:  
157 M:  

We may consider this extract in terms of what Sacks (1992), and Oelschlaeger and Damico (1998), describe as joint productions, and in terms of what Lerner (1996) describes as anticipatory turn completions (all cited by Rapley, 2004: n.p.). For example, Rapley notes that:

...identity is established in and by the successful construction of intersubjectivity: that is to say interlocutors can establish a shared status as members of a common cultural order by the use of a range of devices that constitute the architecture of intersubjectivity. In their study of joint productions in conversations between an aphasic
- and demonstrably neurologically impaired - man, Ed, and his wife, Mary, Oelschlager & Damico (1998) discuss what they describe as ‘motivations for joint productions’ in talk-in-interaction. ...Joint productions, to use Oelschlager & Damico’s (1998) term then, are described as:

the initiation of a turn by one speaker and the syntactically and semantically coherent extension or completion of that initiation by another speaker ...unlike interruptions that constitute an intrusion of talk occurring quite independently and without regard to the syntactic or semantic output of the other speaker (Ferrara, 1992), joint productions serve to advance both the flow of the conversation and the content that makes up the interaction (m/s 6-7).

(Rapley, 2004: n.p.; my emphasis)

That is, joint productions (of which extensions and anticipatory turn completions are examples) can help establish the intersubjective status of interlocutors and, as such, and in their execution, they demonstrate considerable skill. To illustrate some of these points, we may consider the following, as cited by Rapley (2004: n.p.):

Extract 6.5 (from Lerner, 1996: 308, Code CDHQ:II:3)
1    Marty: Now most machines
2        don’t record that
3    slow. So I’d wanna-
4        when I make a tape,
5    Josh: be able tuh speed
6        it up.
7    Marty: Yeah.

Notice, amongst those features described earlier, Marty’s agreement in line 7. In connection to such features, Rapley notes that:

Oelschlager & Damico (1998) point to a number of features of these joint productions: one is their exquisite timing, with completions frequently latched (as in extracts 3, 4 and 5), and also the routine acknowledgement, by Ed as by Marty, of turn completion utterances which “have the effect of indicating his acceptance of M’s contribution to the co-construction and …enabl[ing] him to reassert his turn”.

(2004, n.p.)

We may now continue with our consideration of Extract 6.4, which I repeat below:
Stuart begins a joint production, in the form of an extension (line 146), after first agreeing with Mike. The conjunction ‘and’ along with ‘as well’ mark it as something which is offered in addition to what Mike was saying. There is a sense here of Mike ignoring Stuart’s appeal to the effectiveness of drug treatment, and therefore of Stuart adding and asserting something which Mike was not about to say (i.e., analytically, this is in contrast to an anticipatory completion; yet there is still, skillfully, an element of the intersubjectivity of joint productions, in Stuart’s utterance but not Mike’s). Indeed, rather than allowing Stuart to finish and providing him with the kind “routine acknowledgement” (Rapley, 2004, above) that generally accompanies joint productions, Mike overlaps hurriedly with what Stuart is saying (line 147). And, after Mike has continued to push his official ‘therapeutic’ view (lines 147 to 148) it is Stuart who provides the acknowledgment, again (lines 149 & 152). While Stuart’s deference and Mike’s ‘nice guy’ presentation suggests that the gloves are on, the combination of

\[1\] I am grateful for comments from Derek Edwards (2004) who pointed out in a personal communication that this is an example of an addition and not an anticipatory turn completion. In the paragraph to which this footnote refers, I have used two of Derek’s sentences as my own.
overlap, raised voices, and the re-stating of positions by both parties evidences the struggle which is ensuing between rival accounts of ‘what really happened’ and ‘what really helps’. Mike has missed an opportunity to acknowledge both Stuart’s point of view, his skill in producing an anticipatory turn completion, and their shared intersubjectivity: surely the kind of activities which therapy should at least acknowledge. Instead, following Stuart’s twice repeated agreement with him in line 152, at line 154 - with a hearably questioning intonation - Mike firmly proposes that Stuart capitulate once more. With a latched utterance Stuart concedes again (line 155), to be met with an approving “Mmm.” from his therapist (line 156). The pedagogical episode which has, we should remember, straightforwardly repudiated Stuart’s understanding of his own experience, appears to be complete.

Mike presents his account of Stuart’s experiences, although softened by mitigating padding, as his expert noticing. It is neither Mike questioning Stuart for information, nor an approach towards co-equal dialogue. That is, the sequence may be characterized as being in an information delivery communication format rather than an interview communication format (Peräkylä & Silverman, 1991; Silverman, 1997) or dialogical communication (Leudar & Thomas, 2000). The information is delivered by Mike and, more or less, received by Stuart. Mike and Stuart do not take on respective identities as questioner-answerer as in an interview, and the interaction in practice actually bears little resemblance to the ‘Socratic dialogue’ which in theory underpins CBT. Neither do the interlocutors alternate between questioner-answerer and speaker-recipient identities and vice versa (amongst other possibilities) as in dialogical communication.

3. A personal account: Rationality, medication, and contributing

After Mike has persistently asserted his expert version of Stuart’s coping strategies - and done very little listening - Stuart adopts a sophisticated interactional gambit to
outflank him: Stuart, that is, lays claim to a shared competence among patients - which by definition is unavailable to therapists - by aligning himself with voice hearers/psychiatric patients (lines 158 to 167, Extract 6.6, below) and “other people” (line 180). Let us now turn to Stuart’s follow-on from the pedagogical sequence with Mike:

Extract 6.6 (HVG, S6, MW)

158 S: °Yeah.° (.)
159 ↑ I MEAN >it’d be< sill:y wouldn’t it
160 (0.1) ↓ g-guys ↑ if it- >well if we all< had to er
161 TAKE our-
162 (0.7)
163 S: ↓ Tanya I’m >speaking to you< ↑ if (0.1)
164 T: [Mmm. ]
165 (0.9)
166 S: an’ (0.1) w- (0.8) we’ll >j’st wa- be walking
167 around< like zombies: ↓ b’t
168 (1.1)
169 S: I’ve fou- I: ↑ fi:nd th’t (0.3) ↑ EA:CH time >I’ve
170 been o< a different< pa:th of medica:tion
171 (1.3)
172 S: like >stell ar: zine (.) haloperidol< (0.4) or
173 litiu: m ((clicking sound)) (1.0) I’m not-
174 ((croaky)) I c’n ↑ TA:LK (.) ↓ I mean
175 S: [I c’n ex]↑ press myself (0.4) an’ express my
176 R: [ Mmhmm. ]
177 S: feel:lings. (0.2)
178 M: Mm↓ hmm.
179 (0.9)
180 S: MY donA:TIONS towards other peo:ple ↓ y’ know= ya
181 feel:lings and your- (0.4) ya kno:w. (0.1) ↑ Tha’s
182 the most im↓[por:tant ↑ thing]=
183 T: [ Mm:: ]m=
184 S: =°↓ Is- °
185 (0.2)
186 M: Mm[m. ]
187 S: ↑ TANY]ONE can earn MO:NEY: (. ) ca:n’t they guys
188 ↓ You: know↑=
189 R: =Mmhmm. =
190 T: =Mmhmm.
191 (0.7)

Although having shown himself earlier to be ‘a pretty good student’, in Extract 6.6 Stuart shows resistance to Mike’s therapeutic formulation about events the night before and stresses his own psychiatric story about the related but more general issues of the
place of medication in dealing with potentially distressing voices and achieving a worthwhile life. That is to say, Stuart proposes that, like Tanya and other voice hearers, he is an expert by experience. In lines 158 to 188, above, after a pause and an agreement token (providing some deference before changing topic to an opposing position), Stuart continues to construct a contrasting version of ‘what really helps’. In short, with the specific recruitment of Tanya by name, Stuart presents himself and other voice hearers as rational, voice hearing experts, who actively choose to take medication. He is a valued, contributing, articulate and expressing, yet ordinary, person. When taken as a whole, Stuart’s response at this point is clearly a rebuttal of both the content and information delivery format of Mike’s ‘therapeutic’ formulation of ‘what really happened’ and ‘what really helps’. How is this achieved?

Stuart uses several devices which lay claim to his expert knowledge and ownership of the experiences being discussed. He shows a clear orientation to the reality negotiation which is being enacted: a struggle over whose version of events should be accepted and, more generally, whose versions of Stuart and other voice hearers are real. Recall that, rather than directly disagreeing with Mike and his persistent version of events, Stuart has already added “↑PI.LLS (0.1) as WELL:” to the record (line 146). Mike then pushes his point even more strongly. From line 158, Stuart sidesteps Mike’s account by appealing to Tanya, the other voice hearer present. This implies a contrast between himself and other voice hearers, compared to people who do not hear voices; including therapists. However, Tanya provides minimal uptake (line 164). Stuart then goes it alone with the phrase “I find that” (line 169), presenting his account as contemporaneous knowledge, derived from a rational, personally experienced process. He does not use vague and mitigating terms, such as “↑U’m almost thinking”, which are used by Mike (line 65). Indeed, Stuart constructs his account as detailed and precise. From line 172, he uses a three-part list of medication names, further invoking his and
other voice hearers’ expert - first hand - knowledge of pills; skillfully excluding the therapists. (I discuss the hearable monotonicity of this list - as indicated by emboldening - in connection to Extract 6.6, below). There is perhaps also an implied contrast between this list and Mike’s earlier, mitigated yet technical, three-part list about coping. Stuart constructs his account, in contrast to Mike’s ‘therapeutic’ formulation about the night before, by implying that he rationally chooses what helps, such as medication. He and other voice hearers do not (wish to) become “zombies” (line 167). Rather, he is an expressing and contributing person (lines 175 to 181). Stuart has expert knowledge of personally experiencing and dealing with voices but he is not mad. His position - especially in talk about dealing with distressing voices - should be afforded more respect.

As already noted, Stuart’s account develops similarities between himself and other voice hearers in addition to differences between voice hearers and people who do not hear voices (such as therapists). Stuart then builds a more complex picture by aligning himself with “other people” (line 180). By implication these people are not necessarily voice hearers. They may be ordinary community members - the community that he is a part of, which he contributes to, and with whose members he interacts. At the same time, Stuart skillfully re-draws a line of distinction between himself and certain others. This time, the distinction is not in terms of voice hearers having expert knowledge of hearing voices compared to those who do not (including therapists). Instead, in lines 180 to 187, he contrasts his “donA:TI:ONS towards other people” with “↑ANYONE [who] can earn MO:NEY.” (including therapists). Stuart is a deep giver not a shallow taker. “↑That’s the most im↓por:tant ↑thing↑” (line 182). Stuart manages to achieve a powerful contrast to Mike and Richard’s account. He does so without being directly confrontational and yet without Mike’s beating around the bush. This, then, would seem
to be a patient who may, officially, be a 'medication-resistant schizophrenic', but who is also clearly a socially and interactionally adept one.

4. Doing ordinary, enjoyable things

We have seen that not only is Stuart all too clearly aware of the power asymmetry operative in the interaction, but also that he displays his awareness of this to the therapists. Equally we have seen that when he wishes to present his own version of events he does so in a manner which is both tenacious and subtle; he *displays* his expertise by experience rather than simply (and defeasibly) *claiming* it. But Stuart’s alternative account does not end there: in Extract 6.7, Stuart continues his project of demonstrating his well-developed capacity to be both a rational and self-controlled individual. In a manner reminiscent of the deeply mundane set of interests described by ‘Bob’ in McHoul and Rapley’s (2002) analysis of the management of a psychological testing encounter by a man officially diagnosed as mentally retarded, Stuart takes pains to do ‘being ordinary’ (Sacks, 1992, vol. 2: 215-221). That is, he lists routine, and strikingly mundane, everyday activities as - for him - being of therapeutic value:

Extract 6.7 (HVG, S6, MW)

222 S: ↓I ma:de o:ne frie:nd >°ya know I went up t’
223 vis:it him: er°<
224 (1.8)
225 S: ↑ER: up in Lytton: er (0.1) ↑I-h-caught the trai:n
226 y’ see I had-
227 (0.8)
228 S: ·h an’ (0.3) ↑this w’s a WA:Y (. ) I fou:nd
229 (0.3)
230 R?: Mmm.=
231 S: =↑this w’s the BE:ST WA:Y t’ get rid of ↓y’r
232 voil¨ces.°
233 (0.9)
234 S: ↑J’s be HA:PPY
235 (1.2)
236 S: ↓sit DO:WN >listen to s’me< mu: ↑sic (0.3) ↓catch
237 the bu:s (. ) catch the trai:n (0.3) have lu:nch at
238 the:
239 (1.8)
It is important to note that almost all of Richard and Mike’s responses to Stuart’s past and possible future ways of managing hearing distressing voices and living a fruitful life are absolutely minimal. For example, in Extracts 6.6 and 6.7, there is minimal acknowledgement from those who are supposedly listening to Stuart (lines 176, 178, 186, 189, and 243), despite the long pauses which are present. Most importantly, Stuart has made strong assertions about expressing feelings being “the most important thing” (lines 175 to 182) and that doing ordinary, pleasant, things is “the BEST WAY t’ get rid of y’r voces.” (line 231). Indeed, they are more than just assertions: they are presented as personal evidence, which he has “found” (line 228). These are the ordinary, tried-and-tested, solutions which Stuart presents, not as potentially helpful, but as effective and also grounded in highly specific, detailed empirical experience. Stuart is also hearably, markedly, doing ‘being ordinary’ - and in so doing he displays his rationality. But such a marked display of rationality is not without its paradoxes, given the identities involved: it draws attention to Stuart’s rationality as being questionable. That is, Stuart can be seen to be in a kind of ‘rationality trap’ (Harper, 1999): he is consigned to the category of being irrational and insane, whatever he does; something which the professionals’ non-uptake of Stuart’s point of view makes clear.

It is also interesting to note Stuart’s use of an especially flat intonation in his doing ‘being ordinary’ construction of the solution to hearing distressing voices. I have indicated this feature in the transcript with emboldening. For example, in Extract 6.6, there is a list of medication which is presented in this way: “EA:CH time >I’ve been on a different pa:th of medica:tion (1.3) like >stellar:zine (. ) haloperidol< (0.4) or
lithium ((clicking sound)) (1.0) I’m not- ((croaky)) I c’n ↑TA:LLK ↓I mean [I c’n ex]↑press myself” (lines 169 to 175). In Extract 6.7, there is hearably monotonic list which includes a bus, a train, and having lunch somewhere nice: “↓catch the bus (. ) catch the train (0.3) have lunch” (lines 236 to 237). These instances come across as being rather like the way in which one tends to ‘get through’ reading a shopping list. But there seems to be more than merely enduring a boring list going on here. Irrespective of the mundanity or otherwise of the list items (antipsychotics or public transport) the presentation constructs the list deliverer as having a certain blasé quality (and in that sense, the list items are routine, ordinary), and yet the list deliverer is also presented as experienced in relation to the list items (ie, this demonstrates expertise, and in that sense, an extraordinariness). Mike and Richard, however, do not receive these approaches as being of therapeutic relevance.

Jefferson (1984) suggests that, in everyday conversation, the acknowledgment tokens ‘Mm hm’ and ‘Mm’ serve to exhibit ‘passive recipiency’ on the part of the speaker who delivers them (ie, that the person listening is at least willing to hear more from the speaker). Such use of ‘Mm hm’ contrasts with the more encouraging response of a ‘news receipt’/’topicalizer’ such as ‘Oh really?’ and with ‘Yeah’ as a marker of ‘imminent speakership’. Here, in a therapy session, however, the use of ‘Mmhmm’, ‘Mm’, and even ‘Yeh’ tokens by the therapists appears to be even less encouraging than the ‘passive recipiency’ mhmm of ‘normal’ conversation. Examples such as those in lines 176, 178, 186, and 189 are hearable as expressing disinterest, with their brevity and intonation, and with the notable absence of news receipts and other tokens of affiliation. This produced disinterest, coupled with a lack of other appropriate responses and changes of speaker, leaves Stuart in an increasingly difficult position.

So what were Mike and Richard doing? It seems plausible to suggest that these minimal responses were allowing space for Stuart to self-initiate a topic shift or for him
to ‘run out of steam’ without a therapeutic initiation of repair to Stuart’s turn. These actions may, charitably, then be read as a form of positive discrimination ‘in favour’ of Stuart; as a voice hearer/patient being given ‘special treatment’. He is not being told, directly at least, that he is talking nonsense, or that what he has to say is of no value. Rather this is communicated by the therapists by virtue of their failure to engage with him. Of course such a technique immediately marks out this interaction as essentially institutional, and Stuart as other than an ordinary interlocutor. It is, in effect, marking Stuart as a madman while supposedly, according to cognitive-behavioural therapy theory, ‘normalizing’ his experiences. Whether such a strategy is actually likely to be ‘therapeutic’ is an open question.

Essentially, Mike and Richard’s message is that they, as therapists, are not particularly interested in these ordinary kinds of self help, whether Stuart finds them effective or not. Equally, their specification of what does interest them is also delivered indirectly, which leaves Stuart casting around for some form of engagement from his therapists. To do this, in Extract 6.8, he abandons his everyday coping material and resorts to more obviously ‘therapeutically’ appropriate talk; he acknowledges that, despite his use of these techniques, they are not foolproof.

Extract 6.8 (HVG, S6, MW)

255 S: ↓er (.) visited m’ frie:nd over in Lytton (0.5)
256 came back. (0.2)
257 : ·hh
258 (0.5)
259 M: ((cough))=
260 S: =↑YOU KNOW=it’s a:ll very WE:LL (.) and erm
261 (1.0)
262 S: ↓I mean that cynically ya see
263 (1.0)
264 S: because: er
265 (0.6)
266 S: >↑e:verything< ↓when things go: really well for
267 you
268 R: Mmm.
269 S: ↑so:omething jumps ou:t the net (0.1) you know: an’
270 (0.9)
271 R: >That’s what it see:ms like so[metimes does it< ]
272 S: [Y E:A H. Y e a h.]
As soon as Stuart concedes that his own self-help strategies are not completely successful (in line 266 to 269), long-withheld therapist uptake is immediately forthcoming. Richard picks up the thread in line 271, in receipt of the kind of material which the therapists have apparently been waiting for him to provide (line 269). Richard’s receipt of Stuart’s concession does some therapy work with a minimizing reformulation of Stuart’s account (“see:ms”, line 271; known as ‘reframing’, in classic cognitive therapy terms); a reformulation which immediately opens the possibility that Stuart’s estimation of the situation is substantially incorrect. Richard’s ‘therapeutic’ reformulation essentially suggests that while it may seem to Stuart that ‘something just jumps out the net’ such a seeming may not, actually, reflect ‘reality’: it is possible, that is, that Stuart does not know his own subjectivity. He is, perhaps, out of touch with reality; a reality which Richard knows more reliably than him. He is, as it were, being told by his therapist that he is clearly a schizophrenic. Mike continues this work, in line 281, with his anticipatory turn completion ‘knocks you back’, in response to Stuart’s restatement of his view. However, Stuart resists Mike’s downgrading of his distress with an escalated account completion (line 283). As before, ‘something’ emerges out of the blue; a formulation which carefully preserves the success of his own self-help approaches, since ‘somethings’ which are unforeseeable, unpredictable, and unexpected, cannot be fairly held as evidence of the lack of utility of Stuart’s own strategies. But, in the escalation, contra to his therapists’ misunderstanding of them, the ‘somethings’
which do occur are much more damaging than Richard and Mike allow: they don’t just ‘knock you back’, they ‘destroy ya life’.

Stuart’s tenacious defence of his rational and competent ownership and understanding of his own experience is, however, clearly not to be countenanced by his helping professional interlocutors. In Extract 6.9, Richard shores up the united therapeutic front by revisiting Mike’s coping message one more time (line 295 ff., below). Richard partially concedes to Stuart’s troubles rather than offering sympathy. He translates Stuart’s problem into ‘therapy’ language (“maybe the an↑XI:Ety:”, line 315). Richard presents his professional opinion, again that perhaps Stuart is wrong about his experiences (line 318). Stuart then resoundingly agrees with Richard (line 326) before going on to present some of his own (contrastive) philosophical observations about the world:

Extract 6.9 (HVG, S6, MW)

295 R: We[:ll:]
296 S: [ Ye]ah.
297 R: =again (.) as Mike’s saying i’
298 R: [might be mo]:re than luck (.)(croaky) ↓it
299 M: [ Mmm. ]
300 R: might be something about (0.2) ↑you: (. ) an’
301 about=
302 S: =YE[H.]
303 R: [th]e treatment an’=
304 S: =Yeh.
305 R: ↓how you [dea:1 wi]th things [(th’t)>]
306 M/S: [ Mmm. ]
307 S: [ Mm. ]
308 (0.6)
309 M: Mm[m:]
310 R: [me]a:ns there’s STILL the
311 (0.2)
312 S: is that what-=
313 R: =there’s ↑STILL th[e-]
314 S: [ Y]eah.=
315 R: =maybe the an↑XI:Ety: that=
316 S: =Yea[h. ]
317 R: ↓th]ings are gonna go ↑wro:ing (0.1) ↓bu’
318 R: may:b[e yo]u’re actually getting better at
319 S: [Yeah.]
320 R: making [ them ]=
321 S: [Ye:ah.]=
322 R: =go ↑ri:ght. (.)
In line 326, above, Stuart demonstrates that he has fully learnt his lesson with “↑Yeh. (0.3) De:fini:tel)Y: Ri°chard.". Given the preceding actions and counteractions, this may be taken as a reluctant, ‘finally give ’em what they want’, acceptance. Stuart then skillfully undermines his own presented about-turn, continuing to distinguish himself from being a passive receiver of pedagogical messages, by giving his take on the world: “↓And erm (. ) >↑I w’s thinki:ng< (0.3) see th- (0.4) ↑the WOR:LD’S in a funny: (0.1) PLA:CE at the ↓moment (. ) ↑ya kn[ow:-] (line 327 ff.). At the end, he does not bow to superior numbers.

**Discussion and Conclusions**

I have endeavoured to show the privilege which is locally afforded to the professionals’ version of Stuart’s voice hearing experiences. Mike and Richard, as therapists, in keeping with the professional prescriptions of their preferred therapeutic approach, CBT, are engaged in a straightforward and sustained, if contested, endeavour to persuade Stuart that he - quite literally - does not know what he is talking about. The interaction examined here is grounded, a priori, in assumed professional rationality and supposed patient irrationality. In its prosecution, efforts by Stuart to present himself as a rational, empirically grounded, emotionally and relationally competent person are routinely discounted by his interlocutors. That is to say, by their actions his therapists routinely re-produce Stuart as being of (at best) questionable rationality. Quite how this is supposed to be helpful for Stuart is opaque. He is, as were Harper’s (1999)
informants, caught in a ‘rationality trap’. In a move to offset such social asymmetry, I have tried to ensure that any privilege which exists in my analysis is towards Stuart, the (original) owner of the experiences in question. In this, Stuart is given the kind of respect which would apply to any ordinary person.

Contemporary psychiatry and psychology tend to view voices in terms of psychotic delusions which may be perpetuated through the collusion of professionals who pay attention to the lived reality of the voice hearer’s experience. However, the voice hearers in my transcripts - who have a diagnosis of schizophrenia in addition to hearing voices - present themselves as rational people, not as people in the grip of delusions, past or present. This is consistent with Leudar and colleagues’ (2000) findings that voice hearers, regardless of diagnosis, do not typically mistake voices for other people speaking. Instead, the person goes about a series of publicly available reality-testing procedures to establish the origin and meaning of a voice. Sometimes bizarre explanations are used to explain puzzling voices experiences but, more often than not, voice-talk is about mundane matters and, as Stuart so assiduously tries to demonstrate, the successful management of what may be a highly distressing experience is also, frequently, mundane. In the data corpus also, much of the content of bizarre voice-talk is described in mundane terms. Why then should we assume that voices are invariably associated with the extraordinary, with insanity?

The officially stated aim of the hearing voices group in the present study was to reduce the distress which the group members associate with their experiences. This was to be done by ‘normalizing’ the experience of hearing voices and increasing positive coping skills. I have tried to show that any ‘therapeutic’ normalization and coping skills promotion which occurred during the extracts in this chapter was done at the cost of the therapists privileging their version of ‘what really happened’ and ‘what really helps’. This was despite increasing disconfirmation from Stuart - the one with first-hand
experience of the events in question. Ironically, such privileging could, arguably, be seen as a kind of ‘professional delusion’, in the face of disconfirming evidence from the voice hearer. Remarkably, the otherwise effective interactional resources of Stuart - an ordinary person who hears voices - continue to resound.

This chapter and those which follow confirm, through a close analysis of actual therapy talk, that diagnosed ‘schizophrenic’ patients may be seriously underestimated in both their ability to interact socially and in their purported cognitive abilities. In the case examined, clinical professionals, who are supposedly there to help, tended to make assumptions of rationality - to discern ‘what really happened’ and ‘what really helps’ - on unacknowledged moral rather than empirical grounds. This was done in the course of the professionals performing their official duties as cognitive-behavioural therapists. On the basis of these findings, in an extension of the work of Leudar, Thomas, and colleagues, it is recommended that respectful dialogue with those who have first-hand experience of questionable phenomena should be privileged over professional theory and therapy.
...talking of ‘identity’ as some fixed thing is in violation of the logical grammar of the term’s proper use, and ...the delicate management of a potentially disreputable membership is everyone’s ordinary mundane business (cf. Silverman, 1998; Sacks, 1992)... [It is only by professional fiat that utterly unremarkable [focus] group talk ...becomes a diagnostic indicator of an accountable breach in moral conduct.

(Rapley, 2004: n.p.)

In this chapter, we consider prejudice- and privilege-in-action regarding the sanity status of those in our therapy group for hearing distressing voices (and some of those outside the group). I try to tease out and substantiate the relationship between certain institutional identities; as they are constructed for and from the business-at-hand and/or the business of psychiatry. Some of the identity work’s wider relations to psychiatry and society at large will be addressed in Part 3 of this dissertation.

Section 1 of this chapter sets the scene with the theoretical concepts of sanism and rankism and an introductory consideration of three of Sacks’ concepts: omni-relevant devices, cover identities, and doing ‘being ordinary’. In particular, in the context of the hearing voices group, we are introduced to two omni-relevant devices (PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT) and a cover identity pair (NOT-MAD + NOT-STAFF). Here, I first demonstrate that at least one omni-relevant device operates within the hearing voices group data. I then include a schematic of how identities in the therapy group inter-relate in what I aim to show is sanism-in-action. Section 2 focuses on further demonstrating the operation of the two omni-relevant devices (PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT). In Section 3, we turn our attention to describing and demonstrating the supposedly therapeutic,
therapist actions of what I take to be *not-so-normal-ization* and *not-so-positive discrimination*, as they are enacted within the sanist context of the hearing voices group data. Section 4 describes and demonstrates *negative evaluation responses*; the responses of patients to an ever-present questioning and negative evaluation of their sanity. Section 5 then adds three further understandings of our analytic foci: (1) that, as questionable people by default, the sanity of the patients requires *pasting-in*, (2) that the identities in the hearing voices therapy group form a *hierarchy* in relation to sanity status, and (3) that there is a *normality-abnormality continuum* in action. These understandings, in concert with the analytic foci from the previous sections, all assist in an explication of the actions in this data of voice hearers, therapists, and ‘the mad’.

From the analyses in this chapter, we eventually conclude that prejudice about voice hearing and ‘madness’ is abundant in this supposedly - theoretically - ‘therapeutic’ talk-in-interaction. Despite or because of this prejudice, the voice hearers largely construct themselves as people who are rationally responding to perplexing and distressing experiences. Does the therapist talk in our data assist the voice hearers, as much as might reasonably be expected, to achieve a better understanding of their personal experiences? Will we ever develop sufficiently ‘factual’ and useful accounts of hearing voices whilst voice hearer accounts remain subjugated? I venture to answer in the negative on these issues. But such questions are, in the mainstream, seldom if ever

1 I use the terms ‘voice hearers’ and ‘patients’ (in lower case letters and without inverted commas; ie, when referring to ‘certain’ people rather than constructed identities) somewhat interchangeably. My choice of one over the other may be depend on concerns for prose more than the referencing of a particular ‘type’ of person. For example, ‘voice hearer’ might be used to off-set the more frequent use of ‘patient’. Also, ‘voice hearer’ is used on some occasions to avoid confusion in a sentence which includes a PATIENT identity. However, I tend to use ‘patient’ more than ‘voice hearer’ when I am talking about how the interaction *is* and vice versa when I am talking about how I would *like it to be* (ie, without social power asymmetry).
asked of the professionals. Instead, as we have seen in psychiatric and psychological texts and as we will continue to see in my analyses of actual clinical practices, it is the voice hearers themselves - not their reported experiences, and certainly not the professionals - who continue to be constructed as questionable.

SECTION 1. INTRODUCTION TO CONCEPTS

Sanism and sanism-in-action

Our focus will be on the management of prejudice concerning voice hearers and ‘madness’. I intend to show that throughout the data corpus there are aspects of talk which can be seen as forming a web of privilege and discrimination in terms of a person’s constructed rationality, their mastery of knowledge and grounding in reality. That is, people are treated differently, through talk-in-interaction, on the basis of their sanity status. We shall see that the sanity of the patients is very much a participants’ issue - their sanity is constructed as being highly questionable and they are treated accordingly. Therapists, on the other hand, although occasionally presented in the data as ordinary and fallible, are almost unquestioningly constructed as being in control of themselves and others: therapists are, for want of a better term, super-sane. Thus, sanity and professional status (ie, knowledge and people which/who are constructed as professional) form what may be called a ‘sanist-rankist complex’. For the sake of simplicity, I shall not attempt to finely distinguish here between what may, to some degree, be separated into ‘sanism’ and ‘rankism’. Rather, I shall refer to them both as sanism. This chapter, then, is working towards mapping the identities of sanism. A blend of discourse analysis and membership categorization analysis is employed in this enterprise.
What is ‘sanism’? The term ‘sanism’ has been described by Perlin (eg, 2000) in the context of inequities in mental health law:

Simply put, sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects both our jurisprudence and our lawyering practices. Sanism is largely invisible and largely socially acceptable. It is based predominantly on stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of alleged “ordinary common sense” (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process.

(Perlin, 2000: xviii-xix; original emphasis)

The term ‘rankism’ has been described by Fuller (eg, his non-academic, 2001, publication) in the context of people’s social recognition, or lack thereof, throughout life. Thus, rankism is defined as:

...abuse and discrimination based on differences of power as signified by rank.

Typically, rank-based abuse - rankism - takes the form of disrespect, inequity, discrimination, and exploitation. Though its effects on its victims are the same as the effects of racism and sexism, its immediate cause is different. Color and gender differences are not required for its appearance - only a difference in rank (reflecting an underlying power difference). Since hierarchies are pyramids of power, it comes as no surprise that rankism is a malady to which hierarchies of all types are susceptible.

(Fuller, 2001: 20)

My use of the terms ‘sanism’ and ‘rankism’ will differ somewhat from these authors, methodologically and ideologically, although our basic tenets appear to be compatible.

Higher order theoretical constructs such as these require demonstration in practice; this is what follows, with talk-in-interaction data. This chapter considers such matters in
close-practice, as guided by the data-at-hand, rather than in theory or abstracted analysis (which, I suggest, forms much of the basis of Perlin’s and Fuller’s approaches).

In many individual instances of talk, it is a stretch to say that the sanity of a patient is in question. However, this is a matter to which therapists and patients give much of their time and I intend to show that these instances accumulate; each instance contributing a thread to this tangled sanist web. The person’s rationality, their mastery of ‘self’ and ‘the facts’, are evaluated through the actions of discursively privileging professional accounts and oppressing others.

Rather than alluding to some kind of mental pre-judgement, my use of the term ‘prejudice’ can otherwise be written as ‘prejudice-in-action’. Such prejudice is both constituted in, and constitutive of, the interaction; no one party is solely responsible and it is not something which is, here, conceived as being in the head of either party. In line with Edwards (2003), I consider ‘prejudice’ in terms of evaluative practices, an issue which comes to the fore in Section 4.

**Omni-relevant devices, cover identities, and doing ‘being ordinary’**

The notion of an omni-relevant device, along with the complementary notion of cover identities (or ‘cover identifications’, as they were then known) were introduced by Sacks in a largely hypothetical discussion (see 1992, vol. 1: 312-319).  

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2 It is pertinent to recall, here, my discussion in Chapter 2 on the use of cultural knowledge in membership categorization analysis. In connection to omni-relevant devices (ORDs), in particular, a personal communication from Derek Edwards (2004) highlights some of the pitfalls of such analyse. For example:

The concept of ORDs was introduced by Sacks, who was also the inventor of CA. It is notable that Schegloff, the major exponent of CA after Sacks’ death, has argued against the usefulness of this concept, as have various recent CA studies of ‘institutional talk’, where the relevance of a setting
examples for these constructs were from his now classic data in which ‘teenagers’ do the business of ‘therapy’ whilst having “an automobile discussion”, something which

...is, for teenage boys, a very special kind of topic; one which is perhaps as ideal a one as could be had if one wanted not simply cover identification but a “cover topic.” And that’s because of the range of matters which are expectable and in fact discussed at a place such as this, i.e., therapy topics, which can be discussed under the guise of “an automobile discussion”: Sex, guilt, independence, autonomy, authority, parental relations, the state of society, death, you name it. All can perfectly well be handled as sub-topics of “an automobile discussion”.

(Sacks, 1992, vol. 1: 320)

Thus, ‘therapy’ work may be done, and made more palatable, through the use of cover identities. But what is an omni-relevant device?:

Here, the device of which ‘teenagers’ is a category stands in alternation to the device which contains the categories (therapist/patients). And I’m going to say that that device is an ‘omni-relevant device’.

An ‘omni-relevant device’ is one that is relevant to a setting via the fact that there are some activities that are known to get done in that setting, that have no special slot in it, i.e., do not follow any last occurrence, but when they are appropriate they have priority. Where, further, it is the business of, say, some single person located via the ‘omni-relevant device,’ to do that, and that the business of others located via that device, to let it get done.

and its institutional roles has to be grounded in specific orientations rather than being omni-relevant. From Schegloff’s perspective, the danger of using the idea of an ORD is the temptation for the analyst to see it everywhere, and to use it interpretively for whatever people say.”

I have, however, endeavoured to anchor my analyses in interaction. Nevertheless, see also my footnote quotation of Edwards in Extract 7.16A, below.
The second paragraph, above, provides four criteria by which McHoul and Rapley (2002) establish that an omni-relevant device is operating in their data; a study which we discuss presently. And, in his continuing discussion, Sacks considers how an analytic focus on greeting-and-introduction sequences and closing sequences (what Sacks calls insertable sequences) is a way of confirming that an omni-relevant device is relevant to the interaction bounded by that greeting and closing:

The device is omni-relevant by virtue of the fact that the insertable sequences, while having various kinds of priorities, don’t occur at any specified point, i.e., any point located by virtue of, for example, a last occurrence. In regard to this particular case, that device consisting of the categories (therapist/patients) is omni-relevant for this two-hour conversation; where that is warranted by reference to the fact that the greeting-and-introduction sequence and the closing sequence are controlled by reference to that device. Now, I’m not saying that (1) the only device that is omni-relevant here or anywhere is the one with the categories (therapist/patients) - it may well be that there are other devices in this conversation that are omni-relevant, or that (2) the only way to see that something is an omni-relevant device is by reference to these insertable sequences - there are other ways.

(Sacks, 1992, vol. 1: 314-315; original emphasis)

I have a few points to make on this quote. First, Sacks allows for there to be ways of seeing omni-relevant devices other than via the identification of insertable sequences.

3 Note that the transcriber of Sacks’ lecture, at least, uses the slash symbol in “(therapist/patient)”. Instead, after McHoul and Rapley (2002), I refer to an omni-relevant device containing a therapist and a patient as THERAPIST + PATIENT (ie, with upper case letters to designate identities and a plus symbol to designate the ‘partnership’ between the two identities). That reserves the slash symbol for ambiguous occasions when it is difficult or inappropriate to distinguish between two identities to describe the same person (eg, PATIENT/CLIENT).
My data is not chosen to include such insertable sequences. Rather, I seek to locate omni-relevant devices in other ways - although many of the therapist-patient interactions which I analyze could be considered as insertable sequences. Second, Sacks seems also to be saying that, if the start of an interaction makes use of an omni-relevant device and the end of an interaction makes use of that omni-relevant device then that device is describably relevant for the entire interaction under scrutiny. My third point is that Sacks allows for there to be more than one omni-relevant device in operation at any one time. In this chapter, I take on the task of seeking to demonstrate two such devices: PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT. If the institutional dynamics of the group had perhaps been more like, say, one which included non-voice hearers being trained by member of the Hearing Voices Network then I imagine that an omni-relevant device of something like EXPERT VOICE HEARER + NON-VOICE HEarer might have been in operation instead. However, in my hearing voices therapy group the THERAPISTS/PSYCHIATRIC STAFF almost exclusively occupied the helm, as the controlling experts, and it cannot be said that the identity of EXPERT VOICE HEARER had much influence on proceedings. Indeed, the only clear instances of such ‘fully’ independent from professionals, EXPERT VOICE HEARER identities are those cases shown in some of the extracts below (eg, extracts 7.10 & 7.4); where voice hearers briefly manage to exclude the THERAPISTS/PSYCHIATRIC STAFF from the ensuing talk by addressing each other, as EXPERT VOICE HEARERS. That is, clear EXPERT VOICE HEARER identities do not occur under the auspices of the institutional control of the omni-relevant devices of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT - but rather are actual breaches of those devices - and the therapists do little to support the identity of EXPERT VOICE HEARER, per se.

Sacks also describes the ‘constraints’ of operating within an omni-relevant device. We can also consider cover identities in this regard, as did Sacks. Whilst numerous
identities may be appropriate for the various things which get done in a therapy group/automobile discussion, the fact that THERAPIST + PATIENT is omni-relevant “may set certain constraints on what other identifications they [the interactants] could use” (Sacks, 1992, vol. 1: 316). Sacks goes on to explore the constraints of using a cover identity. Some of those constraints are quoted here:

Suppose that there’s some identification that could be applied to a set of persons, some of whom don’t like that identification for various reasons, but some features of that identification are important for various reasons. What they might want, then, is something we could conventionally call a ‘cover.’ Where a ‘cover’ is an identification which is more palatable, which can hide the problematic one, and which nonetheless allows whatever it is that the problematic one can do, to get done. ...

One of the problems in constructing a ‘cover’ is that it [should] permit you to have a set of activities look like they’re perfectly ordinary.

(Sacks, 1992, vol. 1: 317; original emphasis)

As part of making “a set of activities look like they’re perfectly ordinary” someone might be going about just the sort of actions as one would when doing ‘being ordinary’. I used this notion in support of position that the patient in Palmer (2000) had reasons for the ordinariness of his account. Sacks points out that

...[w]hatsoever we may think about what it is to be an ordinary person in the world, an initial shift is not to think of an ‘ordinary person’ as some person, but as a somebody having as their job, as their constant preoccupation, doing ‘being ordinary’.

...Reports of the most seemingly outrageous experiences, for which you’d figure you’d be at a loss for words, or would have available extraordinary details of what happened, turn out to present them in a fashion that has them come off as utterly unexceptional.

We will revisit this notion a little later, in connection to the hearing voices group data, but first let us explore a way which has been identified for evidencing omni-relevant devices in practice. Decades after Sacks’ work, McHoul and Rapley (2002) made use of some data which represent what they called a “naturally occurring breach study” in order to substantiate the empirical facticity of the omni-relevant device. That is, the authors took their data to contain the use of a cover identity by one of the interactants which was eventually dealt with by another interactant (who had also been ‘under cover’, as it were) as a pertinent absence of an omni-relevant device. It was argued that the ‘absence’ was evidenced by the steps which were taken by the other interactant to reinstate the device and the formal business therein.

In accordance with McHoul and Rapley, I hold that the formal business(es) of psychiatry and therapy constrain(s) the interaction in our hearing voices group data. Further use of the term ‘breach’ (without inverted commas) would be misleading, here, however. Identities, omni-relevant devices, and cover identities are all normatively, institutionally, inter-related. It is not, for example, that the invocation of (cover) identities should be taken as evidence of unawareness of an omni-relevant device, and it certainly should not be taken as proof that such a device does not exist. Rather, the invocation of cover identities may be as demonstrable, as orientation to that device, as are reinstatements of the device. Thus, each of these identities, no matter how presented-as-ordinary some of them may be, are connected to the institutional work of PSYCHIATRIC STAFF + PATIENT. Cover identities are constituted in interaction as pertinent absences of omni-relevance, not complete absences. Later, in connection to Extract 7.7, we will see that the invocation of the identity of EXPERT VOICE HEARER functions as a breach-proper, an actual departure from the professional control of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT.
Let me add a little flesh to my summary of McHoul and Rapley’s paper. Their data involves Bob (who is identified in the analysis as a PATIENT, and elsewhere in the paper as a person with intellectual disabilities) and Mike (who is identified in the analysis as a THERAPIST and elsewhere in the paper as a clinical psychologist). Mike visits Bob in his home to administer a ‘quality of life’ questionnaire. For quite some time they ostensibly talk about everything but the official business of doing such an assessment. However, under the guise of the cover identities of two people chatting, a fair bit of the formal work-to-be-done is orientated to, including Bob indicating his ‘quality of life’. Eventually, Bob asks Mike, “Should we make a start then?”, which equates to ‘Let’s get down to the reason why you’re here’ or ‘Come on, be a psychologist’. In the terminology and approach which I have adopted in this chapter, the cover identities of ACQUAINTANCE + ACQUAINTANCE (ie, NOT-THERAPIST + NOT-PATIENT) are eventually taken by Bob as a pertinent absence of the omni-relevant device of THERAPIST + PATIENT, and Bob’s request to make a start, plus the THERAPIST questions and PATIENT answers in the interview which follow, are a reinstatement of that omni-relevant device (since it is, in fact, always present).

To a certain extent, the analyses in this chapter reflect what I take to be the more ‘adversarial’ nature of my data, compared to that of, say, McHoul and Rapley (2002). That is not to say that McHoul and Rapley’s Mike and Bob were not ‘conflicted’ about doing official business; as their extensive use of cover identities shows, especially for Mike, the slow to lead clinical psychologist. However, McHoul and Rapley’s data includes little or no sense of the vying which I show between interactants in my hearing voices group data.

Let us continue with McHoul and Rapley’s consideration of cover talk:

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4 Mike seems to be a popular name for psychologists, although this one is really called Mark Rapley.
In this respect, the “cover identities” and the “cover topics” they invoke can be seen as ways of dealing with the situation in which these members find themselves: working up to the formal “business” of the visit (the assessment of Bob’s “quality of life”) and so, in some “covering” (informal) way, actually doing it. It is therefore worth noting that the point at which the assessment-proper is initiated (line 174) comes just when the talk has started to turn away from everyday niceties and towards professional-evaluational matters; as though the cover identities and topics had begun to fray or otherwise wear thin. If this is the case, then we are not dealing with a situation where the participants are, as it were, simply waiting for the omni-relevant device to show its face; rather, by invoking cover identities, they are mutually showing the device to be always potentially operable at any given moment.

(2002; original emphases)5

McHoul and Rapley’s analysis demonstrates how each of the four omni-relevant criteria from Sacks are met in their data, that “(a) ‘some activities that are known to get done’ in this setting which (b) ‘have no special slot’ but do (c) ‘have priority,’ and such that (d) it is one of the parties’ business to do those activities” (McHoul & Rapley, 2002, after Sacks, 1992, vol. 1: 313-314) (see the second Sacks quotation of this chapter).

How does this relate to the hearing voices group data? I propose that the identities of PSYCHIATRIC STAFF + PATIENT and of THERAPIST + CLIENT are ever-relevant to the tasks at hand in the hearing voices group interaction. Furthermore, I aim to show that when the interactants stray too far from their institutionally relevant identities (through what other participants take to be the over invocation of cover identities) then moves are made to reinstate them accordingly. Thus, each of these two identity pairs,

5 Note that these emphases are as they were in the draft copy of McHoul and Rapley’s (2002) from which I am working.
PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT, are omni-relevant devices.6

Now that the groundwork of introductory theory has been laid, I must establish that these identities and omni-relevant devices occur in practice, in the hearing voices group data. Earlier, in our third Sacks quotation, it was noted by Sacks that the

...device consisting of the categories (therapist/patients) is omni-relevant for this two-hour conversation; where that is warranted by reference to the fact that the greeting-and-introduction sequence and the closing sequence are controlled by reference to that device.

(Sacks, 1992, vol. 1: 314)

In keeping with this way of establishing that an omni-relevant device is in operation (for a therapy group), below, is an extract from the opening of the first hearing voices group session (Extract 7.1) and an extract from the closing of the final session (Extract 7.2). The talk from these extracts, then, may be taken as relevant to all the group session talk in between. That is, if an omni-relevant device is shown to operate in these extracts then that is the groundwork for showing that the identities therein operate as an omni-relevant device in the rest of our hearing voices group data. However, according, to the omni-relevant device criteria which McHoul and Rapley (2002) derive from Sacks, an omni-relevant device is present if there are “(a) ‘some activities that are known to get done’ in this setting which (b) ‘have no special slot’ but do (c) ‘have priority,’ and such that (d) it is one of the parties’ business to do those activities”. In addition to demonstrating institutional opening and closing sequences, then, I will have evidenced an omni-relevant device if these four criteria are also met.

6 The examples in this dissertation of omni-relevant devices and cover identities relate to identity pairs. However, we may suppose that it is possible for such identity ‘complexes’ to come in more than twos.
We begin at the *start* of the first group session. As people arrive, Stuart has been explaining about missing the bus:

Extract 7.1 (HVG, S1, MW, 0:24-0:37)

1 S: [...] I wouldn’t ’ve missed *any* [bus ]
2 ?: [°Mhm.]°
3 S: er bus at all.
4 M: Oh right-o. ’hh ↑WELL=
5 S: =Yeh= 5
6 M: WELCOME everyo:ne. (0.2) ↓U[:mm ]
7 S: [°Thank]you. Mike.°
8 (0.3)
9 M: thanks for coming↑
10 (0.3)
11 S: Yeah=
12 M: =an:d u:m
13 (0.4)
14 W/S: °M[mm.]°
15 M: [the-]er (0.5) fir:st session ’f (0.3) ↑the
16 hearing voices group↑ hhh ·hhh
17 S: Yes.

In lines 1 to 3 Stuart, may be seen as adopting an identity which, perhaps subserviently, requires approval. It is Mike who gives the approval, in line 4, albeit rather dismissively. That is, Mike confirms Stuart’s lower institutional status and begins to adopt an identity which has more social power than Stuart. Indeed, Mike has more pressing concerns, for it is Mike, in the dominant identity (which we soon see as PSYCHIATRIC STAFF/THERAPIST), who officially opens the therapy session (lines 4 & 6). And it is Stuart in his deferent identity (which we soon see as PATIENT/CLIENT) who acknowledges Mike as opening the session in the ‘in-charge’ identity (which we soon see as PSYCHIATRIC STAFF/THERAPIST). In lines 15 and 16, we have a clear notification that this is a therapy group for hearing voices, so that Mike, as the person leading the proceedings, is the PSYCHIATRIC STAFF/THERAPIST, and Stuart and the others are PATIENTS/CLIENTS. Thus, we can already see, that therapy is an activity which (a) is “known to get done in this setting”, which (b) has “no special slot” (ie, Mike need not have formally opened the
session when he did), but, when he does, (c) it has “priority”, and (d) “it is one of the parties’ business to do those activities” (ie, Mike). That is, we have evidence of an omni-relevant device (PSYCHIATRIC STAFF/THERAPIST + PATIENTS/CLIENTS) in this hearing voices therapy group interaction.

Now that an omni-relevant device has been established in the hearing voices group data, Extract 7.2, below, provides an analytic opportunity to consider some of the finer points of my claims about identities and omni-relevant devices. The extract comes from the end of the final hearing voices therapy session. Mike has begun to sum-up about what he takes to have occurred in the group over the eight weeks, and to formally close the session:

Extract 7.2 (HVG, S8, MW, 66:42-67:15)

1  M: [...]>it’s [ inter]esting for me as well you
2   ?: [°Mmm.°]
3  M: know   [°Mm.°]=
4  W: [°Mm.°]=
5  M: =it’s been< ei:ght wee:ks: (.a[nd ]
6  W: [°Mm.°]
7  (0.2)
8  M: [>it’s go]nna continue: to be a part of< my li:fe
9  W: [°Mm.°]
10 M: for a-=
11 S/W: =Mm[m.]
12 M: (f)or a long [ti:me] coz I’(h)ve go(hh)t
13 B: [Mmmm.]
14 M: (hh) (hh) (hh) mon(h)ths and [mo:n]ths of=
15 S/W: [°Mm.°]
16 B: =[°Hmm.°
17 M: =[·hhh wr:i:ting stuff u:p ·hhh and it’s (0.3) ya
18 know: I I- [ thi]nk (1.2) °u:mm° (0.4) if it’s
19 T/B: [°Mm.°]
20 (0.5) ((shuffling sound)) (1.1)
21 M: mea:nt as [mu:ch ] to everyo:ne who’s here (0.3)
22 T/B: [°Mm.°]
23 M: as it [has t]o me: (0.4) the:n (0.1) ya know
24 B: [°Mm.°]
25 M: hu[:ge impact ]
26 W: [WE’VE ACHIEVED SOMETHING=
27 M: =it’s had a hu[:ge imp[act ] on MY LI][:FE ya]
28 W: [WE’VE ACHIEVED] SOMETHING]
29 T: [°Mm.°]
30 M: know.=
31 T: [°mm. ]
32 W: [We’ve] achieved something then >Thaven’t< we.
33 M: Yeah. Big [ t i ]:me.
First, we note that it is Mike (as PSYCHIATRIC STAFF/THERAPIST) who is leading this summing-up of the group (line 1 ff.). Next, we may note that Mike’s saying that the group will continue to be a part of his life because he has to analyze the data may perform several functions. On the one hand, with talk of all the data for him and him alone to analyze, it cements his identity as being the person who is (at least supposed to be) in control of the whole group. On the other hand, from line 17, he goes on to (also) relate what the group has meant to him to what he hopes it has meant to others. This is clearly targeting the voice hearers as PATIENTS/CLIENTS, with a therapeutic message of Mike’s hope that they will continue to live with and process what they have learnt from the therapy, after the group has ended. Notice that, until line 26, the voice hearers, as PATIENTS/CLIENTS, duly acknowledge Mike’s message (lines 4, 6, 9, 11, 13, 15, 16, 22, & 24). In line 26, Walter can be said to interrupt Mike, with a raised voice. Walter’s repeated statement ‘we’ve achieved something’ (lines 26, 28, & 32) manages to acknowledge Mike’s message that something has been achieved, whilst, at the same time, he turns the spotlight back to the ‘we’ of the group and/or the voice hearers. Through his actions, then, Walter invokes the identity of NOT-MAD, here. Indeed, Mike responds to Walter’s initial ‘interruption’ with the latched statement that “=it’s had a huge impact on MY LIFE ya know.,” re-emphasizing his experience (lines 27 & 30). It is only after Walter’s final re-statement “We’ve achieved something then >haven’t< we.” (line 32) that Mike explicitly acknowledges what Walter is saying:
“Yeah. Big time.” (line 33). However, Mike does not, say, ask Walter what he considers to have been achieved. Rather, after letting a little time pass for further acknowledgement, Mike takes the reins once more, as PSYCHIATRIC STAFF/THERAPIST: “Mmm. (. ) ·hhh (. ) And I don’t think we’ve done lots of fancy: tricks with ummm (0.8) with handsouts […]” (line 41 ff.). A clearly drawn topic-action distinction may be of use here. As applied to this part of this extract, the topic of Mike’s statement undermines the value of “fancy:” therapy-related “tricks” (and, thus, to some extent, the topic straddles the NOT-STAFF ‘side of the fence’). However, Mike’s actions (eg, doing the summing-up) identify him as the PSYCHIATRIC STAFF/THERAPIST, the person who is in charge of proceedings. Thus, overall, despite Walter’s efforts to claim some agency, and despite those topical aspects of Mike’s account which undermine formal therapy, the voice hearers are identified as PATIENTS/CLIENTS and the institutional omni-relevant device prevails, as such devices do, by definition.

It may be worth, before proceeding, to provide a general consideration of how the identities so far described might be constructed in the hearing voices group data. In subsequent analyses, I aim to show that participants move ‘strategically’ between the various identities - their adoption and their ascription - depending on the task at hand. For example, the NOT-STAFF identity can be seen to cover the identities of THERAPIST/PSYCHIATRIC STAFF which have predicates such as being professional, technical, special, formal, and somewhat aloof. Professional identities (PSYCHIATRIC STAFF and THERAPIST) are achieved through features of both the presentation and the topic of talk. The cover identity, NOT-STAFF, allows for formal work to be done but in a more pleasant, informal guise. The invocation of PATIENT (ie, a questionably sane PSYCHIATRIC PATIENT) or a (psychologist’s) CLIENT invokes PSYCHIATRIC STAFF or THERAPIST, respectively. To summarize,
THERAPIST/PSYCHIATRIC STAFF is not ordinary, but the NOT-STAFF cover identity goes some way towards ‘being’ ordinary.

Let us arrive at working definitions for some of the voice hearer identities. To invoke a NOT-MAD cover identity for her/himself, a voice hearer must produce her/himself as rational, skilled, and ordinary. The NOT-MAD identity can be seen to cover the identity of MAD PERSON. It does the same for PATIENT and CLIENT - though it is required less for PATIENT, and lesser still for CLIENT, on the basis of the sanity status connected to those identities. Being a person of questionable sanity has attributes such as being ‘overly’ deferent to professionals (when coherent), in addition to, paradoxically, being incoherent, irrational, not demonstrating skills, being without appropriate feelings, and being more or less controlled by the madness/illness. The cover identity may perform some of the work of therapy/psychiatry but in a less formal and an ostensibly more palatable way.

PATIENT/CLIENT identities are achieved by the deference which is afforded to the therapists, the invocation of psychiatric symptoms by either party, and the invocation of a THERAPIST/PSYCHIATRIC STAFF identity. To summarize this side of the coin, PATIENT/CLIENT is not ordinary, but the NOT-MAD cover identity goes some way towards ‘being’ ordinary.

We also see fleeting glimpses, in the hearing voices group data, of one or more of the patients breaking away from their institutional identities of PATIENT and CLIENT, and their cover identities of NOT-MAD, through the invocation of an EXPERT VOICE HEARER identity. This is normatively constructed as being something of a voices-worn but worldly-wise, and experienced in dealing with hearing voices, identity. It is not so common as PATIENT and CLIENT, but when it occurs in some of this chapter’s extracts, EXPERT VOICE HEARER (as distinct from PATIENT and especially CLIENT) is invoked by the patient as a counter to THERAPIST + CLIENT. A topic-
presentation distinction may be of use here. The identity of EXPERT VOICE HEARER concerns experiencing and dealing with voices independently of patienthood and clienthood. Thus, EXPERT VOICE HEARER is always about hearing voices as a topic (which may not be so ordinary). However, a fully independent from professionals EXPERT VOICE HEARER identity, must, by definition, also involve an ORDINARY presentation (ie, the manner of speech; the delivery) of that topic. If the topic were presented as NOT-MAD, then that would still be under the control of a psychiatric omni-relevant device, which would preclude full independence from professionals. On the other hand, NOT-MAD can be about almost anything (so long as it does not invoke a madness-related identity), and quintessentially NOT-MAD involves both an ordinary, everyday topic and an ordinary presentation of that topic.

It should be explicitly acknowledged that my distinctions between certain identities may, on occasions, be unclear; even for identities which in a sense oppose each other, such as PSYCHIATRIC STAFF and NOT-STAFF. Also, on occasions, I do not distinguish between PATIENT and CLIENT and between PSYCHIATRIC STAFF and THERAPIST. This lack of clarity may be due to several factors. First, it may be due to the generality and theoretical nature of certain of my discussions. However, there may also be ambiguities in my specific analyses of actual interaction. For example, in my analysis of Extract 7.2, above, I argued that Mike invoked both the identity of NOT-STAFF and the identity of PSYCHIATRIC STAFF/THERAPIST in close proximity. In such cases, we may see that the ‘the lack of clarity’ is due to the fact that identities are not static things. Rather, identities are dynamic, they may be contributed to and undermined by more than one party, and they may serve to achieve various functions; to manage various tensions. On occasions, the identities and their functions are conflicting and, on occasions, they are conflicting/related (as in the ambiguous relationship between omni-relevant identities and cover identities). Thus, also, NOT-MAD and
PATIENT may be seen to operate in close proximity; as in Harper’s (1999) ‘rationality trap’, and in keeping with the omni-relevance of the institution of psychiatry and of psychotherapy to the hearing voices group, as it occurred.

Let us pick up on these topic-action and topic-presentation dichotomies, to tease out the distinctions between THERAPIST / PSYCHIATRIC STAFF and between PATIENT / CLIENT. I suggest that the identities of THERAPIST and CLIENT may be invoked through a psychological therapy topic being ‘under discussion’ but that such ‘identities’ do not fully ‘resonate’ unless the voice hearer is imbued with more skill and agency (as is required for personal change) than is usual for a psychiatric PATIENT. That is, it is not only ‘talking the talk’ (ie, the lexical choice, the topic of talk) which contribute to identity but also ‘walking the walk’ (ie, the non-topic presentation - the delivery - of talk; plus the sequential, talk-in-interaction, aspects of identity). Thus, on occasions, it may require all of these features to sufficiently, coherently, invoke a given identity, for example, to be fully produced as a CLIENT: in the hearing voices group interaction, the identity of CLIENT tends to be undermined/mixed/superseded with the more sanist identity of PATIENT. A full invocation of CLIENT would require not only a therapy-related topic, such as a discussion of cognitive coping skills, but it would also involve interactional relations which ascribe to the receiver of the professional service a greater rationality than that which comes with PATIENT. THERAPIST + CLIENT, however, is still a formal, asymmetrical relationship, but less so than PSYCHIATRIC STAFF + PATIENT. It is important to note also that, above all, the PSYCHIATRIC STAFF identity is to do with espousing, administering, and controlling the medical model and associated treatments. Thus, the PSYCHIATRIC STAFF identity invokes PATIENTS as a co-identity; as passive recipients of treatment.

Returning to omni-relevant devices, I demonstrated earlier that one or more omni-relevant device(s) are operating in the hearing voices group data. Sacks’ notion of
collection R and collection K is useful here (Sacks, 1972a: 37 ff.; 1992). In my analyses of the hearing voices group data, the two omni-relevant identities are part of collection K (as in the professional plus layperson relationship of TEACHER + STUDENT). We may also note that cover identities are part of collection R (as in the layperson plus layperson relationship of FRIEND + FRIEND). As such, omni-relevant device identities have a more formal/institutional relationship with each other and cover identities have a more informal relationship with each other. Note, though, that with cover identities, this is an apparent informality on two counts. First, even ‘just chatting’ has its own system and formalities. Second, cover identities involve a kind of everydayness which is further constrained by their relationship with an omni-relevant device.

It has been established, then, that there is the collection K relational pair of PSYCHIATRIC STAFF/THERAPIST + PATIENT/CLIENT - ie, one or more omni-relevant devices - operating in the hearing voices group data, but we have not yet distinguished between the two omni-relevant devices. With regards to my claim that there are two omni-relevant devices operating in our hearing voice group data, such a proposition brings with it a considerable degree of complexity in terms of the ways in which the various identities might inter-relate. Therefore, I next present a theoretical summary of these relations, as an orientation to the subsequent analysis. This summary is not intended to stand apart from Sacks’ or McHoul and Rapley’s work. The distinction between the two omni-relevant devices and the evidence for these inter-relations will follow in subsequent sections.

Following Sacks on omni-relevant devices, my consideration of identities in this section looks at them in terms of their formality/institutionality (that is, their departure from the institution of ordinary conversation). Sanity-related issues of ‘normality’, ‘abnormality’, rationality, etc, are somewhat different to that kind of ‘ordinary’. Nevertheless, it is generally (mundanely) assumed that it is ordinary and sane folk who
engage in ordinary and sane conversation. It is also assumed that it takes a kind of super rationality/sanity to operate as the dominant person in a PSYCHIATRIC STAFF + PATIENT or THERAPIST + CLIENT (ie, formal) interaction; to evidence the specialist expertise, knowledge, and skills of a psychiatric and/or therapy professional. And, ironically for the latter identity pair, it is assumed that it also takes irrationality (/insanity) to operate as the subordinate person. I claim, in these senses, that PSYCHIATRIC STAFF + PATIENT is a more formal omni-relevant device (ie, more rational therapist, less rational patient) than THERAPIST + CLIENT. That is, I claim that the former subsumes the latter in terms of formality, such that, if both are in operation - as I claim them to be - then PSYCHIATRIC STAFF + PATIENT is the most powerfully constraining.

An ‘absenting’ of an omni-relevant device typically involves identities which are more ordinary than that device: cover identities. In the hearing voices group data, with the ever-relevant formal identities of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT, the identities which are used to cover such formalities may be described as NOT-STAFF and NOT-MAD. Cover identities, by definition, are presented as being more ordinary than the omni-relevant identities which they serve to cover. A cover identity, therefore, may be taken as a pertinent absence of an omni-relevant device. Cover identities come in pairs, as do omni-relevant devices. Besides cover identities, there may be other identity pairs that are invoked in which the identities are also more ordinary than, or otherwise depart from, the omni-relevant device. We shall consider some of these later.

Before we go on with omni-relevant devices, let us consider NOT-MAD a little further; especially its connection to ‘ordinariness’ and ‘normality’. NOT-MAD accounts can be about almost any topic, but quintessentially they involve both an ordinary, everyday topic and an ordinary presentation of that topic. But how does NOT-MAD
differ, from the action of doing ‘being ordinary’ and the identity of ORDINARY/NORMAL? NORMAL people and voice hearers, alike, are concerned with showing that they are ordinary, rational people: everyone has the job of doing ‘being ordinary’. However, NOT-MAD differs from NORMAL because NOT-MAD is, a priori, a part of the ‘rationality trap’: NOT-MAD is more than doing ‘being ordinary’, it is the ‘overly’ ordinary response to the prejudice-in-action of the omni-relevant device of PSYCHIATRIC STAFF + PATIENT.

We have it, then, that doing ‘being ordinary’ is a pervasive, everyday practice of everyone and that the ‘over’ application of doing ‘being ordinary’ is one the interactional features which mark psychiatric patients as not being ‘normal’. Similarly, in their analysis of the management of a stigmatized identity by people with an intellectual disability, Rapley, Kiernan, and Antaki noted that:

Examination of the conversation analytic literature would, however, suggest that what has come to be known as ‘passing’ (with its clear implications of deception and the intent to mislead - these people are not, after all, ‘really’ ‘normals’) may merely be a version of what are common members practices. Sacks has suggested that ‘doing being ordinary’ is a pervasive feature, or recurrent pattern, of the accomplishment of everyday social life - the presentation of self as merely an ordinary actor, with the implication of normalcy, of being just like other folks, and as such, not particularly accountable. As he puts it:

It is almost everybody’s business to be occupationally ordinary ... people take on the job of keeping everything utterly mundane ... no matter what happens pretty much everybody is engaged in finding only how it is that what is going on is usual, with every effort possible ... (Sacks, 1984, p. 419.)

(1998: 811)

And, in line with my consideration of doing ‘being ordinary’ in a psychiatric setting Rapley, in connection to intellectual disability, describes how

“[d]oing being ordinary”, as Harvey Sacks (1984) observed, is a pervasive part of the business of every day social life because there is, pervasively, always the possibility
that you will be seen to be not ordinary. For people already identified a priori as definitionally “non-ordinary” such normative social demands must be seen as heightened: of course the difficulty for persons so identified - and here the fundamentally moral nature of such judgments becomes evident - is that the psy professions construct their attention to the everyday business of being mundane as accountable moral action. As Bogdan and Taylor have it: “to be called [retarded] is to have one’s moral worth and human value called into question. It is to be certified as ‘not one of us’” (Bogdan and Taylor, 1994: 14).

(2004: n.p.; my emphasis)

Thus, we may see why those who are “already identified a priori as definitionally ‘non-ordinary’” may work especially hard at doing ‘being ordinary’, so as to be identified as NOT-CLIENT (as in McHoul & Rapley, 2002) and/or NOT-MAD (as in the hearing voices group data). However, the prejudiced institutions of which they are a part, have them a priori as “not one of us”, so that, so long as they are a part of such institutional interaction, they can never break free. Such pronounced doing ‘being ordinary’ equates to demonstrable otherness. As Harper (1999) puts it, in connection to ‘paranoid patients’, they are caught in a ‘rationality trap’.

Returning, more specifically, to omni-relevant devices and their pertinent absences, if a PSYCHIATRIC STAFF + PATIENT omni-relevant device is in operation, then one or both of the identities from either of the following less formal pairs may be taken as a pertinent absence of that device:

- NOT-STAFF + NOT-MAD
- THERAPIST + CLIENT

In a sense, then, each of these two identity pairs can act as a more ordinary cover for formal PSYCHIATRIC STAFF + PATIENT work.

7 This is not a must list, nor is it exhaustive.
And, if such a PSYCHIATRIC STAFF + PATIENT omni-relevant device is in operation, then one or both of the identities from the following pair may be taken as a (full) reinstatement of that device:

- PSYCHIATRIC STAFF + PATIENT

Since this is the most formal (and by that I mean the least seen-to-be-ordinary) identity pair, then only a ‘full’ invocation of one or both of the identities from the omni-relevant device itself can restore that device to ‘open’ (ie, completely uncovered) operation.

Returning to our consideration of pertinent absences, and taking PSYCHIATRIC STAFF + PATIENT as our example, it is worth noting that an ‘absence’ may directly relate to either or both of the identities in that device (eg, the ‘absence’ might involve NOT-STAFF and/or NOT-MAD). The co-identity (NOT-STAFF or NOT-MAD) is implicated in the ‘absence’, either way. Note that such an ‘absence’ may be performed by one or both of the therapists and/or by one or more of the patients through an invocation of either or both of the cover co-identities (ie, NOT-STAFF and/or NOT-MAD). Similarly, when the ‘absence’ is resolved through the invocation of PSYCHIATRIC STAFF or PATIENT then the co-identity (PSYCHIATRIC STAFF or PATIENT) is implicated in the reinstatement, even if it is not ‘directly’ invoked. Note also that such an ‘absence’ may be resolved by one or both of the therapists and/or by one or more of the patients through an invocation of either or both of the co-identities in the omni-relevant device (ie, PSYCHIATRIC STAFF and/or PATIENT). That is, for pertinent absences and their resolutions, the person performing the action may or may not be the same person about whom the identity is invoked. This holds for all omni-relevant devices in operation; for both PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT.

Now let us consider the operation of THERAPIST + CLIENT, this time as an omni-relevant device rather than an ‘absence’/cover. If there is a THERAPIST + CLIENT
omni-relevant device in operation, then one or both of the identities from either of the following pairs may be taken as a pertinent absence of that device:

- NOT-STAFF + NOT-MAD
- PSYCHIATRIC STAFF + PATIENT

The first of these identity pairs (NOT-STAFF + NOT-MAD) can act as a more ordinary cover for formal THERAPIST + CLIENT work, just as it did for PSYCHIATRIC STAFF + PATIENT. I include PSYCHIATRIC STAFF + PATIENT as a pertinent absence of THERAPIST + CLIENT, even though it/they are not more ordinary than THERAPIST + CLIENT, because it is an ‘absence’ of THERAPIST + CLIENT in other ways. First, PSYCHIATRIC STAFF + PATIENT is more asymmetrical than THERAPIST + CLIENT. It is thus an absence of THERAPIST + CLIENT. Second, PSYCHIATRIC STAFF + PATIENT is a pertinent absence of THERAPIST + CLIENT in so far as THERAPIST + CLIENT can be demonstrated as being omni-relevant, throughout periods of its ‘absence’. Each of the omni-relevant devices may be either active or pertinently absent at any particular time, such that when one is active the other is pertinently absent and vice versa. This is a departure from McHoul and Rapley (2002) to the extent that their study included a pertinent absence involving cover identities; a move to more ordinary identities. We shall return to this issue presently.

And, if there is a THERAPIST + CLIENT omni-relevant device in operation, then one or both of the identities from the following pair may be taken as a reinstatement of that device:

- THERAPIST + CLIENT

It is worth noting that patients do not tend to be the ones who reinstate THERAPIST + CLIENT after an ‘absence’. This suggests that there is uneven support for such a device; that, in this sense, therapists uphold it more than patients.
We may also note that, with two omni-relevant devices in operation, and because PSYCHIATRIC STAFF + PATIENT is more formal than THERAPIST + CLIENT (ie, since the former subsumes the latter in terms of asymmetry within each identity pair), the invocation of PSYCHIATRIC STAFF + PATIENT may be taken as in some ways reinstating and in other ways being a pertinent absence of THERAPIST + CLIENT. This represents/predicts the confusion-in-action which may occur with two multiply inter-related omni-relevant devices in operation. Here, the identity difficulties arise not only from THERAPIST + CLIENT being subsumed by PSYCHIATRIC STAFF + PATIENT but because, in the hearing voices group, the same people, namely therapists, do the job of both THERAPIST and PSYCHIATRIC STAFF. The same can be said, of course, for the co-identities (ie, for PATIENTS and CLIENTS). In connection to this, I suggest that ‘within’ person identity conflicts and identity ‘crises’ may occur when somewhat conflicting identities are attributed to the same person within a short period of time.

Sacks’ description of omni-relevant devices has it that a cover identity is a more ordinary way of performing official business. Similarly, McHoul and Rapley (2002) have it that, in their data, a cover identity (ie, an identity which is more ordinary than official identities) was a pertinent absence of a THERAPIST + PATIENT omni-relevant device. But McHoul and Rapley do not distinguish between THERAPIST and PSYCHIATRIC STAFF because it is not relevant to their data. It is, however, relevant to the hearing voice group data. Therefore, I suggest that, with the occasioned vying between two different omni-relevant devices which is present in my data, PSYCHIATRIC STAFF + PATIENT can be a pertinent absence of THERAPIST + CLIENT, even though, unlike McHoul and Rapley, the identities in such an ‘absence’ are less ordinary than THERAPIST + CLIENT. Of course, this possible definitional problem does not arise on the occasions when I claim that THERAPIST + CLIENT is
an ‘absence’ of PSYCHIATRIC STAFF + PATIENT, since the former is more ordinary than the latter. Any pertinent absences which feature cover identities are also unproblematic in this way - since cover identities are most ordinary - regardless of the omni-relevant device which is active at the time.

So then, in this chapter, I propose that the omni-relevant devices of PSYCHIATRIC STAFF + PATIENT, and, to a lesser but still significant extent, THERAPIST + CLIENT, instantiate and cement the sanism which is (by definition) inherent in those identities. This is to say that the identities, THERAPIST, CLIENT, PSYCHIATRIC STAFF, and PATIENT, are constructed in and through sanist actions; actions which can be demonstrated as being prejudiced and privileging along sanist lines. I will endeavour to tease out these identities and the sanism-in-action involved. Focusing on the patient rather than the therapist in this immediate discussion, I will also try to show how the omni-relevant devices and sanism operate in relation to the cover identity of NOT-MAD. A key problem for the participants to manage is that, on the one hand, NOT-MAD is used as a cover identity under which a patient can do the institutional job of ‘symptom’ reduction whilst still maintaining some ‘normality’. Also, as NOT-MAD, a patient can do the job of doing ‘being ordinary’ (Sacks, 1992, vol. 2: 215-221); something which is even more important when one’s sanity is being ever-questioned. However, on the other hand, in tension with being NOT-MAD is the fact that overtly doing the institutional work of ‘therapy’ can only ever be done (by definition) under the ‘abnormal’ voice hearer identities of CLIENT and/or PATIENT.

Putting both the ‘normal’ and ‘abnormal’ sides of this therapy equation together, in order to be justifiably receiving therapy one must show both improvements and continuing problems. Perhaps an image of a juggler, with two feet on uneven ground will help here. As a PATIENT/CLIENT one must systematically juggle having been, being, and/or becoming ‘normal’ and ‘abnormal’ (as if in a normality-abnormality
continuum). And one must respond to uneven ground and prevailing winds (within the interaction). But the hearing voices group is not a level playing field; the side of MAD PERSON and PATIENT is, I argue, lower down (ie, subordinate) in terms of sanity status and is, thus (according to my juggler metaphor) weighed down with more ‘gravity’. The subordination is not so pronounced with CLIENT (which would be in or towards the middle, I suppose) and certainly not in the immediacy of NOT-MAD (which would be on the other side, whilst it holds as a cover). It is as if the voice hearer is juggling between ‘normality’ and ‘abnormality’ whilst being constantly tugged down, lopsidedly, on the side of MAD PERSON and PATIENT. That is, the patient’s sanity is constructed in the interaction as ever-questionable.

Furthermore, within this interactional system, the fall-back or resolution position - when the pursuits and niceties of doing ‘therapy’ or doing ‘being ordinary’ will not quite do, for either or both ‘sides’ - is to the device of PSYCHIATRIC STAFF + PATIENT. This is visible in the resolution of reality disjunctures, which, on some occasions, may only be settled by attributing a lower status to one of the participants (see Chapter 5, on Georgaca, 2000). In the hearing voices group data, it turns out that negotiating (one might say ‘prescribing’ or even ‘dictating’) Reality is what cognitive-behavioural therapy is ‘all about’; something which also turns out to be a foundation of dominant psychiatric practice.

It is more than a little ironic, considering how much the patients work to show that they are NOT-MAD, that the therapists and patients succeed, all in all, in constructing the patients as being very much second to the PSYCHIATRIC STAFF in terms of sanity and its related achievements. It makes sense, given the supposed nature of ‘mental illness’ and given the relationship between psychiatric social power and sanity status, that rationality is so much at stake in a psychiatric setting. This is especially so in a psychiatric setting in which cognitive-behavioural therapy is applied, since CBT is
centrally based on demonstrations of rationality by the therapist to the client. Recall that rationality includes such matters as being socially skilled, feeling, expressing, and contributing. Insanity is supposed to be characterized precisely by the absence of such rationality.

What of the voice hearers’ categorization as, officially, PATIENTS? It is important to note that, in terms delineated by DSM-IV, all the voice hearers in the therapy group were clinically diagnosed as currently experiencing symptoms which are characteristic of both acute and chronic psychosis. Indeed, what can be described as first-rank ‘auditory hallucinations’ and ‘delusions’ were verbally reported by the majority of voice hearing group members as occurring (between, and sometimes within) the group therapy sessions which are the subject of these chapters. That is, the voice hearers were not currently taken to be exhibiting sufficient (new/untreated/dangerous) ‘symptoms’ to be inpatients of a psychiatric ward. They had all experienced their ‘medication resistant symptoms’ for many years, after all. Nevertheless, I do not believe it an exaggeration to say that they would, most likely, have all become inpatients on the spot if they had described their current ‘symptoms’ as new cases in a potential intake interview for a ‘mental health’ unit. I make a special point of this issue to contrast the officially reported ‘severe mental illness’ of the voice hearers with the rationality which they display in interaction.

To conclude this part of the introduction with a wider view of the data, we may now consider the hearing voices group data presented in this chapter as a whole. The voice hearers are pervasively identified as PATIENTS, despite, or because of, the work which they do in maintaining a cover identity of NOT-MAD. There are also the show-throughs of MAD SELF and the use of MAD OTHER (sanity-related identities which we will see more of later). It appears that much of what therapists and patients do is to negotiate a tension between PSYCHIATRIC STAFF + PATIENT, THERAPIST + CLIENT, and
the cover identities. This is the voice hearer’s ‘rationality trap’ (Harper, 1999), in this particular form of interaction: the voice hearers do not ever quite get away from being identified as questionably sane. This trap, this sanist web, is constructed by both the voice hearers and the therapists. In the data, overall, participants are massively concerned with managing a balance between various rationality/sanity-related identities, depending on the situation, so that neither strays too far above or below certain parameters. This is psychiatry, as it is instituted; along sanist lines. This is not ‘just’ a local tit-for-tat: particular identities are favoured over others in a way which is not generically conversational. This is, I argue, partly to do with a sequential/conversational level of organization, partly to do with a locally relevant identity level, and partly to do with a (sub-)culturally relevant identity level. There are institutional (and by that I mean beyond conversational) norms at work here. It is a particular person who tends to perform a particular action, in keeping with the identities and rules which are locally constraining/available to them. And it is a particular person who tends to respond to that action, in accordance with those identities and rules which constitute them (cf. Sacks, 1992). For example, overall, PATIENT operates as the a priori, underlying, default identity for, and of, the patients; which can be traced, in part, to each of the levels of organizational influence just mentioned.

To illustrate this institutional asymmetry, let us turn the rationality trap on its head, for a moment. Consider a hypothetical scenario in which a therapist ‘over’ invokes their own ordinariness in a way that is similar to the ‘rationality trap’ for patients. How might that reflect on the therapist? Are they as likely as patients to have their sanity questioned? The answer is clearly ‘no’, because of their a priori sanity status. Indeed, in Section 3, below, I argue that, amongst other examples, therapists making a special point of rendering themselves as ‘normal’ (alongside the patients, as it were) may backfire and result in the patients’ rationality being further constructed as questionable.
In line with the analyses and discussion in Chapter 3, of CBT being an adjunct to biopsychiatry, it may be said that CLIENT is to some extent merely a variation on the voice hearers’ PATIENT identity, regardless of the ‘window dressing’: the medical model is, ultimately, dominant and, hence, PSYCHIATRIC STAFF + PATIENT(S) is the principal omni-relevant device. It is also worth noting that, according to these constructions (and by definition), PATIENT and CLIENT (even a patient’s construction of NOT-MAD, if it is clinically taken as a mere ‘cover’ for something more problematic ‘beneath’) require professional psychiatric assistance, by definition. If any job is to be taken analytically as the main job at hand for the interactants, then it is psychiatric treatment for psychiatric patients (ie, PSYCHIATRIC STAFF + PATIENTS). Cognitive-behavioural therapy for clients (ie, THERAPIST + CLIENTS) occupies a somewhat secondary location, in terms of ordinariness/formality/power and in terms of a ‘bottom line’, default position. Moreover, both omni-relevant devices enact both the privileging of professionals, one the one hand, and prejudice against voice hearers, on the other.

Professional privilege is defined here as the authority which is afforded to professionals and their accounts of voices and dealing with voices, over the voice hearers and their accounts. Given the job to be done, and with consent, then what could possibly be wrong with that? For one thing, I argue that privilege and prejudice are opposite sides of the same coin; you cannot have one without the other. Indeed, privilege and prejudice are seen here as an enactment of two omni-relevant devices (PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT). Such privilege and prejudice are not required to get the job done in the way that a lay customer commissions and receives a service of knowledge and skill from an expert mechanic who is fixing the customer’s car. In this example of a mechanical expert fixing things, a social power hierarchy in terms of each person’s presumed, underlying rationality is not
required for each party to perform their respective institutional identities. But, in the case of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT, the latter identity in each device must be constructed as being of lesser, *global*, rationality than the former in order for each to carry out their institutionally ‘therapeutic’ tasks of fixing/regulating the patient’s *mind*. Such ‘therapeutic’ practices, of course, are founded on mentalist and individualist assumptions.

**SECTION 2. OMNI-RELEVANT DEVICE EXAMPLES**

**Introduction**

Here is a summary of my earlier considerations of omni-relevant devices, before we move on to more hearing voices group data. Following on from the work of Sacks (1992, vol. 1: 312-319) and McHoul and Rapley (2002), I argue that, operating within these interactions, are two omni-relevant devices: PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT. These are the identities which have to do with the official business of the hearing voices group. Thus, these identity devices are omni-relevant. Besides the kind of demonstration of omni-relevance which I performed earlier, the operation of such a device can be shown through a demonstration of its pertinent absence (eg, through the use of cover identities) and when such ‘absences’ are resolved (ie, moves are made to restore the device). Confirmation comes - as in the conversation analytic next-turn proof procedure - when an ‘absence’ is followed by a reinstatement (McHoul & Rapley, 2002).
‘Absences’ by therapists: Not enough PSYCHIATRIC STAFF + PATIENT

In this subsection, we see examples of pertinent absences of the PSYCHIATRIC STAFF + PATIENT omni-relevant device; ‘absences’ initiated by a therapist. My use of the term ‘not enough’, in this context of omni-relevant devices, and my later use of other quasi-quantitative terms such as ‘too much’, refer to the way in which the omni-relevant devices operate within the bounds of what might be called a ‘homeostatic interactional system’, such that if a person departs ‘too far’, either way, from those normative bounds then identity moves are initiated to redress the balance. These, then, are participants’ concerns. The ‘absences’ are confirmed by the response which occurs. Thus, in the two extracts below, there are examples in which one or more of the therapists are rendered by the voice hearer who reinstates the omni-relevant device as being not sufficiently contributing to the upholding of the identities of PSYCHIATRIC STAFF + PATIENT.

1. “I prefer sensitividy”

The talk below comes just after Walter had been describing, in the hearing voices group, how some people search for an external panacea for their internal illness, whereas the solution needs to come from within:

Extract 7.3 (HVG, S3, MW, 19:54-20:43)

1 M: [...] this is (1.7) ((rustling paper))
2 S: °Yes Mike.°
3 M: a (0.2) handout::t (0.4)
4 W: °Oh o[kay.°]
5 M: about the: er:m: (0.1) stress:=
6 W: °Mm.°
7 M: ➔ vulnerability< it’s called the vulnerability
8 ➔ >lcoz that’s what the books call it but like I
9 ➔ say: I prefer sensitividy< (0.1) ·h hh (0.1) U:m=
10 S: =Yes. Than- than’you Mike.
11 (0.6)
12 M: ➔hand (0.2) and that includes: (1.1) u:m (0.4)
13 S: °(Er)°
In lines 7 to 9, Mike may be taken as downplaying and/or rewriting ‘psychosis’ by saying that he prefers to use the term “sensitividy” rather than “vulnerability”. This hearing is confirmed by Stuart’s response: “that does happen you know (. .) it’s true: You do become (. .) psychotic er-r when you hear voices Mike” (lines 15 to 20).

Mike’s turn (lines 7 to 9) is a therapist initiated ‘absence’ of the PSYCHIATRIC STAFF + PATIENT device. In lines 8 to 9, as a lower pitched, hastily delivered, under-the-breath comment, Mike negatively evaluates the official version and presents his own, personal version (“↑↓coz that’s what the books call it but like I say: I prefer sensitividy↑<”). Along with “sensitividy” being presented casually, this renders Mike
as more of a NOT-STAFF person and the voice hearers as more like NOT-MAD people than PATIENTS.

Stuart’s turn in lines 15 to 20 resolves the ‘absence’ by invoking the identity of PATIENT, through a clear assertion (from the position of his own first-hand personal experience, in contrast to Mike’s supposition) that “it’s true: You do become (. ) psychotic”. The assertion is further clarified and (personally located) with a tie-in to hearing voices (“when you hear voices Mike”).

Besides a hurried “=Yeah.” in line 17 (after Stuart’s initial assertion that “it’s true:” in lines 15 & 16), Mike clarifies his own position as being in connection to Walter and the earlier discussion of an assumption regarding internality-vs-externality. That is, in response to Stuart’s reinstatement of PSYCHIATRIC STAFF + PATIENT, Mike side-steps Stuart by talking of “models” including “assumptions” (lines 35 to 39) - as a THERAPIST - and by addressing Walter (lines 42 to 46). This talk of assumptions renders Walter as a CLIENT, as more rational than a PATIENT: someone who can understand such matters, at least when told of them. This is achieved through the therapy topic of ‘models’ and ‘assumptions’ and the action of highlighting Walter’s contribution to the discussion (lines 42 to 46). Ironically, though, at the same time, Mike’s action of ignoring Stuart constructs him as a PATIENT: a passive recipient of treatment, whose ‘ravings’ are to be ignored once a diagnosis has been made. Indeed, Walter’s take-up of Mike’s therapy message remains minimal (line 48), which, together with Stuart as a PATIENT, leaves the omni-relevant device of PSYCHIATRIC STAFF + PATIENT to the fore, despite the (partial) activation of THERAPIST + CLIENT.

(Note: This interaction continues as Extract 7.9, below, with the covering of both omni-relevant devices).
2. “the medical... establishment”

Prior to this example of omni-relevant device operation, following an account from Stuart about people who, apparently bizarrely, explain hearing voices as a religious experience and the need to go to church more, Mike has described how there are many different theories about voices. Here, Mike goes on to describe medical explanations:

Extract 7.4 (HVG, S3, MW, 59:51-60:50)

1. M: → I guess you(’d) fi:nd that (.) <the medical:1 (0.8)
2. → u:m: (1.0) u::m: (1.4) esta:blishment (0.2) ↑would
3. → te:nd to: (.) think of voices (.) as very much
4. → (1.1) ↓so:me:thing to do with (.) the ↓brai:n
5. W: >↓Mm[m.<]
7. W: =↓Mm[.hmm. ]
8. M: [i:n the] [brai[n. ]
9. S: [ Yea[R. ]
12. M: U:m:
13. S/W: °Mm.°
14. (1.0)
15. M: >it’s (0.1) th’t voices don’t come from the (.)
16. ↑outside<
17. W: °N:[o.°]
18. M: [ >i]ven though they< (.) sound like (.) they
19. M: d[o:]
20. W: [ Y][eah.]
21. T: [ M][mm. ]
23. (0.3)
24. W: ↓°Yeah.°
25. M: At ti:mes (.) ↓an’ sometimes they sound like
26. [they’re-°]
27. S: [ ↓Mmm. ]
28. W: ↓Y[eh.]
29. M: [ th]ey’re ↑in your head too (.) er fr’[m-]
30. S/W: [Mm.]
31. M: from (.) ↓what I’ve heard (0.2) ’hh u:m:
32. W: >There’s some[thing] ↑askew: (.) SOMETHING (.)
33. M: [( _)]
34. W: ↑AYWRY- AWRY IN THE BRAI:N (.) they think I- th-
35. that’s what they think don’t they? (.) ↑doctors
36. think tha::t.<<=
37. M: =⇒↑WHI:CH TAKES US BACK to that biol[ogical ]
38. M: [(()clap))]
39. M: stu:ff< (0.1) ↓protec[tive an]d
40. W: [↓Yeah. ]

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In the above extract, in lines 1 to 50, first Mike then Walter cover the PSYCHIATRIC STAFF + PATIENT device through their use of topic and action to invoke identities which, ambiguously, are part of either NOT-STAFF + NOT-MAD or the THERAPIST + CLIENT device. For example, Mike focuses on the topic of the medical model as the establishment (line 2), as something to be potentially undermined. And Walter follows suit with the same topic “that’s what they think don’t they (.). doctors think that:.t.” (lines 35 & 36), emphasizing the word “think” to produce an (intrapsychic) appearance versus reality contrast (Avery & Antaki, 1997). In the case of Mike, given that he is ostensibly a therapist instigating the cover, then the identity of PSYCHIATRIC STAFF (and hence the omni-relevant device) is also made pertinently absent, in action. Similarly, Walter’s duly following on from Mike produces Walter as either NOT-MAD or a CLIENT in action, thereby rendering the identity of PATIENT (and PSYCHIATRIC STAFF) as pertinently absent.

Furthermore, Mike’s painstakingly slow delivery of “the medical establishment” position (lines 1 to 2) marks this as a delicate matter
(Silverman, 1998); an orientation to the dominance of the biopsychiatric position. As something akin to an appearance versus reality device, Mike’s account may be taken also as an implicit negative evaluation of medicine in that it points to the relevancy of a non-medical position.

However, in lines 15 to 19, there is yet another appearance versus reality device from Mike: “>it’s (0.1) th’ voices don’t come from the (.) outside even though they sound like (.) they do:”. This represents a change of tack compared to presenting the medical position in which the problem is something biological and “in the brain” (line 8), but which was implicitly undermined by a non-dominant, ‘better’ position (lines 1 & 2). Rather, in lines 15 to 19, there is the promotion of a third position in which the voices just “sound like” they come from the outside (lines 18 to 19). This psychological account is ‘middle-of-the-road’ in that it is not incompatible with the medical position. I say ‘psychological’ because describing the voices as ‘sounding like’ they come from a position either outside (lines 18 to 19) or inside the head (lines 25 to 29) constructs them as being more subjective (ie, more open to interpretation and influence from others) than a biological object. So then, Mike moves from being a THERAPIST/NOT-STAFF person, who implies criticism of biopsychiatry, to being more of a THERAPIST, whose emphasis is more compatible with biopsychiatry. Line 31, “from (. ↓what I’ve heard (0.2) ·hh u:m:”, is interesting in that Mike adds it to the end of his ‘psychological’ position account, as a cover for the professional deliberations which have ensued.

Walter, from line 32, then dutifully steps in to pick up on Mike’s earlier description medical position, which brings Mike back to implicitly criticizing biopsychiatry “[TH]AT’S what (0.1) most doctors would say” (line 43). Although Mike moderates that with “°I think” (line 44), Walter continues with the implicit criticism, as a CLIENT/NOT-MAD person who is, nevertheless, in a position of personal experience
on such matters and can, thus, describe the medical professional position: “Yeah they do: (. ) ↓"yeah." (0.1) ↓PUT (IT)DOWN THE I:LLNESS. (. ) Yeah” (lines 45 to 49).

Taken as a whole, then, the interaction described thus far represents a pertinent absence of PSYCHIATRIC STAFF + PATIENT, by both Mike and Walter. Nevertheless, Mike’s ‘middle-of-the-road’ THERAPIST in lines 15 to 19 can also be seen as a reinstatement of a collection K device (ie, as being a move from NOT-Staff + NOT-MAD towards PSYCHIATRIC STAFF + PATIENT).

The ‘absence’ of PSYCHIATRIC STAFF + PATIENT is further evidenced by Stuart’s unfinished response, in lines 52 to 56: “>They’re not tryin’ a be funny Mi:ke. (0.1) Because-< i- if y- if it gets y-". Interestingly, Stuart begins to reinstate the identity of PATIENT, initially not by presenting himself as a PATIENT per se, but by arguing in support of the psychiatrists’ point of view. Notice that he addresses his appeal to Mike, a privileged professional, and not to Walter, a voice hearer and the most recent speaker. Walter, in turn, identifies himself and other voice hearers in terms of the grave effects of voices, something which is in keeping with Stuart’s restitution of the seriousness of voices but which, unlike Stuart, does not necessarily hold to the medical model: “↑IT’S NOT A ( . ) FUNNY THING but is it? it’s (s’ch) a- it’s a- (0.1) it’s a (0.1) ↑a SOUL destroying thing (. ) ↓isn’t it Tanya?” (lines 57 to 61). Notice that Walter does this by appealing to Tanya, as an EXPERT VOICE HEARER, rather than to Stuart or Mike (to whom Stuart appealed). I will discuss further the significance of this exclusion of the professionals, in connection to Extract 7.10.

‘Absences’ by therapists: Too much THERAPIST + CLIENT

This subsection includes two examples of therapist initiated pertinent absences of the PSYCHIATRIC STAFF + PATIENT omni-relevant device, as confirmed by voice
hearer responses to reinstate that device. The ‘absences’ featured in this subsection begin with a clear ‘over-invocation’ of THERAPIST + CLIENT.

1. “not running away from them”

Before this extract, Richard suggested that Walter should think more positively about the way he deals with voices. Walter then talked of living in fear of his voices getting very bad again and him being re-hospitalized. Walter went on to mention the need for him to ‘pick up his beliefs’ for how he can ‘go against’ and ‘stave off’ the voices. Mike then said that what they were doing in the group, talking about voices, is one way of voice hearers turning their attention towards the distressing voices. He continues:

Extract 7.5 (HVG, S4, MW, 78:03-79:31)

1. M: And:
2. S: °Yeh.°=
3. M: → =th’t it’s not i:t’s no:t (..) it’s not (0.2)
4. → ↑running awa:y from th’m↑ (..) or: <turning a
5. → bli:nd eye:↓↑ (0.3) it’s:> (..) ↑turning and
6. → facing them (0.1) t’some degree:↓↑
7. [...] ((22s omitted in which M describes his experience of the benefits of talking about problems))
8. W: Yeh it ↑does:. (..) ↓Yeh--
9. M: → =>Um:: (0.5) rather th’n: (1.4) u::m: (0.6)
10. → either pretending °it’s not dthere:: (0.2) or::°<=
11. W: =>SOMETIMES I cushion the blow (..) I soften the
12. blow from the impact (..) you know what I mean I’m so--
14. W: =I brace myself[f f’ the]se voices to come and
15. M: [°(_ _)° ]
16. W: when they come ·hhh well I g- (..) I just gotta:
17. (0.1) er-r (0.3) I just gotta (0.1) bounc: ba:ck
18. from it (..) I just gotta (..) er:
19. W: [go (it) ] a way- s’ch a way (..) that it
20. R?: [°(_ _)°] a way- s’ch a way (..) that it
21. W: doesn’t (0.1) take over my who:le ↑mi:nd (..) ↓you
22. (..) know what I mean? [^t]
24. W: When it star:ts (..) I’ve gotta (0.1) cushion the
25. impact I thin’ (..) cushion the
27. M: [ S’  ↑S::TRUGGLE ]
28. (0.2)
29. M: S[OUNDS LIKE A ↓STRUGGLE.]
30.
This extract opens with Mike being very much a THERAPIST (lines 1 to 6). The topic is therapy, invoking THERAPIST + CLIENT, rather than PSYCHIATRIC STAFF + PATIENT, in its ‘psychological’ approach of actively turning and facing the voices, rather than passively relying only on medication to alleviate the ‘symptom’. Also, the presentation is in line with the explicitly therapy topic. There is, for example, no informal, NOT-STAFF, presentation to soften the therapy message.

However, after Walter’s agreement in line 9 (“Yeh it does. (.) Yeh-=”), Mike’s delivery is rather more faltering, with longer pauses and the use of ‘um’: “>Um:: (0.5) rather th’n:: (1.4) u::m: (0.6) either pretending ”it’s not dthere:: (0.2) or::” (lines 10 & 11). This marks the delicate position of the crux of Mike’s therapy message: he is, as an expert THERAPIST, telling the voice hearers that it does not usually help to pretend that the distressing voices are not there.

We see that this is not sufficiently to do with PSYCHIATRIC STAFF + PATIENT for Walter, when Walter’s response serves to reinstate that omni-relevant device: “>SOMETIMES I cushion the blow (. ) I soften the blow from the impact (. ) you know what I mean I’m so-” (lines 12 to 14). This, and the rest of Walter’s response to Mike in lines 12 to 24 presents Walter as being responsible for his own personal change with regards to voices. That is, Walter’s point is presented with some of the active language of a therapy CLIENT: for example, “I brace myself f f’ these voices to come” (line 16). To that extent Walter seems to be invoking the identity of CLIENT or EXPERT VOICE.
HEARER. However, Walter’s opening phrase, as an action in counter-response to Mike’s THERAPIST push for active CLIENTS, concerns a rather passive ‘cushioning the blow’ (line 12) and he emphasizes the word “soften” (line 12). Indeed, Walter talks about ‘cushioning the impact’ of the voices (with emphasis on the word ‘cushion’), twice more, at the end of his response (lines 26 to 28). Even the active-sounding words “brace” (line 16) and “bounce back” (line 19), concern ‘weathering the storm’ of the distressing voices rather than actively engaging with them. Furthermore, there is Walter’s four or five times repetition of the phrase ‘I just gotta’ (lines 18 to 20, & 26), and the mentioning of the (ever-relevant, PATIENT) potential for the voices to “take over” his “whole mind” (line 23); which, though, he presents himself as trying to come to terms with the voices, neither renders him as a successful CLIENT nor an EXPERT VOICE HEARER. In sum, all of these features amount to Walter constructing himself as a desperate PATIENT: a reinstatement of the PSYCHIATRIC STAFF + PATIENT omni-relevant device.

In lines 29 to 42, though, Mike formulates Walter’s account, again as a THERAPIST. Initially, this is done by downgrading Walter’s account to a “↑S::TRUGGLE”, which invokes a more active identity for Walter than PATIENT and constructs the problem as something which may be overcome through such activity. After interrupting Walter to do this (line 29), Mike displays an orientation to his steam-rollering of Walter, with his hesitation and his approaching NOT-STAFF use of moderating features: “SOUNDS LIKE” (line 31), “I s’pose” (lines 37 to 39), “what we’re hoping” (line 39), “↓°I imagine what you’re hoping°” (lines 40 & 41), “↑some:how finding:ways” (line 41).

Let us take a look at a couple of these phrases in a little more detail. The “we’re”, in “what we’re hoping” (line 39), can be taken as distributing Mike’s responsibility for his own actions and gaining justification by linking himself to Richard and the work of
other THERAPISTS. This is done in connection to an intrapsychic term, “ho:pi:ng” (line 39), rendering the therapists as human in their subjectivity and as benevolent in their intent. The doubly mentalist “(0.2) >an’-an’-an’- (.) ↓°I ima:gine what you’re hoping°< (.)” (lines 40 to 41) is also interesting. First, it is presented as not overly presumptuous by being marked as an ‘under-the-breath’, other position, comment (with a faster delivery, pauses either side of the phrase, and a pitch reduction). Second, the phrase is presented as a supposition. Third, with “what you’re hoping” being in a similar format to “‘what we’re ho:pi:ng”, there is a joining of ‘we’, the THERAPISTS, and ‘you’, the CLIENT, in a common pursuit. Who, in their right mind, would not want to ‘lessen the struggle’ and get some ‘help’ to do it?

Walter, again, duly takes on some of the identity of CLIENT, with “↑°Yeh.° (0.1)
↑That’s basically it” (line 43). But, as he does so, he also displays his reservations concerning the move back away from PSYCHIATRIC STAFF + PATIENT.

2. “being able to share”

This extract also features a therapist initiated ‘absence’ of PSYCHIATRIC STAFF + PATIENT by invoking too much THERAPIST + CLIENT. Here, Mike picks up the talk after Stuart has been contrasting how much he now understands about hearing voices, as a result of coming to the group, compared to his prior ignorance:

Extract 7.6 (HVG, S5, MW, 49:14-50:33)
1 M: → [AND (. ) THERE MAY BE PEOPLE (. ) TH(H)ERE MAY BE]  
2 → ((smiley voice))  
3 S & B:[{{(laughter)} ]  
4 S: ↑°Yeah Mike°  
5 M: → (hh) (hh) there may [be people]  
6 B: [↑Hm↓m↓m]  
7 M: → that you come acro:ss: (0.1) th’t (. ) erm (1.1)  
8 → ((shuffling sounds)) who are at a stage with  
9 → hearing voices °themse:live[s°↑ that could benefi]t  
10 W: [↑°Yeah. Could be::°. ]  
11 M: → fr’m fr’m (0.1) being ab[le t]o share:
S: (0.2) [↑°Mm.°]
W: °Mm.°=
M: →=with you guy[s ]
S: [↑°M]
M: →a[:nd (.)] ya know (0.5) so u:m (0.3) hopefully
B: [°Yeah.° ]
M: →there’s a kno:ck o:n effect.
(0.2)
?: ↓°Mmm.°
(0.2)
M: ↓°Yeh?°
R: ↓°Mmm.°
W: >(A) LOT OF IT’S NOT REVEA:LED to us yet but would
y- would you say that at some extent< (.) until it
comes out in the o:pen <we can’t see these
things> you know what I mean. Things >th’t are-
er< blocked to me I’m sorta ·hh in a tunnel (.)
and there’s no er light at the end of it I think
 (. ) if I could see the light at the end of the
tunnel I’d know a bit ·hh more about the light
that surrounds e:verybody: (.) sorta [like thei]r
R: [ ((coughs))]
W: ·hh ha:lo: o[r (.) aur:as] or karmas things-
M: [ ((coughs))]
W: things like that which’re ·h very impor:tant when
we’re talking about sickness and (0.1)
R: ↑>WHEN I [WAS]<
W: [AND] WHAT COMES AFTER the other life
an’=
R: =°Ye[ah.°]
W: [you ] know [I I °(_ _ _)° ]
R: [I wonder if that] (0.1) fee:ling
R: of being in a tu:nne:l
(0.2)
W: Ye[ah.]
R: [is ] (0.5) <not knowing:> (0.4)
W: where it’s coming from
R: [where it’s where it’s gonna come fro:m]
W: [Yeh (0.1) being confu:sed abou]t
R: what has happened.=
W: =Yeah. Er con[fu:s]ion (.) yeah confusion
R: [So: ]
W: reigns supreme in m[y life. ]
R: [<When you] kno:w a >little
bit<
R: <m[ore: ] about it>=
W: [°Yeh° ]
W: =Yeah (.) I can leave that (.)
W: [alone and go °onto something (else)°]
R: [you’ll fee:l a bit more in cont]ro:l=
R: [=°I expe:ct.°]
W: =[ Bit more in] contro:l (.) yeah.
(0.2)
M: Mmm.
W: Ye[ah (.) ] °that’s what I find (. ) per:sonally
In lines 1 to 19, we see what may be a pertinent absence of the PSYCHIATRIC STAFF + PATIENT omni-relevant device, through Mike constructing the voice hearers as too much like CLIENTS. How is this done? First, following on from what Stuart was saying before the extract begins, Mike is constructing the patients as having learned something of benefit from the hearing voices group. Second, Mike is ‘predicting’ - or rather sanctioning and encouraging - that the patients “share:” (line 11) what they have learned. This constructs the voice hearers as being more like active CLIENTS than passive PATIENTS. The fact that it is Mike, a therapist, who is ‘predicting’ the sharing; the use of the quasi technical term “stage” (line 8); and the use of the phrase “kno:ck o:n effect” (line 19), to imply a passing of knowledge from THERAPIST to CLIENTS to others, all construct the patients as being more like CLIENTS than independent-from-professionals EXPERT VOICE HEARERS.

The ‘absence’ of PSYCHIATRIC STAFF + PATIENT is confirmed when Walter eventually moves towards something of a reinstatement of that device: “when we’re talking about sickness and (0.1) AND WHAT COMES AFTER the other life” (lines 39 to 42). This is an interesting mix which leaves open both being treated as a PATIENT and holding an afterlife view of hearing voices. Indeed, before Walter mentions “sickness” (line 39), there is considerable renegotiation of the nature of
voices/life/madness as being “NOT REVEA:LED to us yet”, like being in a tunnel with no light, but with the hope of moving towards an understanding of “the light that surrounds e:verybody:” (lines 26 to 36). This renders Walter as a NOT-MAD identity, with knowledge of the afterlife; an afterlife which is/would be common to us all (“us”, line 26; “we”, line 28; “you”, line 29). Here, in understanding that the afterlife is involved but that we can know very little of such matters until it is revealed, Walter claims some authority: “things like that which’re ·h very impor:tant” (line 38). His entire turn, though, in response to Mike, is initially phrased as a question (“would you say that at some extent”, line 27), which continues to make Mike’s identity as a professional (of some kind) relevant. Furthermore, there is the PATIENT identity coming up the rear, when all else fails, as it were (“when we’re talking about sickness”, lines 38 to 39), managing to co-mingle with Walter’s helplessly ‘knowing-about-not-knowing’ version of the NOT-MAD identity.

In turn, Richard and then Mike both work to reinstate THERAPIST + CLIENT by softening Walter’s position regarding not knowing; to construct him as more of a CLIENT and less of the rest (lines 45 to 82). First, Richard provides a therapy formulation of Walter’s account. Walter had it, thus: “I’m sorta ·hh in a tunnel (.) and there’s no er light at the end of it” (lines 30 to 31). In contrast, Richard’s formulation is: “I wonder if that (0.1) fee:ling of being in a tunne:l (0.2) is (0.5) <not knowing:>” (lines 45 to 49). Richard’s version is more about feeling and (not) knowing - the provinces of cognitive therapy - than actually being. With an appearance versus reality device, then, Richard is ‘suggesting’ that, for Walter, there may have been an appearance of actually being in a tunnel, but that it was/may have been really only to do with feelings and thoughts. Such a ‘realization’ would pave the way for (further) ‘therapeutic change’: “<When you kno:w a> >little bit< <more: about it> you’ll fee:l a bit more in contro:ll <I expe:ct.” (lines 57 to 64). Thus, ‘therapeutic change’ is talked
into being. There is a brief hiatus of this, when Walter picks up on Richard’s use of the term ‘confused’ and runs with it a little ‘too far’, rendering himself as a confused PATIENT: “Yeah. Er confu:sion(.) yeah confusion reigns supreme in my life” (lines 54 & 56). However, Richard continues to construct Walter as a CLIENT: “So: <When you know a> >little bit< <more: about it> you’ll fee:l a bit more in contro:l °I expe:ct.”” (lines 55 to 64). Otherwise, Walter gives appropriate acknowledgement of the therapy message with ‘yeahs’ (eg, lines 48 & 60) and affiliatory repetition (“Bit more in contro:l (.) yeah”, line 65). For Mike’s part, he then drives the ‘therapeutic change’ home, under the cover of humour, by drawing a contrastive link between the therapy message and Walter’s account of being in a tunnel with no light: “’S there a little(.) chink of light?” (line 71). Under the cover of what may be taken as ‘knowing laughter’, Walter responds with mostly compliance: “’I(H)M HEADING TOWAR:DS THAT (_ _ _ _ _) ((smiley voice))” (line 76). Mike then confirms his dominant, ‘in the know’ position, under the cover of lampooning himself and especially Walter: “=↑¼KN(H)E[W: THERE WOULD BE ((smiley voice)) SOMETHING SO:MEWHERE.”” (lines 79 to 82).

Overall, then, besides Walter’s earlier NOT-MAD part, this extract includes the same general format which we saw in Extract 7.5: THERAPIST + CLIENT, PSYCHIATRIC STAFF + PATIENT, and then THERAPIST + CLIENT. Ironically, though, in accordance with Harper’s ‘rationality trap’, but in terms of professional action, we may also see that the version of therapist domination which comes when they enforce THERAPIST + CLIENT over voice hearer initiated instances of PSYCHIATRIC STAFF + PATIENT, serves only to make the ‘default’ position of PSYCHIATRIC STAFF + PATIENT all the more relevant.
‘Absences’ by voice hearers

Following my explication of therapist initiated ‘absences’ of the PSYCHIATRIC STAFF + PATIENT omni-relevant device, this subsection features examples of ‘absences’ which are initiated by voice hearers of THERAPIST + CLIENT and/or PSYCHIATRIC STAFF + PATIENT.

1. “things get better from now on”

In Extract 7.7, below, there is a pertinent absence of the THERAPIST + CLIENT omni-relevant device which is initiated by a voice hearer’s invocation of NOT-MAD. This, then, is an example of a voice hearer being rendered as ‘not enough’ THERAPIST + CLIENT.

Immediately before the extract, Mike was describing how it seems that Stuart is able to think back on particular distressing voices experiences and even ‘have a laugh’ about some of them. In an utterly mundane account, Stuart then gave an example of being able to do just that. Mike suggested that if the voices become distressing then Stuart will be more likely to be able to deal with them positively. Stuart then responded by thanking Mike because no-one ever says that. He finishes on what Mike takes to be a particularly positive note:

Extract 7.7 (HVG, S7, MW, 24:10-25:00)

1   S:  → I thi::nk things get better from now on ↑wouldn’t
2       → they?
3   (1.4)
4   S:  Yeah.
5   M:  ((cough))
6   (0.2)
7   M:  I- I- (.) I think erm (0.5) · hhh I think it’s
8   ↓always gonna be:: (0.4) u:m (3.7) to so:me
degree: (.) there’s always g[onna be ] an aspect
9   [ ↓”Mm.” ]
10  S:  [ 
11  M:  ’f (.) ’f there being a challenge:
12   (0.4)
13  S:  Yeh=
In this extract, Stuart is rendered as having adopted a NOT-MAD identity; a pertinent absence of the official business of ‘therapy’ progress talk. This is evidenced by Mike’s cough (line 5) and his reinstatement of the THERAPIST + CLIENT device (line 7 onwards). After little uptake, Mike softens his THERAPIST position with “I- I: would imagine.” (line 14), a concession to those, such as Stuart, who have first-hand experience of voices. Mike receives more uptake, in line 15, and then goes on to elaborate his THERAPIST message, from line 16.
Stuart, however, interjects (“But WE ALL (HAVE A/CAN) LAU:GH”, line 38), which Mike uses to moderate his THERAPIST message to: “j’st relAX a bit more and erm “have a lau:gh even mo:re.” (lines 40 to 42; incorporating Stuart’s ordinary term ‘have a laugh’). But Mike goes on to summarize the way it is (“alWAYS”, notwithstanding the “I guess:”), in a way which is fully compatible with THERAPIST + CLIENT and even PSYCHIATRIC STAFF + PATIENT (in its implicit and ambiguous reference to voices/madness as “it”): “°I guess it’s (0.2) there’s° alWAYS the possibility of it ↓knocking back on that door°” (lines 47 to 51). This even includes a not usually disputed, end-of-discussion, idiom: “knocking back on that door” (see Potter, 1996: 168). Thus, the professional position establishes its dominance.

2. “we learn from every... pain”

The extract below includes two ‘absences’ by patients, first of one omni-relevant device and then the other. Before this talk, Stuart and Walter had been describing how confusing it was during and after their ‘first episode’ of hearing voices, and how much they needed hospital staff to explain what they were experiencing. Mike then drew a contrast between that first time and how much the group members now know about voices and how much they can help themselves. Here, Walter agrees:

Extract 7.8 (HVG, S3, MW, 50:07-50:41)

```
1  W:  We LEAR:N from every (. ) thi:ng we do wrong don’t
2  we=
3  S: =Yeah
4  S: → [we learn [from our] experiences ↓°Mike.°]
5  W: [from ever[y- (. ) ] EVERY PAI]:N
6  T: [ Mmm. ]
7  W: AND EVERY:=
8  M: =GOOD and ba[:d. ]
9  W: [every]y- (0.2) ·hh
10 W: → EVERY: ERM: (0.2) every sickness we have >e- every
11 → par:t of it< there’s (it) a:ll goe:s down
12 → somewhere: doesn’t it ·h
13 M: [Righ[t. ]]
14 T: [↓°Mmm.°]
```
Lines 3 and 4 include a possible pertinent absence by Stuart of the PSYCHIATRIC STAFF + PATIENT device - the talk of learning from mistakes and responsibility for mistakes renders him too much like a CLIENT and not enough like a PATIENT. Although Walter himself begins the extract with “We LEAR:N from every (. ) thi:ng we do wrong don’t we=” (line 1), it is Stuart who, after initial agreement, ‘oversteps the mark’ by going on to directly address Mike, as opposed to Walter, with a more upbeat kind of learning than Walter: “=Yeah we learn [from our] experiences ↓°Mike." (lines 3 & 4). Stuart’s learning account is not anchored in mistakes like Walter’s (W: “every (. ) thi:ng we do wrong”, line 1). Walter resolves the ‘absence’ by invoking PATIENT in lines 5 to 10. In the middle of this, Mike moves to turn the account back, away from the suffering of a PATIENT, and towards a more ‘progressive’ CLIENT, who experiences and learns from “GOOD and ba:d.” (line 8).

Walter’s account, however, with its developing talk of the universe in lines 10 to 18 becomes more of a renegotiation of the nature of hearing voices/madness; it becomes
more about being NOT-MAD than about being a PATIENT. That this is itself a pertinent absence of THERAPIST + CLIENT (and to some extent of PSYCHIATRIC STAFF + PATIENT) is evidenced by Mike’s invocation of THERAPIST + CLIENT in line 19, which moves the account back along to the institutional side of things: “I-IT DOES IF YOU’RE paying attention”. Walter’s response, in line 21 to 23, in its adoption of Mike’s words, “paying” and “attention”, acts as an acceptance of Mike’s reinstatement of the omni-relevant device. However, it also includes Walter’s own word, “knowledge”, from his NOT-MAD bid. In lines 24 to 35, Mike then moderates his account, though he still pushes it home, with a largely NOT-STAFF cover identity presentation of a THERAPIST + CLIENT topic (“an’ I guess you can actually”, “without paying attention really”, “ya probably l- gonna”, “j’st”, “a- (.) bit of a [scientist in yoself ya know?”, “That’s cool.”, “I like the sound o’ that”). Rather than the harsher ‘paying attention’, Mike builds this latter account around the notion of “noticing” (line 29), something which Walter duly adopts “Yeah (.) just NOTICING what it i:s (.) yeah.” (line 30). With a sprinkle of ‘yeahs’ from the patients, all is ‘nicely’ institutional once more.

3. “I can save the health department” + “I’ll make a profit”

The following interaction occurs after Mike was saying how he prefers the term ‘sensitivity’ to ‘vulnerability’, in connection to a group handout. Stuart responded by stating that hearing voices really does involve psychosis, and then Mike directed his talk back to Walter. Mike now continues with leading the proceedings concerning the handout:

(Note: This is a continuation of Extract 7.3, above).

Extract 7.9 (HVG, S3, MW, 20:43-21:19)

1 M:  ↑There’s p[e:n:si:] ((different voice))
What have we here then? Lines 3 to 27 are taken up with a joint ‘absence’ by both a patient and a therapist of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT. This is done under the cover of humour and the cover identities NOT-MAD and NOT-STAFF. Hearably, the joke begins with Walter in line 3, producing a demonstration of institutional understanding, sarcasm, and rebellion: he’ll give the pen back if the institution cares so much about just “three metres of writing” (line 10). The emphases on “SA:VE” (line 4), “HEALTH” (line 6), and “three” (line 10), along with the ‘smiley voice’ delivery and the laughter (line 8), highlight the ludicrous and ironic aspects of an employee of the health department being so penny-pinching about such
trivial matters, just like “the rest of us?” (lines 13 & 15). Thus, Walter parodies being sucked dry as a PATIENT, by a heartless, dollar-as-the-bottom-line, upholder of the institution, whilst Walter constructs himself as being very, cleverly, NOT-MAD. Mike, in a show of affiliation, has already joined the ranks to ironically ‘play’ with his PSYCHIATRIC STAFF identity, as cashing in whenever he can, with “Oh: I’ll ’ave ’em back off you.” (line 9), which is marked as ironic by the hearably ‘smiley voice’ and the informal truncations and turn-of-phrase. Mike also emphasizes the irony with the words “profit” and “SELL”, in lines 16 and 22. This is what happens, when all the ‘niceties’ are said and done, “at the end of the (day)” (lines 16 & 18) (a phrase which, nevertheless, is hearably marked by the change as an ‘under-the-breath’ comment which subverts authority).

It is not so long, though, before the joking mutually subsides: Stuart adopts a subordinate position to Mike “That’s right Mike (0.1) isn’t it” (lines 24 & 25), and the laughter reduces (lines 26 & 27). Mike then holds the floor with “Er:rn” (line 28), and, after suitable pauses (lines 30 & 31) and marking the upcoming change as not so much a change of topic (with “OKAY::so:”, line 31) (see Antaki & Rapley, 1996: 304, regarding ‘so’), he reinstates one of the omni-relevant devices. Thus, Mike turns away from the parody of the health department as a heartless business and returning to his THERAPIST + CLIENT business of ‘therapeutic’ chart sales (lines 31 to 35).

In connection to the above extract, it is worth noting that patient initiated ‘absences’ of the omni-relevant devices appear to be less common in the data corpus, compared to therapist initiated ‘absences’ (EXPERT VOICE HEARERS apart, which are actual departures, in any case). And, those patient initiated pertinent absences which involve digs at the identities of PATIENT and/or CLIENT which do occur, tend to come as either humorous comments (with laughter), as above, or ‘under-the-breath’ comments (if without laughter). Such digs stand in contrast to the rather freer scope of therapists’
actions (for example, Mike’s open digs at the ‘establishment’ in Extract 7.4, above). Patient initiated ‘absences’ which more directly involve and challenge the identities of PSYCHIATRIC STAFF or THERAPIST, are very rare in the corpus, and many of these incorporate humour. That is, therapists have the social freedom and power to initiate ‘absences’ from the omni-relevant devices without humour. Patients, however, do not ‘get away with it’ without the use of humour unless they mark their subversion as an ‘under-the-breath’ comment, or are ‘getting away with it’ under the guise of NOT-MAD whilst also being given professional approval/patronization in the form of not-so-positive discrimination (as in Chapter 6, with Stuart’s long stretch of doing ‘being ordinary’). We consider the subject of not-so-positive discrimination in the following section.

A voice hearer initiated actual breach

We finally come to a more detailed consideration of a complete departure from the omni-relevant device of THERAPIST + CLIENT through the invocation of EXPERT VOICE HEARER (and NON-VOICE HEARER). Indeed, in its departure from orthodox psychiatric interaction this is a breach-proper of both THERAPIST + CLIENT and PSYCHIATRIC STAFF + PATIENT.

1. “There’s nothing good about voices”

The talk below comes as Mike has been introducing a written chart for rating the severity, or otherwise, of voices. Towards the middle of this extract, there is an example of a voice hearer, Walter, constructing himself as an EXPERT VOICE HEARER. In response, Walter is then constructed by Mike as ‘not enough’ THERAPIST + CLIENT.


1 M: [...] in terms of DISTRESS (. ) so [TEN  ] is the
The extract begins, in lines 1 to 9, with what appears to be a pertinent absence by Mike of the PSYCHIATRIC STAFF + PATIENT identities. Once again, this is an account which can be seen as ‘too much’ THERAPIST + CLIENT, given that that rating distress, with the goal of lowering it, is just the sort of activity in which a THERAPIST seeks to engage their CLIENT. The raising of the possibility, led by Mike, that hearing voices may involve ‘zero distress’ may be taken as minimizing the distress that voice hearers experience.
Walter’s response (“=THERE’S NOTHING GOOD ABOUT VOICES (.) I THINK THE ONLY GOOD VOICE IS A DEAD VOICE (_) (isn’t) (it) Stuart”, lines 16 to 21), though, is not a reinstatement of PSYCHIATRIC STAFF + PATIENT. It is not the kind of confirmation of the ‘absence’ of that omni-relevant device akin to those which I have shown in analyses so far. Instead, Walter’s response is a clear instance of a departure from THERAPIST + CLIENT through the invocation of EXPERT VOICE HEARER (and NON-VOICE HEARER). Here, the identity of EXPERT VOICE HEARER is invoked by Walter, concerning himself and concerning Stuart. This is done by the topic being counter to the usual ‘therapeutic’ delicacy (Silverman, 1998) for voice hearing matters (as evidenced by the Mike and Richard throughout the data corpus); by the presentation as a protracted raised voice (ie, not the deference of a PATIENT); by the action of being a counter to Mike’s THERAPIST + CLIENT account of ‘zero distress’ voices being possible (lines 1 to 9); and through the action of Walter’s eventual addressing of Stuart (lines 19 & 21). This addressing of Stuart is interactionally important, since, on this occasion, it constructs Stuart as another EXPERT VOICE HEARER, rendering Mike as an inexpert NON-VOICE HEARER and effectively excluding him from the discussion which he had been controlling as a THERAPIST from lines 1 to 9. Thus, the addressing of Stuart also acts as a counter to Mike’s THERAPIST + CLIENT. Lines 16 to 21 clearly have neither the subordinacy nor the deference towards professionals of a PATIENT or a CLIENT. Nor does this categorize Walter as NOT-MAD. Rather, this is best described as a brief, unsupported, suspension of controlling omni-relevant devices. Indeed, as an actual absence from THERAPIST + CLIENT and PSYCHIATRIC STAFF + PATIENT, this is a breach-proper of those omni-relevant devices, rather than a pertinent absence. Such a breach-proper only confirms the operation of those omni-relevant devices because of what the breach is not; as a contrast with the devices which are not currently active. Such a departure is not the
kind of ‘absence’ which is brought about by, say, an invocation of cover identities or another omni-relevant devices which may serve as a cover (such as THERAPIST + CLIENT, in the case of PSYCHIATRIC STAFF + PATIENT being ‘absent’), where the cover still renders the device being covered as relevant (ie, pertinently absent) throughout the ‘absence’.

When Walter gets little response from Stuart, though (lines 22 & 23), he renders his account as more of a personal experience: “That’s what I find” (line 24). Given the personal aspects of most reported hearing voices experiences (in modern times at least) one would think that this would be a ‘safe’ holding position, at least for a while.

Walter’s account, however, is taken as a breach of THERAPIST + CLIENT, and Mike begins to reinstate those identities; the identities invoked earlier by Mike’s account of rating distress. The first hint of Mike orientating towards Walter’s turn as being a breach is his coughing in line 20. Then, we have the dispreference markers (‘↑We:ll (0.2) I guess’, line 28), followed by the hastiness of the message delivery in lines 28 to 31. The message, in lines 28 to 30, also lays claim to expert professional knowledge about the experiences of some voice hearers: “<so:me people ha:ve voices that they: (0.1) they get o:n with and they’re not a negative ↓thi:ng::>”. But, rather than this being an invocation by Mike of EXPERT VOICE HEARER and NON-VOICE HEARER - with the voice hearers as experts on hearing voices - Mike is constructing himself as something of an expert on ‘getting on’ with voices, and thereby upholding THERAPIST + CLIENT, where voice hearers remain subordinate.

Walter’s response, though, is far from full agreement (“↓No:.”, line 32), so that Mike then gives some concession to Walter: “=↑But that all depends o:n (. ) ↑o:n: ( . ) on what you know- on what you’re experiences-” (lines 33 to 35). Walter’s final response is to accept this negotiated CLIENT position, with a latched repetition of Mike’s turn (lines 36 to 37).
Section summary

We have considered various aspects of omni-relevant devices, in theory and in practice. I have shown how two omni-relevant devices, PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT, operate in the hearing voice group data as part of an *a priori* ever-present social interactional management of interlocutors in terms of sanity status and related matters. It is important to note that, overall, the actions of the therapists were largely in accordance with officially sanctioned, pre-set, therapy procedures for bringing about cognitive changes in clients, as we saw described in the CBT manuals which were analyzed in Part 1 of this dissertation.

In this section, I have argued that PSYCHIATRIC STAFF + PATIENT - in which the sanity of voice hearer’s is most in question - is more omni-relevant in the data than THERAPIST + CLIENT. My investigations turned on the analysis of omni-relevant device pertinent absences and the subsequent reinstatement of the device which was made ‘absent’. In the course of analyses, we saw examples of a NOT-MAD identity which involved doing ‘being ordinary’. However, it turned out that EXPERT VOICE HEARER was the only identity which fully - though all too briefly - departed from the omni-relevant devices and their sanist social control. Neither other voice hearers (who typically responded as PATIENTS) nor the therapists (who typically responded as THERAPISTS or PSYCHIATRIC STAFF) tended to support instances of the EXPERT VOICE HEARER identity. That is, PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT remained dominant overall: professionals treating patients, along sanist lines.
SECTION 3. NOT-SO-POSITIVE THERAPIST ACTIONS

Introduction

Within the data corpus, even in the few isolated instances where therapists directly discuss issues of stigma, believability, and the ‘reality’ of voices, there is much therapist tiptoeing around the issue of madness. What does this achieve? Through this kind of talk, therapists can display a general ‘political correctness’ and sensitivity to the patients’ personal issues. That is, the therapists manage to not be ‘too challenging’ for the patients’ ‘fragile minds’, and, in so doing, they produce their patients as requiring such kid-glove handling. In Chapter 2, we saw how normality-abnormality continua served to normalize the ‘symptoms’ of ‘psychosis’, as described in theory. Indeed, therapists can make a special point of deliberately constructing what are generally taken to be ‘abnormal’, madness-related phenomena as being ‘normal’. Normalization is assumed, indeed explicitly prescribed by some exponents of CBT, as a therapeutic practice, to assist in the reduction of patient distress and stigma:

The assumption of a continuity between normality and psychosis has important clinical implications. It opens the way for a group of therapeutic techniques that focus on reducing the stigma and anxiety often associated with the experience of psychotic symptoms and with diagnostic labelling. Kingdon and Turkington (1991; 1994) have described such approaches as normalising strategies, which involve explaining and demystifying the psychotic experience. They may involve suggesting to patients that their experiences are not strange and un-understandable, but are common to many people, and even found amongst people who are relatively normal and healthy. Normalising strategies can instil hope and decrease the stigma and anxiety which may be associated with the experience of psychotic symptoms. The reassuring benefits of these relatively subtle clinical interventions can be striking.
We may note that there are two categories of normalizing practices in connection to this extract. There is implicit normalization, as a result of theorizing about the ‘normality’ of the experiences in question. This includes the describing and positive evaluation of an “assumption of a continuity between normality and psychosis [which] has important clinical implications”. There is also explicit normalization, through explicitly putting the normalizing theory into practice. For example, performing “normalising strategies”, in actual practice, which are explicit amongst professionals at least. As presented by Fowler et al., above, ‘normalization’ of either kind is nothing other than potentially or actually a ‘good thing’. Indeed, ‘normalization’ is the central theme of Kingdon and Turkington’s approach to ‘schizophrenia’.

So why do I claim that, on some occasions, these kinds of practices amount to prejudice-in-action? Why do I consider normalization practices to be, on occasions, ‘not-so-positive discrimination’ and/or ‘not-so-normal-ization’? First, I argue that these professional actions are performed on the basis of the patients’ presumed questionable sanity status. Second, I argue that, in connection to my first point, these professional actions can be shown to contribute to sanism-in-action, and that, when they do, then they are surely confirmed to be not-so-therapeutic actions. 8

How might positive discrimination, normalization, and their not-so- versions fit in with therapy talk more generally? Such practices may be part of the way in which therapists manage the interaction so that the issues discussed in connection to madness and hearing voices are only those that lie within the delineated discourses for which the therapists have demonstrated their interest. Therapist steering of group proceedings towards the domination of certain renderings of certain issues may be also seen as a

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8 I am not arguing that such actions are confined to therapists. Rather, I have chosen to limit my investigation to such actions as performed by therapists.
form of ontological gerrymandering: “the way particular realms of entities or terrains of argument are made relevant and ignored” (Potter, 1996: 176). The steering of talk towards a patient’s successful application of coping strategies (but only usually talk about in the very recent past, the present, and the future) can be considered in such light. Rhetorically self-sufficient arguments to this effect might be something like ‘You cannot change the past’, ‘You won’t get far with emotional and irrational talk’, and ‘You won’t get anywhere with mad talk, besides getting to the attention of therapists’ (see Wetherell & Potter, 1992: 177). These kinds of clinching arguments are, by definition, constructed as being highly resistant to disputation.

Therapeutic coping discourses, by therapists and/or patients, tend to strip away potentially important contextual information and talk about the personal meaning of hearing voices experiences. Such moving away from topics which are not to do with the prescribed and privileged kind of rational coping - quite literally, the sanitization, therapist-and-clientization, and desocialization of talk - is achieved, in part, through the therapist-led promotion of coping strategy accounts and through the tiptoeing of therapists around the subject of madness. Ironically, sanism is thereby upheld: the THERAPIST knows best, and PSYCHIATRIC STAFF + PATIENT is never far away.

_Not-so-normal-ization_

Some examples of a therapist’s receipts (actions or in-actions) of a patient’s NOT-MAD identity invocations may be considered as ‘normalization’ (ie, problematic normalization: not-so-normal-ization). The most explicit form of normalization, problematic or otherwise, is a procedure in which a THERAPIST makes a special point of formulating hearing voices experiences - which would otherwise (by default) be taken as evidence of psychosis - as being ‘normal’ (Kingdon & Turkington, 1994). Other examples of ‘normalization’ might also include instances of when a therapist
invokes the identity of NOT-STAFF, towards achieving an effect which is something like, ‘We’re all in this together’.

One problem with such ‘normalization’ by therapists is that it may undermine a patient’s construction of the experiences as being extreme, for example, as being very distressing and requiring help. This might also undermine a voice hearer’s description of voices as, say, telepathy. Furthermore, making a special point of someone’s ‘normality’ may serve merely to highlight the fact that their ‘normality’ is constructed as questionable. Thus, we may see that this family of practices, may, on occasions, be akin to Harper’s ‘rationality trap’, but in terms of therapist actions to do with ‘normality’ more generally.

It is worth noting, here, that there are many other alternative ways (ie, less direct, more subtle, less sanist) ways in which therapists and patients might render hearing voices experiences as being ‘normal’, including joking about the experiences, delivering them in an ordinary way, and/or not exhibiting prejudice about a person’s rationality. Dialogue (between co-equals) - or even an asymmetry in the other direction - would surely have a profound and pervasive impact on developing relationships; demonstrating that the therapists ‘practice what they preach’.

Not-so-positive discrimination

Positive discrimination is defined in the Concise Oxford Dictionary as “the practice of making distinctions in favour of groups considered to be underprivileged”. The generally purported aim of such practices is to benefit the underprivileged group. However, recall the example of what I took to be ‘positive’ discrimination regarding Stuart’s long stretch of doing ‘being ordinary’ in Chapter 6? I raised questions about whether there were negative consequences from such therapist actions. Now we can pick up on where we left off, but with different data.
I suggest that the prescribed, professional-led procedure of a therapist giving concessions to patients which would not be given under ‘normal’ circumstances to ‘normal’ people may all too easily become what I call ‘not-so-positive discrimination’. As with ‘normalization’, I use the ‘not-so-’ prefix to distinguish this process from any instances of positive discrimination in the world which should be taken, overall and on closer inspection, to actually have a positive effect. I intend to show that occasions of what might be described as not-so-positive discrimination - by the PSYCHIATRIC STAFF/THERAPISTS, towards the PATIENTS - add to oppression of the patients. These therapist actions maintain division on the basis of ‘mental health’ criteria and professional position; they are not ‘affirmative actions’ which, upon closer examination, work towards creating a (micro and macro social) ‘level playing field’ between people.

**A common drawback**

To summarize, both of these professional-led procedures,\(^9\) normalization and positive discrimination, share a common drawback in that they may double back on themselves to bite their own tails and strengthen the identities of PSYCHIATRIC STAFF + PATIENT and/or THERAPIST + CLIENT. Hence, my use of the ‘not-so-’ prefix, when this is demonstrably the case. That is, these procedures can add to the privileging of professionals and contribute to negative discrimination against voice hearers. In the not-so- instances described below, these procedures serve as token gestures; as window dressing to the PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT jobs

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\(^9\) I use the term ‘professional-led’ because either a therapist performs the procedure or, if it is a patient who does so, then there is evidence in the data that the patient has to some extent based their talk on therapeutic discourse (ie, it locally appears to be principally sourced from the talk of therapy professionals).
to be done; as sweeteners for the bitter prejudicial pill which endures, despite, or because of, the niceties of therapy.

**Examples of not-so-positive therapist actions**

'Normalization': “*we're all... the best experts on our own lives*”

We begin with an example of not-so-normal-ization. Richard has been laying the groundwork for the group by saying that there may be strategies for dealing with voices which the voice hearers know but he does not, or which some voice hearers know but others do not. Mike then summarizes that account, as follows:

Extract 7.11A (HVG, S1, MW, 20:52-21:42 (A & B))

1 M:  And I- I: think we’re \textit{↑}a:ll (0.7) \textit{↓}erm (1.5) in
2   the lo:ng run gonna be the (.) the \textit{↑}best experts
3   \textit{↓}on our own\textdegree{} \{li:v\}es.
4 W: \textit{↑}Yeh.\textdegree{}
5 W:  Yeah.=
6 M:  \text{=Y}a know
7 M: \textit{↑That’s TRUE:. Yeh. Yer ri:ght y[a hit]}
8 W: \text{[Mmm. ]}
9 T: \text{[(Yeah) ] ((high pitched, breathy))}
10 M: \text{[(   _   _   _   _  ) \textdegree{}}
11 W: \text{=[the nail on the head Mike. \textdegree{}Yeah.\textdegree{} (. ) \textit{↑}YEAH WE}
12   KNO:W MORE SO THAN ANYBODY ELSE \textgreater{}would wouldn’t
13 they?< Got \text{[(hit) o]ver the head by th’m more than}
14 T: \text{[(Yeah) ] ( \{high pitched, breathy\})}
15 W: \text{anybody e:lse \textit{↓}wouldn’t [ we Tan]ya? Ya kno:w.\textdegree{}}
16 T: \text{[↓Yeh::h. ] ( \{breathy\})}
17 \text{(0.2)}

In line 1, Mike’s self-repair of ‘I’ (which places more emphasis on ‘I’ to claim/admit greater ownership of the account), plus his long pauses, both mark the delicacy of what he is saying about the patients being just as knowledgeable about their lives (and thereby as rational). Indeed, the phrase “in the lon:g run” (line 2) implies that Mike is privy to an (expert) understanding of how ‘things’ will ‘work out’. The account, then, despite the ‘window dressing’, seems to be Mike’s expert opinion, as a THERAPIST.
The account is also presented as concerning “our own lives” (line 3) and not voices in particular. Thus, Mike does not render himself here as an inexpert NON-VOICE HEARER and the patients are not constructed as EXPERT VOICE HEARERS. Since the ‘we’ to which Mike refers can also include other ordinary folk, and since it is addressed to the patients in the broad context of talking about voices, this is an example of ‘normalization’, of the patients and the therapists. However, the expert status for the ‘we’ (including the patients) is described as being achieved “in the long run” (line 2). That is, according to Mike, in connection to the principal recipients of this message and to the overall context, perhaps this achievement can be attained by the patients through therapist help, eventually. In lines 1 to 3, Mike claims ownership of expert knowledge concerning the voice hearers’ own lives, though he does so delicately, and he asserts that they are the “best experts” on their own lives. Thus, Mike’s delicate orientation to the questionable rationality of patients turns out increasingly to be little more than ‘normalization’ as a token gesture. This, then, appears to be further evidence of (here, implicit) privilege for professionals and prejudice against the patients and their personal agency. But is this confirmed in subsequent turns?

Walter’s response, in lines 4 to 15, appears to be an emphatic acceptance of the ‘normalization’ components of Mike’s account. This is so, especially in lines 8 and 11 “That’s TRUE: Yeh. Yer right ya hit the nail on the head Mike. “Yeah.””. Walter’s ongoing uptake from the end of line 11, however, bears nothing of Mike’s tentative delivery: “YEAH WE KNOW MORE SO THAN ANYBODY ELSE >would wouldn’t they?< Got (hit) over the head by th’m more than anybody else “wouldn’t we Tanya?< Ya know.”. His loud delivery, the topic of him being a voice hearer talking about hearing voices (in implicit contrast to Mike’s account), and his enrolment of Tanya, another voice hearer all mark this as a show of EXPERT VOICE HEARER solidarity.
This leaves Mike somewhat isolated from the ‘we’ and he then takes steps to deflate Walter, as it were:

Extract 7.11B (HVG, S1, MW, 20:52-21:42 (A & B))

18 M: SO:
19 W: Hm. =
20 M: Having er: additional STAFF an’ hospital sta:ff
21 an’ ↓family and friends ↑as extra support:
22 (0.4) and (0.3) providing information that c’n
23 ↑help. (0.2) ↓That c’n a:ll add to your "knowledge
24 a:nd um and control over these issues yea[h.]
25 W: [Mm.]
26 (0.5)
28 (0.4)
29 W: Mm.
30 M: ·hhh ((hand slap)) ↑COOL! WELL (.) "how about we
31 wack on the video: ↓for
32 M: [erm (.) ↑tew’n’y minutes or so?]
33 S: [ ↑Yeh. ( ↓_ ↑Eh? )° ]
34 S: ↓Yeh.°
35 M: [↑t] Yeah?(0.3) ·hhhhh
36 M: [(clapping sound)) (°(_ _ ↑_)°]
37 S: [>An’ (I:) can ta:lk about it ] afterwards
38 ↓can’t we Mike?° ((croaky))
40 S: [Yeh]
41 M: ·hh
42 S: ↑°Yeh°.
43 M: So I’ll nee:d to keep an eye on the _clo:ck [...]

Lines 18 to 24, in Extract 7.11B may be taken as a reinstatement of a PSYCHIATRIC STAFF + PATIENT omni-relevant device, following Walter’s departure from that device in lines 4 to 15 of Extract 11A. Thus, Extract 7.11A, with its EXPERT VOICE HEARERS, included an example of a patient breach of that omni-relevant device. Line 18 (7.11B) is prefaced with the word ‘so’, marking this as Mike’s expert formulation, a knowledgeable distillation of the earlier accounts. But notice how this formulation includes “STAFF” (line 20, in emphasis), plus “hospital sta:ff”, and “↑family and friends” (line 20). So as not to present an overriding of the previous accounts, these agents of change and control are emphasized as being “<↑as extra support:°” (line
21), as additional help (note the slow delivery and the emphasis on ‘support’). But this is clearly an officially sanctioned “control over these issues” (line 24).

In this light, Walter was no longer being enough of a PATIENT and, in response, Mike took steps to invoke the PATIENT identity by highlighting a voice hearer’s need for help from medical staff and family (lines 20 to 24). As described in the introduction to this chapter and in line with Chapter 3, this can be seen as a dilemma for psychology practitioners; a dilemma which is all the more acute when operating within what is a largely orthodox psychiatric system. Mike re-establishes his own identity as a PSYCHIATRIC STAFF member by this knowledgeable reinforcement of the work of such professional identities (including lines 20 & 21). He also leads the proceedings (lines 30 to 31) and orientates to his being in control of the session (line 43). These PSYCHIATRIC STAFF actions are softened by a smattering of NOT-STAFF in Mike’s casual claim to grasping the facts (line 27) and his casual, egalitarian, use of words in lines 30 and 39.

Lines 18 to 24 may also be taken as a counter-move to what is taken by Mike to be an extreme position, on the basis that moderation is ‘good’ (see Wetherell and Potter, 1992: 164). The ‘extreme’ position being countered by Mike is Walter’s earlier adoption of EXPERT VOICE HEARER (in Extract 7.11A). In contrast to his position which gave the patients expert status, Mike’s privileging of this more ‘balanced’ position - in which voice hearer knowledge concedes some of its power to professionals and family - is not enthusiastically received by the patients. For example, after minimal uptake (line 25), there is a pause (line 26), Mike agrees with himself in line 27, there is another pause in line 28, followed by further minimal uptake (line 29), and Mike takes institutional control over the proceedings by ‘asking’ about putting on a video (lines 30 to 32). But nor is Mike directly challenged in his reinstatement of a professional omni-relevant device; which I take to be evidence of patient acknowledgement of professional
privilege. Either way, despite, and to some extent stemming from, Mike’s use of not-so-normal-ization, PSYCHIATRIC STAFF and PATIENT identities on the whole dominate throughout the above interaction.

‘Positive discrimination’: “maybe passing Year 12... isn’t the benchmark”

Below is an example of what I take to be not-so-positive discrimination. Extracts 7.12A and B (which are not quite contiguous) follow-on from a series of questions and answers - mostly from Richard and Mike, to Tanya - about the topic of Tanya exploring ways of dealing with voices which say she is dumb. Richard and Mike’s main line of questioning was about whether, and under what conditions, Tanya had experienced benefits from using thoughts, about evidence of being successful in her life, to counter the voices (ie, a cognitive coping strategy). Tanya’s answers were generally along the lines of the voices responding to her evidence, sometimes with a concession (for example, that she did pass high school exams) but combined with another criticism (for example, that she only just passed). Richard then changed tack a little by asking whether there are activities during which Tanya feels more confident and is more successful with dismissing the voices. Tanya then responded positively about arts and craft. We now join this sequence at a point where Richard provides an account of why ‘thinking’ is not for all people:

Extract 7.12A (HVG, S7, MW, 48:17-48:57)

1 R: >Coz see:< t- (0.8) this sort of (1.5)
2 ↓intellectual stuff or (.) you know thi:nki:ng
3 T: Mmm.
4 R: ↑i::s (0.3) s- of- (0.1) [^t] (0.1) ma:y be oka:y
5 for:: (0.5) people who’ve read about it like Mike
6 and I have done this univer:sity course an’
7 T: Mm

10 Due to untranscribed gaps between extracts, line numbers restart for extracts 7.12A and B. However, they are part of the same interaction.
Here, Richard draws a distinction between people who go to university and specialize in skilled “intellectual stuff” (line 2; about thinking and about doing therapy) and people who don’t. This distinction is constructed on the basis of time spent in training and in practice. He makes a particular point, in line 18, of saying that his distinction is not on the basis of being ‘dumb’. So far so good. Richard has not yet fulfilled our rough definition of not-so-positive discrimination, as outlined above. In particular, although Richard has made a special point of giving people who are not university trained in such skills the concession of not attributing to them a lack of intelligence - even though they are presented as not good at being “intellectual” and “thinking” - he has not yet clearly discriminated between the patients and ‘normal’ people.

Extract 7.12B (HVG, S7, MW, 49:25-50:14)

1  S:  See I- I- I- I: didn’t actually pass Year
2  Twe:live (0.2) ·hhh an’ um (0.2) >I thought I w’s
3  going quite well ya see c’z I got myself into-
4  (.) I got five hundred (p’)cent< to get into (0.2)
5  co:live:ge (0.1)
M: °Mm↓m.
S: ·hhhhh ↓And er: ·hhh=
R: =Can I: just finish o[ff COZ ]
S: [YEH yeah]
R: see MA:YBE pa:ssing Year Twelve
S: [Yeah you c’n ↑GO o:n for ↓me ↑I: don’ wanna talk]
R: any °more ↓go: [on.°]
M: [Mm. ]
R: J’st [↑J’S'T wan’ve well]
M: [(Hh) (ha) ·hhh]
R: you [ get ta:ling and ↑ta:lk mo:
S: [>(Please no) ↑no do:n’t ↓sto:p.< ]
R: [↑I: was [sayin- ] oh: ]
S: [ >↑No: [no: tru:ly ] I wo:n’t] ta:lk<=
M: [((cough))]
W: =(Hh) [(hh) ·hh]
R: [(hh) ↓go]od o:n you Stuart ·hh (hh) ↑I:’m
gonna be ↓stopped talking [°in a minute° ]
W: [(hh) ↓(hh) ↓(hh)]
T: (Hh)
R: Just the point ’f (0.3) the things that you do::
M: m:m=
R: =that make you feel goo::d
(0.5)
T: ↑Ye[:ah]
R: [ It ] might be that you do mo:re of that.
(0.5)
T: Ye[ah.]
S: [ Ye][:a h ! ]
R: [(Ya know)] ↑doesn’t matter w- (.) ↑why:
down it makes you feel good but it just they just
(0.2) ↓does: so[: ] do: it ↓an’ you c’n figure
T: [Mm↓m:]  
R: out why: it does (_(_). ]
T: [>]Mm.<]
(0.5)
M/W: [Mmm. ]
S: [Yeah.]
R: [ OR: ] >later or: [you don’t even-avta< work out]
T: [Yeah.]
S: Er later yeah.
R: [ OR: ] >later or: [you don’t even-avta< work out]
T: [Yeah.]
S: [ Yeh yeh °(yeah)° ]
R: why::: >°J’s’t [do it°]<=
S: [ No:: ]=
T: =[Y e a h : : ]
R: =[an’ be ha:ppy:] (. ) coz it (. ) ↑ma:kes ya
down ha:pp[y: ]
W: [Y(h)e]ah
T: Mmm↓:.
With “GO o:n for ↓me ↑I: don’ wanna talk any “more” (7.12B: line 12 ff.) and “>(Please no) ↑no don’↓stop s” (7.12B: line 18), Stuart displays either reluctant but deferential capitulation, or irony, in response to Richard’s interruption which begins at line 8. We may wonder if Richard really expected to be told ‘no’ to his question “=Can I: just finish off COZ” (line 8). Richard then comes through with his point that passing Year 12 (ie, high school exams) may not be “the benchli::ne” (lines 11 to 12). In any case, Richard treats Stuart’s display at ‘face value’, as being capitulation: “(hh) ↓good o:n you Stuart ·hh (hh) ↑I:’m gonna be ↓stopped talking “in a minute”’ (lines 23 & 24).

From line 27, Richard may be taken as making a clearer distinction - although it remains only implied - between patients and ‘normal’ people. His point culminates in saying that it doesn’t matter why a certain activity makes “you” feel good, because “you” can figure out why later or not at all; just be happy because it makes you happy. Where’s the harm in that? This may be taken as referring back to the preceding talk about using cognitive coping strategies to help with the voices (since the patient is supposed to have a reduced capacity for rational thought, which would not help in this regard). I am not saying that there is anything wrong with arts and crafts, per se. Far from it. Rather, I am saying that the voice hearers are being constructed here as PATIENTS, by someone who currently is perhaps more of a PSYCHIATRIC STAFF member than a THERAPIST (since therapy was ‘not working’ in the preceding talk). It is a good thing for these patients to occupy themselves in activities and to not think too hard during those activities - ignorance is bliss and that’s okay for “you”. There is no talk of Tanya considering whether she might move on to expand her use of arts and craft for self-expression, or make a living from it, or study art. There is no talk of how she might be assisted in meeting such practical, personal, and intellectual challenges. This kind of ‘setting your sights low’ might be more about social restrictions than personal choice; no matter how it is presented. Just lower the benchmark.
What other indications are there that this interaction is not-so-positive for some of the interactants? For one thing, there are Mike’s two coughs, which seem to punctuate particularly awkward social moments. The first coughing moment is at the end of when Richard has started to tell Walter what Walter does extremely wrong: “YOU DO: ALL OF THAT ALL THE TIME” (7.12A: line 9). The second cough comes towards the start of when Stuart is capitulating (or doing ‘capitulation’) to Richard: “↑No: no: truly I won’t talk” (7.12B: line 21). The question arises: do such moments occur despite, or because of, the preceding example of ‘positive’ discrimination?

Furthermore, as in the example of not-so-normal-ization above (extracts 7.11A & B, in this example of not-so-positive discrimination there are also smatterings of the cover identity NOT-STAFF, serving to soften the path of discrimination; features which we can now see as patronization. Perhaps of most note in this regard, there is the casual, friendly, use of language in “↓good o:n you Stuart ·hh (hh) ↑I’m gonna be ↓stopped talking “in a minute” (line 23) and “you don’t even-avta work out why::: >”J’st do it“< an’ be ha:ppy: (.) coz it (.) ↑ma:kes ya ↑ha:ppy:” (from line 46). There is also, in lines 23 and 24, Richard’s further aligning of himself with the cover of being a NOT-STAFF person who, just as he interrupted Stuart, is also subject to being cut-short just like any other ordinary person. Nevertheless, it is the therapist(s) who are clearly in the dominant position throughout this interaction. Thus, the professionals are peddling ‘dumbed down’ CBT for voice hearers, who the professionals (and, to some degree, the voice hearers themselves) construct as ‘mentally challenged’.

**Section summary**

Two kinds of CBT-prescribed therapist actions have been examined: ‘normalization’ and ‘positive’ discrimination. By analyzing a highly selected example of each, I have shown both actions can, in some instances, be considered for what they do to uphold
sanist power asymmetries rather than undermine them. I, thus, describe such instances as not-so-normal-ization and not-so-positive discrimination.

SECTION 4. NEGATIVE EVALUATION RESPONSES

Introduction

Let us now consider another view of circumstances in which madness-related identities are constructed in therapy, within the context of omni-relevant sanism. In as much as the sanity or otherwise of the ‘patient’ interlocutors in the data to hand is, at best, questionable, it is important to remember that for such stigmatized groups there is the ever-present possibility that they will be taken to be other than regular people. As we noted earlier, in his analysis of the way in which people described as intellectually disabled talk about themselves, Rapley (2004) notes that:

“Doing being ordinary”, as Harvey Sacks (1984) observed, is a pervasive part of the business of everyday social life because there is, pervasively, always the possibility that you will be seen to be not ordinary. For people already identified a priori as definitionally “non-ordinary” such normative social demands must be seen as heightened: of course the difficulty for persons so identified - and here the fundamentally moral nature of such judgments becomes evident - is that the psy professions construct their attention to the everyday business of being mundane as accountable moral action. As Bogdan and Taylor have it: “to be called [retarded] is to have one’s moral worth and human value called into question. It is to be certified as ‘not one of us’” (Bogdan and Taylor, 1994: 14).  

(Rapley, 2004, n.p.)
If we read ‘schizophrenic’ for ‘retarded’ or ‘intellectually disabled’, we can then see how Harper’s ‘rationality trap’ may be sprung. Like Harper’s interviewees and Rapley’s intellectually disabled informants, the voice hearers here face a double bind. It may be all too easy for them, in doing ‘being ordinary’, to be seen by their therapists as ‘protesting too much’ and, hence, providing yet further evidence of their questionable sanity. But how, then, are the voice hearers to manage potentially negative ascriptions? In their analysis of the management of potentially negative attributions about, or evaluations of, one’s character as ‘racist’, Wetherell and Potter (1992) describe (as they put it, ‘crudely’, but usefully for me) five standard discursive moves for dealing with such negative evaluation:

...one can (a) admit the offence but offer mitigations or excuses, or (b) deny the offence and claim that one is wrongly accused, or (c) accept the blaming in its entirety and perhaps intensify or expand on it by giving other examples (ask for other offences to be taken into account, if you like). One could also (d) undermine the accusation itself by renegotiating the nature of the offence, recategorizing it as something less negative and more excusable, or (e) redirect the accusation to another group of people, carefully separating or distancing oneself from the accusation.

(Wetherell and Potter, 1992: 212)

In Wetherell and Potter’s data, the negative evaluation in question was whether the respondent is racially prejudiced. In the hearing voices group data, there is, in the senses which I describe in this chapter, an ever-relevant, underlying potential for a negative evaluation as to whether, and to what degree, a voice hearer is sane. Thus, what I take to be negative evaluation responses in my data are both a part of, and a response to, the implicit accusation that arises from the sanist omni-relevant devices which were demonstrated earlier as operating in this data corpus, most notably PSYCHIATRIC STAFF + PATIENT.
Before we look at some data on this, I had better pave the analytic way by considering how Wetherell and Potter’s negative evaluation response categories might apply as an explicatory framework for the ways in which madness is constructed in our hearing voices data. For example, how might the above five responses to a current or highly potential evaluation of madness relate to voice hearer identities?

Although these categories came to my analyses, to some extent, pre-formulated, they provide an explicatory opening to matters which had already emerged from my poring over the hearing voices group data. My consideration is mostly in relation to formulations of identity, or identity avowals, from a voice hearer regarding her/himself.

Transposing Wetherell and Potter’s first category onto the hearing voices data, Response A., an admission of madness with mitigations, might correspond with occasions when the voice hearer constructs their identity as PATIENT and/or MAD SELF (with the latter being either in the past and/or involving mitigating, non-biological causes or triggers). For example, under the PATIENT identity, a voice hearer may avow being ‘sometimes mad but only when ill’ or construct themselves as having experienced ‘the voices sending them crazy’. Via an avowal such as this, it can be taken that a part of the self remains separate from the ‘illness’. With MAD SELF (PAST), though, I use the term ‘SELF’ to denote a formulation of identity which retains madness as an essential/integral quality of the person, albeit historically. Thus, someone might admit to ‘real madness’ but only in the past. Similarly, a patient might avow themselves of ‘real madness’, but only with an emphasis on ‘illness’ to mitigate against blame.

The second Response, B., a denial of madness, corresponds with instances of the patient constructing themselves as an EXPERT VOICE HEARER and/or a NOT-MAD person. For example, speakers may make claims, directly or indirectly, to be ‘rational’, ‘in-control’, and ‘ordinary’. Descriptions of the performance of mundane reality tests on the nature and content of the voice can be used to contribute to this project. For
example, speakers may report asking questions of themselves such as ‘Was it a voice or was it a real person speaking?’ or ‘Is it true what the voice says?’ Reality testing procedures - and the production of ‘final’ reality findings - are presented as occurring at the time of the voices experience, some time later, or in the therapy session.

An entire acceptance of madness, perhaps with intensification, Response C., is much less common than the other responses. Acceptances include occasions when the voice hearer is constructed, by themselves, as being MAD SELF (PRESENT). For example, the voice hearer may be ‘potentially, and terribly, ill at any time and so must be helped and must take medication, at all times’. Functions of such extreme formulations centre on soliciting counter-responses in which either the (implicit) accusation is reduced or otherwise modified, and/or some kind of amelioration is either provided or promised. Constructing the patient as MAD SELF (PRESENT), though, is seldom done by patients. When it is, laughter or other softeners are involved. It is perhaps never done by therapists, given their tiptoeing around the subject of madness. Rather, therapists construct PSYCHIATRIC STAFF + PATIENT or THERAPIST + CLIENT. However, patient acceptances of madness, like the example above, may be located in various and/or indeterminate time-frames, whereby the voice hearer constructs him/herself as MAD SELF (PAST) in tandem with MAD SELF (FUTURE). On such occasions, the sense is conveyed that the patient is in a lull between inevitable ‘storms’ of ‘illness’. If they were to change the way they deal with voices too much then the floodgates of ‘illness’ would open and they would be swept away. Ironically, these storms seem to occur even with medical treatment, but ‘they would surely be worse without it’.

The fourth Response, D., renegotiating the nature of the offence, would correspond with instances of the patient constructing her/himself as an EXPERT VOICE HEARMER and/or NOT-MAD person. Unlike Response B., however, a direct denial of madness is not made but the nature of the voice hearing experience is couched in different terms.
Instead of originating in, and publicly displaying, madness, the patient’s experiences may be constructed as being due to, for example, ‘spiritual’ issues, ‘other people’s nastiness or problems’, ‘good times turning bad’, or ‘magic’.11

Response E., redirecting the accusation to other people, involves the invocation of a MAD OTHER identity. MAD OTHER may be constructed in the course of describing ‘other people’s nastiness or problems’, as an implicit or explicit contrast with the patient as EXPERT VOICE HEARER or NOT-MAD, for example. Rapley, Kiernan, and Antaki (1998) note that this particular response to the implication or attribution of a disabled identity was widely used in the interviews they studied. In a sense, this response may be seen as prejudice by patients against a third party, as a counter prejudice by a second party against them. The second party can include therapists. Thus, the invocation of MAD OTHER may be taken as being rather like a relocated tit-for-tat, where the PATIENT’S retaliatory response against prejudice from a powerful PSYCHIATRIC STAFF / THERAPIST is to construct a denigrated third party. Such a MAD OTHER may function as a contrast, in a similar way to MAD SELF (PAST), thereby strengthening the patient’s identity as NOT-MAD or EXPERT VOICE HEARER. For example, ‘I’m not like one of those crazy people’. MAD OTHER is a category which is protected against induction (Sacks, 1992), since raving mad people are presented as being simply, clearly, irrefutably, mad. There is supposed to be no point in trying to have a rational conversation with a mad person, after all: a view which, upon inspection, highlights the paradoxically heroic nature of the application of CBT to ‘schizophrenics’ in toto. In the examples in the data to follow, MAD OTHER is also safe from refutation by the person being thus identified because that party remains

11 It is worth noting, at this point, that respectful consideration of accounts of the meaning of such renegotiations of madness - for example, the *dialogical* consideration of accounts about ‘delusions’ and ‘bizarre’ hearing voices experiences as metaphor *may* be fruitful for all involved.
anonymous, or at least they are not in the room and are unlikely to hear that they have been so identified.

A general summary of the relationship between responses to the accusation of madness and the identities which are invoked to manage that ascription may be represented as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Typical identity/ies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. mitigated admission</td>
<td>PATIENT or mitigated MAD SELF</td>
</tr>
<tr>
<td>B. denial</td>
<td>NOT-MAD or EXPERT VOICE HEARER</td>
</tr>
<tr>
<td>C. entire acceptance</td>
<td>MAD SELF</td>
</tr>
<tr>
<td>D. renegotiate nature of offence</td>
<td>NOT-MAD or EXPERT VOICE HEARER</td>
</tr>
<tr>
<td>E. redirect towards other(s)</td>
<td>MAD OTHER (ie, self as NOT-MAD)</td>
</tr>
</tbody>
</table>

Naturally, discursive practice is typically more flexible than these five categories and related summaries might suggest. For example, temporal factors may come into play, where, despite, or because of, a mitigated admission of occasional madness, there is an emphasis on not being mad in the present. To achieve this, a denial, or even an acceptance with intensification, may be employed to invoke MAD SELF (PAST) as a contrast to the mitigated admission. Thus, a patient may construct themselves as ‘previously mad but now rational’.

Patient responses to sanist prejudice-in-action are concerned largely with the management of *agency* (with a focus on ‘I can/can’t do such and such’) and *responsibility* (with a focus on ‘I did/didn’t do such and such’). Given the therapy setting, it is not surprising that both of these factors tend come to the fore in relation to some kind of change in the individual; namely, an improvement in or worsening of the individual’s distressing voices.
The extracts in the subsections, below, were chosen to highlight some of the interactional intricacies involved in negative evaluation responses. As such, the extracts include a range of the response categories which I have described, above. However, they are not organized alphabetically, by response category. This consideration of negative evaluation responses rests on the fact that, given the omni-relevance of PSYCHIATRIC STAFF + PATIENT identities which I have demonstrated as operating in the hearing voices data corpus, there is an ever-relevant, implicit questioning of the voice hearers’ sanity: an ever-relevant accusation of madness.

Examples of negative evaluation responses

Responses B, C, and D: “I feel much better now”

In response to a direct request from the therapists, this extract begins with Stuart describing a recent voices incident:


1 S: I w’s in be:d (.) ↑I woke up in the middle of the night >an’ I w’s thinking< (0.8) oh I feel mu:ch better n- no:w that I’m going to the (1.0) er:
2 hearing voices grou↑:p.
3 (0.4)
4 M: I’m gla:d I a::sked then.
5 S: Yeh.
6 M: ·hh º(h) (h) (h)º
7 S: ↑And u:m (0.8) a- a- an’ I heard all these voi:ces around me
8 (0.3)
9 M: Mmmm.
10 (0.6)
11 S: and u:m (0.2) ↓I w’s thinking I don’t have to ↑worry anymore {↓because I’ve got this- got this} hearing ↑voices ↓group (0.2) ((banging sounds and next few turns))
12 (0.3)
13 W: Hm.
14 M: Hmm.=
15 S: =↑t’ ta:lk about it.
16 R/M: [Mmm.]
17 W: [Hmmm.]
In Stuart’s opening (lines 1 to 4), he describes himself as having undergone a remission, if not a cure, due to his attendance at the hearing voices group. That is, he straddles the identities of PATIENT (he requires ‘therapy’) and NOT-MAD person (yet now he can handle his distressing experiences). He works up an implied contrast between his present state and how he used to be, as MAD SELF (PAST). Indeed, this entire extract can be seen as Stuart producing himself as an ideal CLIENT - evidencing progress and attributing his progress to being inspired by therapy talk (lines 15 to 16, & 21). In lines 1 to 4, he does this once and, in lines 14 to 21, he makes this position even clearer, though still with little uptake from his listeners (lines 6, 8, 22, & 23).

In terms of discursive moves for dealing with an ever-present potential for a negative evaluation of his sanity, Stuart’s opening account (in lines 1 to 4), with its specific rationality claim (an I was thinking’) may be taken as implying a denial of current madness (response B.; in this instance, NOT-MAD) and an acceptance of prior madness which is mitigated by the madness being in the past (response C.; PATIENT and MAD SELF (PAST)). In lines 24 to 27, Stuart perseveres to renegotiate the nature of the offence (potential madness) by affirming his mental state as being unaffected by drugs other than those prescribed by his psychiatrist. In effect Stuart’s claim to sanity here rests on the psychiatric paradox concerning insight: sanity can only be conferred on the patient when there is an acceptance by the patient that they are mad enough to require psychiatric medication. This achieves several things in defence of Stuart’s present sanity status. On the one hand, the clarity of Stuart’s mind further attests to the clarity of his progress and of his report of that progress. Also, hearing voices experiences are linked to altered mental states other than madness. Indeed, along with
Stuart’s general thrust of presenting himself as NOT-MAD, we may take this extract, overall, as an example of renegotiating the nature of the offence (response D.): he may have been ‘out of touch’ with reality but only in a way which is akin to an ‘altered state’ from taking mind altering substances. Thus, on the night in question, Stuart was a NOT-MAD person, who was in a grounded and ordinary mental state - rational thought - (X) when all of a sudden he heard voices (Y) (see Wooffitt, 1991, on the ‘I was just doing X... when Y’ device in accounts of paranormal experiences). It is may be of note, here, that Stuart’s account is carefully recipient designed. That is, rather than claiming personal agency and mastery (readily defeasible claims, after all) he is careful to attribute his success in dealing with the voices to the helpfulness of his therapy, and hence, by implication to the skill and expertise of his therapists who are, as he speaks, waiting to sit in judgment on him.

Shortly after this account Richard moves on to formulate and collaboratively elaborate on Stuart’s account:

Extract 7.13B (HVG, S2, MW, 28:10-28:38)

1 R: And this experience you’ve ha:d (0.2) ↓a couple of
2 nights ago ↓where you had (0.1) a:ll the voic-
3 (0.1) voices s’t of (0.6) er- talking ↑to
4 R: [you an-]
5 S: [Yes th-] ↑yeah. ↓Yeah.
6 (0.2)
7 R: And you s[aid loo]k (0.1)
8 S: [ Yeah. ]
9 R: you don’t ha:ve to worry <abou:t (.) tha:t
10 because::> (. ) ↓you [can’t hear any ↑voi:ces ]
11 S: [ Oh- oh: Yeah. Yeah. ]
12 (0.2)
13 R: ↓ºO[kay.º]
14 S: [Yeah.]
15 R: ·hhh (0.2) ↑Wha::t would have happened in the
16 pa:st (0.1)
17 S: Ah↓h=
18 R: =if you’d (0.5) ↓heard all those voi↓:↑[ces]
19 ?: [Mmh]m.=
20 R: =↑Ho:w would that have affected you?

See also my reading of Palmer’s (2000) data, as described in Chapter 5.
It is interesting to note that, in the latter part of Richard’s formulation, Stuart is now produced as a candidate for a NOT-MAD identity on the grounds that he doesn’t “have to worry about that because…” he “can’t hear any voices” (7.13B: line 10). This appears to be either a radical, therapeutic, reformulation of Stuart’s account (who only moments earlier had stated quite clearly that he *can and does* still hear voices) or perhaps is a mishearing of what Stuart has said. Either way, the latter part of Richard’s formulation does not entail Stuart being a PATIENT but rather someone who is now NOT-MAD. Led by Richard, he and Stuart co-produce a denial of madness in the present and, implicitly, in the future via a highly specific contrast case with Stuarts prior experience of voices and his actions concomitant with that experience (response B.). Also, actual (past and present) progress is, once again, blurred with hypothetical (possible future) progress, this time with the phrase “don’t have to” (line 9).

From line 15, Richard and Stuart then go on to co-construct an acceptance of Stuart’s MAD SELF (PAST), which serves as a contrast to Stuart as currently NOT-MAD. The account of the MAD SELF (PAST) is led by Richard and amounts to a mitigated acceptance of prior madness from Stuart (response C.). Of note, once more, is the careful management by Stuart of the forms of talk appropriate to the therapeutic encounter: thus when asked ‘what does that [going mad] mean to you?’ (line 26) he carefully provides an ‘insightful’ and concretely specified instance of his former mad behaviour not, for example, some metaphysical/existential abstract account.

Yet throughout extracts 7.13A and B, throughout Stuart’s account and Richard’s subsequent formulation and joint elaboration, there is the ever-looming spectre of MAD
SELF (FUTURE): the stress on therapy attendance, compliance with medication and the avoidance of non-prescription drugs all serve to make Stuart’s contemporary NOT MAD self conditional. At bottom, he remains a PATIENT. That is, in these accounts, the future may well include MAD SELF but for the grace of therapy. In this sense, the identity of CLIENT (and even NOT-MAD) remains dependent on the identity of PATIENT.

Response D: “if I don’t eat”

In the talk which precedes the extract below, Richard comments on how often Stuart’s accounts of voices are set when Stuart is doing the dishes. Stuart then explains that his voices tend to be worse in the evening at that time. Richard now explores a solution:

Extract 7.14 (HVG, S6, MW, 26:09-26:35)

1 R: I mean ha: [s th]ere been talk of about >maybe
2 S: [Er]
3 R: taking< your:: (0.5) medication a >little bit< ↑earlier ((questioning))
4  ↑
5 (1.3)
6 S: ↑OH: >y’ see Richard< I can’t do that b’cause
7 (0.6) it’s erm eight o’clock is the best ti:me
8 R: Mmhmm.= 9
9 S: =and you ha- (.) you must (._) have it with foo:d
10 you see. Y’ can’t ju[st ]
11 R: [↓Ri]:ght.
12 (0.5)
13 S: >y’ s- or ER< my mi:nd goes funny you see
14 R: ↑°Mmhmm.°
15 (0.5)
16 S: I kee:p on >thinkin’< weird though:ts (0.2)
17 >because< I do:n’t
18 R: ↑Mmm↓mmm.
19 S: ↑if I don’t °ea:t°
20 (0.6)
21 R: [Righ↓t.=
22 S: =Yea↓h.

Although Richard’s question about medication casts Stuart in the identity of PATIENT (taking medication to alleviate distressing voices being, of course, a category bound predicate of the insane), Stuart’s response to be a resolutely rational tale about his mind
going “funny” if he hasn’t eaten. That is, despite the use of the phrase “weird thoughts” (which it is not emphasized), there is no specification of madness: he could just as easily be a diabetic talking about the experience of hypoglycaemia. To this extent it is an invocation of NOT-MAD and a renegotiation the nature of the offence (response D.), akin to the reference to drugs in Extract 7.13A, above. Note, that this account from Stuart is completed, after a strong beginning (lines 6 to 9, 10), with a faltering ending (lines 13 to 22) with minimal uptake from Richard. This minimal uptake is evidenced by the low tone in “↑Ri:ght” (line 11), hearable doubt in “↑°Mhhmm.” (line 18), and the apparent disinterest conveyed in the long, gradual reduction of tone in “↑Mmm↓mmm.” (line 18) and to a lesser extent in “↑Righ↓t.” (line 22). This is confirmed by Stuart quickly adding his own agreement to his position, although this, too, is hearable as less than emphatic (“↑Yeap↓h.”, line 23). Once again, it would seem that Stuart’s efforts to disavow a PATIENT identity, via his renegotiation of potential madness is not well-received by his therapists.

Response A: “it’s a weakness” vs “chemicals in the brain”

Extracts 7.15A and B are taken from a discussion about the underlying cause(s) of voices. In the first extract, Walter ‘wonders’ whether the experience is a consequence of personal moral failing:

Extract 7.15A (HVG, S2, MW, 7:13-7:46)

1  W:  Is it a weakn[ss do] you think Tanya (.do you
2  R:  [(_ _)]
3  W:  think it’s a weakn[ss do ya it’s so:mething you
4      can’t get a handle o:n and something’s gonna ·h
5  W:  worrying you and troubling [you an’] ↑that
6  T:  °Mmm[m°.]
7  W:  [↓Yeap↓h.
8  T:  ↓Mmm.
9  (0.6)
10  W:  Usually if we haven’t done something wro:ng in the
11  fi:rst place ↓sometimes these things happen.
In the sense that Walter’s account concerns a failing in personal moral fortitude and an inability keep from making mistakes which bring on voices, he could be taken as renegotiating the nature of the offence (response D.) and invoking a NOT-MAD identity. This is achieved through an account of voices characterized by a mundane and vernacular delivery of “so:me:thing you can’t get a ha:ndle o:n” and “something’s gonna wor:y you and trou:bling you” (lines 3 to 5) and by the rehearsal of the common-knowledge notion that ‘bad things happens to good people’ in lines 11 to 12. However, Walter’s account is hearable as such a tale of woe that may be taken as more of a mitigated admission of madness (response A.) and the invocation of a powerless PATIENT identity, than a renegotiation of potential madness. Curiously, in keeping with the moral account, and yet perhaps inviting a biological explanation, Walter then marshals a mechanistic idiom concerning physical causation (“To every a:ction there’s an equal and opposite rea:ction”, lines 12 to 14). Furthermore, the subsequent vacuum metaphor clearly suggests a metaphorical and not a literal reading of his account: “↑maybe it could be that va:cuum cau:sed when we do make mistakes and we d- we do wea:ke:n and er ·hh an’ do:n’t >put a lot into it. Maybe we< leave ourselves o:pen for "these er voi:ces [th’t” >co]me into our minds.” (lines 14 to 18). The passivity of the voice hearers being described in this vacuum metaphor (someone who does “wea:ke:n” and does not “put a lot into it”) also leans towards an invocation of PATIENT.
Nevertheless, Richard’s response from line 21 is a dispreferred one (marked by the high initial pitched “↑Well”; the hesitation and self-repairing delivery; the ambiguous lexical choice of “interesting”; and the moderator, “rea:lly”). Walter’s account is, it would seem, neither CLIENT nor PATIENT enough for Richard despite Walter’s clear signalling of his willingness to accede to his therapists’ expert knowledge in these matters (lines 18 to 20). Indeed, in the next extract we see how the discussion develops:

Extract 7.15B (HVG, S2, MW, 8:13-8:54)

1  R:  D’ y- what do you [think about]
2  W:  [(↑°Oh I dun]no°)
3  R:  Walter thinking th’t (.) he was <negle:ctful: or
4     did something: wr:ong::> (0.2) [and th]at’s why
5  W:  ↓Mmm.  
6  R:  he’s got ↓voi:ces. ((nasal))
7  W:  ↑Mmm. 
8  T:  No I don’t [think ] it’s u[mm ]
9  W:  [↑Yeah.]  [↓Mm.]
10  T:  true.
11  (0.5)
12  R:  You don’t?=
13  W:  [↓Oh (.) °>probably not.<° (.) ↑No.]
14  R:  [Wha- wh- what would y]our
15  (1.6)
16  R:  ↓°What was ↑your: understanding?°
17  (1.0)
18  T:  Th’t ↑so:me- (0.8) ↓some- (.)↑something’s gone
19  wrong: u:mm (0.5) °with the chemo:ls: in the
20  ↓bra[in.°]
21  R:  [↑Mm]hm.
22  W:  °Yeh.°=
23  R:  =°>Chemicals in the< brai:n: (0.4) ↑to↓kay.°
24  (2.9)
25  R:  What about you Belinda?
26  (1.8)
27  B:  I think I agree with Tanya (. ) it’s got some’ing
28  to do with a chemical in the ↑brai[:n. ]
29  W:  [↓°Mm.°]
30  Many: Mmm.=
31  W:  =↑(That’s) true:. Yeah. °↑That’s ↓true°

In Extract 7.15B, lines 1 to 6, Richard’s question to the others in the group about what they think about Walter’s account does a lot more than just solicit their views. First, the mere fact that Richard, as a PSYCHIATRIC STAFF/ THERAPIST, is questioning the
account without having agreed with it heralds a process of negative evaluation. This is confirmed in Richard’s formulation of Walter’s account (which is contained within the question). Although an accurate summary of Walter’s account, the word “thinking” (line 3), along with the clear, ‘in-a-nutshell’ summary that Walter believed that he was “neglectful: or did something: wrong: [...] and that’s why he’s got voices.” (lines 4 to 6), is quite a different take on Walter’s musings. Furthermore, the nasal voice with which the formulation is delivered is hearable as a parody of Walter’s account. Richard’s question is also targeted at the other patients, which, if they disagree with Walter’s account, also markedly undermines the basis of that account.

Both Tanya and Belinda then go about disagreeing with Walter’s ‘version of events’ by describing the underlying cause of voices as biological (chemical/s in the brain, lines 19 & 28). Furthermore, immediately after Tanya’s response, Richard quickly and quietly repeats Tanya’s words (“Chemicals in the brain”, line 23). This is followed by a “thoughtfully” delivered agreement token “okay.” (line 23). This response serves as a subtle positive evaluation of the first offering of the biochemical account. Richard then asks Belinda her view and she (duly) agrees with Tanya (lines 27 to 28). Both Tanya’s and Belinda’s accounts may be taken as a mitigated admission of madness (response A).

Not to be completely left in the cold, Walter starts to show himself as doubting his own account, half way through Tanya’s disagreement with Walter’s (“Oh (. ) probably not. (. ) No.”, line 13). He duly completes his about turn with “(That’s) true: Yeah. (That’s true)” (line 31), after Belinda agrees with Tanya (also disagreeing with Walter’s first account) and after there is a bout of general agreement with the biological account (line 30). Thus, after the biomedical account is stated three times by three different people, Walter finally comes around to response A.; bowing to
the overwhelming pressure to construct himself and other voice hearers as that kind of a PATIENT.

**Responses D, B, & E: “Magic”**

Below, we have a contiguous series of extracts which illustrate a renegotiation, a denial, and a redirection of the potential, ever-present accusation of madness. Mike has been leading a discussion on the triggers and causes of hearing voices experiences. After discussing some candidates put forward by the patients, which Mike has categorized as *triggers,* he now goes on to ask about *causes:*

Extract 7.16A (HVG, S3, MW, 55:43-56:51 (A to D))

1. M: So what causes the voices?
2. (0.9)
3. S: M:agic a ((smiley voice)) (hh)
4. Many: E(hh) (hh)
5. W: Magic (hh) (ha) (ha) [(ha)] ((smiley voice))
6. M: [M a ]gic (?) ((different voice))
7. M: Excell[ent.]
8. Many: [(hh)] (ha) (ha) (ha) [(ha)]
9. S: [ No ] truly that’s
10. M: some[thing]
11. S: [Alright.]
12. W: [ Mm. ]

In Stuart’s response to Mike’s question about what causes the voices, the ‘smiley voice’ presentation and laughter particle (line 3) indicate that Stuart is inviting group laughter. Stuart’s response may be taken either as being completely in jest or as using humour to cover a serious point concerning his views on the subject of magic and hearing voices.¹³

¹³ Note Derek Edwards (2004), in a personal communication on the analytic use of omni-relevant devices in regards to this extract:

Rather than analysing this straight away in terms of clinically relevant ORDs, it could be analysed, at least to start with, in terms of what such expressions might be doing in any kind of mundane
As the latter, it can be considered a renegotiation of the nature of the offence (response D.) and an invocation of a NOT-MAD (cover identity) or an EXPERT VOICE HEARER identity (given that voice hearers are in the best position to make such controversial claims about voices and magic). Either way, the other participants treat Stuart’s response as a joke (lines 5 to 9). Indeed, it appears that the other participants are laughing with Stuart rather than at him; that they are casting him as NOT-MAD or EXPERT VOICE HEARER, rather than MAD PERSON. Regardless of Stuart’s framing of his turn as a joke, however, if he is taken as being serious about magic as the cause of voices and if the others consider magic to be a ludicrous explanation then there is a reality disjuncture between Stuart and the others in the group.

Indeed, for Stuart, the joke runs rather too far. He comes back in line 10 with a clarification that he is serious about the magic explanation. This, then, is a restatement of his renegotiation of potential madness (response D.), given that he is again invoking the identity of NOT MAD by constructing himself as a rational individual with a grasp of the facts, from his point of view at least (“No truly that’s what I think it (is)”, lines 10)

interaction. It looks like an orientation by Stuart, just as anyone might do, to a likely sceptical receipt of his term ‘magic’. Anybody might orient to it that way, where more or less credulous talk about magic, spoon-bending, horoscopes, mediums, ghosts, etc., can be part of any mundane conversation. One interesting thing is whether Stuart is doing it differently from how anyone might (which was Palmer’s theme, of course). So Stuart may be over-interpreted here as orienting to such an ORD category as ‘Patient’ or ‘Not-Mad’. Indeed, it could be by seeing the sheer normalcy of his talk (at this point), that his psychiatric categorization becomes questionable. The main line of analytic conclusions may end up in the same critical place, but the immediate use of institutional role categories as ‘omni-relevant devices’ may pre-empt seeing the talk ‘in its own terms’ as Schegloff puts it, prior to interpretation in terms of contexts and categories. A useful comparison could be made, therefore, with everyday mundane conversation, where ‘omni-relevant categories’ are not so tempting to use.

(original emphases)
to 11). That he states the magic position as being from his point of view serves to construct him as all the more reasonable (and reasoning) in acknowledging that others may see things differently. It also closes the distance a little between his position and that of the others. Stuart does however soften his position still further, with “something like that” (lines 13 & 15).

Mike then engages Stuart in a little ‘Socratic questioning’:

Extract 7.16B (HVG, S3, MW, 55:43-56:51 (A to D))

17 M: It-
18 S: =Ye[ah. ]
19 M: [D-Do] you feel that it is magic or does
20 M: it [ ↑seem ]
21 S: [I do, I-]
22 M: like magic?
23 S: No no I feel >that it’s like< magic.
24 S: °(_ _ [ ]°)
25 W: [ (Mm )][hmm. ]
26 M: [Like ] magic
27 (0.5)
28 S: [Yeah. ]
29 W: [(Mm.)] ((high pitched moaning))
30 M: [ i s ] that different from i: s magic?
31 (0.6)
32 S: Er:: (0.3) yes it is different from it is- (.) no
33 no · hhh (0.1) er: if it was magi:c (1.5) the-
34 there- to me there isn’t any difference
35 S: ya [know (c’z _ _)]
36 M: [Righ:t. Okay. ] It’s- it- it really does seem
37 M: li[ke m a g i c. ]
38 S: [>seem like magic<] (.) yeah.
39 M: Ri[ght.]
40 W: [ Mm]m
41 M: Okay.
42 S: ↓°Mm.
43 (1.5)

Mike’s ‘Socratic questioning’ (lines 19 to 22) further suggests that Reality and (Stuart’s) sanity are at stake, here. Mike’s question turns on whether Stuart feels that it is magic or whether it just seems like magic. In fact, both of the two options offered place Stuart and magic into vague territory, objectively-speaking. Thus, Mike may be seen as leading Stuart towards a forced choice of either a PATIENT identity or an institutionally sanctioned NOT-MAD; an identity which does not accommodate talk of
magic as Real. Stuart’s response picks up his part in doing therapy, but, with the claim that “I feel that it’s like magic”, equivocates about a categorical choice in Mike’s terms. However, Stuart’s amalgamation of Mike’s two options merely increases the shakiness of the ground on which he is positioned concerning whether he is in line with Reality (“No no I feel that it’s like magic.”, line 23).

Mike then drives the point home further with a ‘pass’ (Schenkein, 1978) in line 26 and a restatement and explication of his initial question (line 30). And Stuart duly puzzles through what he has been set to do by Mike (lines 32 to 33), before settling again on his personal and pragmatic position (“to me there isn’t any difference”, line 34). Ironically, although this position is rendered as ordinary by Stuart (in that there is a lack of distinction between magic and the everyday experience of hearing voices, and that this is arrived at through everyday, personal experience; line 34), and although it is evaluated as extraordinary and institutionally unacceptable by Mike (through the distinction between it Really being magic and it just feeling like it is magic; lines 19 to 22), a ‘voices as really magic’ account may be taken in a realist-mentalist sense to reflect underlying madness and as being just the kind of MAD SELF and PATIENT which psychiatry is supposedly in place to deal with and in some ways calls for. But, here, Stuart is not doing his proper job as a CLIENT, an identity which itself requires a little something of the irrationality of MAD SELF and PATIENT.

Still not letting go, Mike practices what can be taken as some bridge-building ambiguity of his own, with his use of both “rea:llly” and “seem” in the same sentence (line 36). Nevertheless, although there is prosodic emphasis on “rea:llly”, it is only the seeming which is presented as real. That is, Mike’s utterance proposes that magic is only real-seeming. Stuart complies more fully this time, with repetition of Mike’s phrase “seem like magic” (line 38). That is, he takes on something of a dutiful CLIENT

14 See the mirror metaphor in Chapter 1.
identity. Stuart does say his turn rather quickly, though; a possible indication that the
CLIENT identity is not being fully adopted. And, indeed, all is not yet done:

Extract 7.16C (HVG, S3, MW, 55:43-56:51 (A to D))

44 S: Mm[m.°]
45 M: [ ER]:M: (0.6) any other ideʌas? (0.6) Wha- wha-
46 what cau:ses the voiʌ:ʌces?= 
47 S: =·h (No) I’m not say:ing- I’m not say:ing I
48 believe in ma:gi: ya hh-(know).=
49 M: =ïWe- yer- ((croaky))=
50 S: =↓I’m just saying er (1.0) >↓well what I← what
51 I’m saying is
52 (0.2)
53 M: As if by ↑magic. ((cool voice))
54 S: As i:f by magic. (. Ye[ah.]
55 M: [ Mm]m. 
56 (0.4)
57 S: ↓Yeah.=

Even after Mike has begun to change the topic away from magic (lines 45 to 46), Stuart
attempts a resolution of the reality disjuncture without being denigrated (see Chapter 7,
on Georgaca, 2000). Mike’s change of topic serves to rescue Stuart and to seek a more
satisfactory answer to his original question about the cause of voices. Lines 47 and 48
then provide perhaps the clearest instance in this interaction of Stuart presenting himself
as NOT MAD (‘I’m not say:ing I believe in ma:gi: ya hh-(know).’). This, then, is
another example of defending his sanity by denying madness (response B.), to counter
any implicit construction of him as PATIENT by his interlocutors. Stuart gets into
difficulty in lines 50 and 51, however, and Mike ‘rescues’ him by providing a statement
which is compatible with the denial of Stuart as mad (“As if by ↑magic.”, line 53) and
which settles on a version of the relationship between voices and magic which is
institutionally acceptable. In an indication of his acceptance of the ‘therapeutic’
message, Stuart then duly repeats Mike’s phrase: “As i:f by magic. (. Yeah.” (line 54).

Next, though, we have yet another bid by Mike to change the topic away from magic
(and madness), and another revisiting by Stuart:
Extract 7.16D (HVG, S3, MW, 55:43-56:51 (A to D))

58 M: =Tanya (0.2) what do you think causes the
59 °voices°=
60 S: =>I don’t believ- no-< yeah that’s [right.]
61 M:                                    [That’s] cool.
62 M: [That’s cool. I- (Hh) (ha) (hh) I haven’t got ]
63 ((smiley voice))
64 S: [You know. (0.6) I don’t believe in ma:gi:ci:an] (Stuart.)=
65 M: you [pinned as a ma↓gi:ci↓an] (Stuart.)=
66 W: [ Mmm (hh) (hh) ]
67 S: =No.=
68 W: =You ca:n with °Stuart°
69 M: [(Hh) (hh)] ·h Tanya.

This extracts includes more laughter (lines 62, 66, 69). Stuart’s response of initially defending his rationality (“=>I don’t believ- no-<”, line 60) shows that he takes this laughter as being about him rather than with him. Mike’s jovially delivered phrase “I haven’t got you pinned as a ma↓gi:ci↓an (Stuart.)” (lines 62 & 65) may be taken as a ‘nice’ way of saying ‘I don’t think you’re a nutter, honest’, which, along with Stuart himself, continues to run the risk of protesting too much about Stuart’s sanity (ie, Harper’s ‘rationality trap’). In its denial, the term “pinned” goes some way to acknowledging that a power asymmetry is, however, relevant.

Walter, though, in the context of the joking, appears to do less tiptoeing around the matter: “You ca:n with °Stuart°” (line 68). Hearably, this may be taken as constructing Stuart as a MAD OTHER. Thus, Stuart’s NOT-MAD/EXPERT VOICE HEARER did not get him far, with Mike or Walter. From Walter’s point of view, Stuart as a MAD OTHER would also serve to redirect any accusations concerning his own sanity status (response E.). Indeed, in a turn which is not incompatible with this analytic reading, Mike, as a tiptoeing professional, then promptly ends his own laughter and quickly redirects the talk to another person and topic (line 69).
Responses E & D: “carrying on about Jesus”

Extract 7.17A contains another instance of response E. (a redirection of the ever-present, potential accusation of madness), this time by Stuart, as a continuation of the earlier discussion about magic. Elsewhere in the corpus there are more obvious critical accounts of (other) mad people, such as those who ‘hang around’ psychiatric hospitals talking to themselves. Here, though, the focus is on Stuart’s experience of Christian people who evangelize:

Extract 7.17A (HVG, S3, MW, 58:16-58:30)
1  S: And per- so- i- [if-]
2  T: [ Mm]m.
3  S: Mike if someone walks up to you and starts (1.0)
4 er carrying on about Je:sus you know and you’ve
5 never believed in Jes(us) (1.0) it’s like ↑what do
6 r-? (.) What- ↓you thi:nk ↑come up and throw the
7 bible at me: for?
8 W: (Uhh) (hh) [(hh) (ha) (hh)] hhh
9 S: ↓It’s ↑magic. ]
10 M: Right.

The ever-present, potential accusation of madness continues to be renegotiated in terms of magic (response D.). However, it is the socially sanctioned activity of evangelical proselytizing which is constructed as being equivalent to a belief in magic: as unwarranted, irrational even (“What- ↓you thi:nk ↑come up and throw the bible at me: for?”, lines 6 & 7). This, then, effects something approaching a redirection of the accusation of madness (response E.). Those who engage on thrusting the gospel onto unwilling others, that is, may be just as equally held to hold irrational beliefs as someone who believes in magic. With this redirection, there is also an implicit denial of madness; an invocation of a NOT-MAD identity by Stuart. By working through this behavioural puzzle in the group, he is also giving a public demonstration of his rationality.
Stuart’s position is elaborated in Extract 7.17B, as he deliberates further on the matter. His negative evaluation response becomes clearer also:

Extract 7.17B (HVG, S3, MW, 58:55-59:28)
46 S: But Mike what brings=
47 W: =(_)=
48 S: =what brings that o:n? If ya don’t been beli:ve
49 in religion or Je:sus f’ years and year:s (0.6) y’
50 know of all ya- (. ) li:fe you nev- you’ve never
51 been tau:g:h:t that way (0.7) when all of a sudden
52 someone comes up with a bi:ble
53 (0.5)
54 M: °Right.°
55 S: ↑and they >start sending you to< ↑chur↓:ch.
56 S: [↑So y- (0.1) and then you complain] about hearing
57 M: [Well I: think (0.3) °Mmm.° ]
58 S: voices ↓and they [say: ]
59 ?:                  [(_ _)]
60 (0.5)
61 S: >well you’d better go t’< chur:ch more often.
62 W&M: (Hee) (hee) (he) (ha) (ha) (heh) (heh)
63 W&M: [ (hh) (hh) (hh) (hh) (hh) ]
64 S: [ya know (. ) to absolve ya ↑si:ns.]
65 M: WELL I GU[E:S] (. ) IS- ]
66 S: [↓And I think:]  
67 M: is that re[f l e c t i n g ]::
68 S: [Yeah (. ) ↓sorry.]
69 S: ↑It’s silly though ↑isn’t it Mike?
70 M: ↑Well (0.1) is th[at ↓reflect]ing-=
71 S: [↓(Rea:llly.) ]
72 S: =°Yeh.° ↑C’z Jesus is dea:d. ↑He die:d ↑year:s ago
73 [...]

In lines 46 to 52, the behaviour of evangelical Christians is characterized as being baseless, as being without reason or context for coming into Stuart’s life. Indeed, the story is even structured in terms analogous to the tales of the unexpected analyzed by Wooffitt (1991, 1992), and in the context of mundane disbelief, “someone comes up with a bi:ble”; an extraordinary occurrence happening to a rational, ordinary person. Stuart’s talk in lines 55 to 61 is, then, concerned to show that the position of Christians is beyond rational proof; that it is empirically baseless: indeed in line 72 a direct appeal to the empirical fact of Jesus’ death is made. Stuart thus shows his own capacity to make rational, empirically grounded judgements, and delicately points to the fact that he
is aware of the operative double standard that certain irrational beliefs are permissible and that others, such as the notion that voices may be ‘like magic’, are not. As an appeal to the argument for the cultural relativity of evaluations of moral conduct this is difficult to better.

After his account receives less than an enthusiastic uptake from Mike (“Well I: think (0.3) “Mmhmm.””, line 57) and much laughter from the others in the group (line 62), and as the laughter continues (line 63), Stuart provides additional detail, from within a Christian frame of reference (“ya know (.) to absolve ya "signs.”, line 64). This presents further his grasp of relevant information, his reasonable consideration of the Christian point of view, and his wish to seek agreement with those in the group. It also strengthens his argument by making it clear that he is tackling evangelists on their own terms.

Response D: “like a baptism of fire”, “a war within yourself”

Immediately before this extract, Stuart had been talking about an experience of hearing voices, which Mike formulated as being Stuart’s ‘first episode’ of psychosis and suggested that Stuart’s reactions to such experiences were more controlled now, as a result of knowing more about voices. Walter then describes the early experiences of hearing distressing voices, as a renegotiation of the nature of the offence:

Extract 7.18 (HVG, S3, MW, 48:42-48:55)
1 W: It’s- it’s like a baptism of fire you don’t want
2 to be there but circumstances say that you are
3 >you know what I mean? like
4 M: [[Mmm. ]
5 W: in a war: or something like that. (0.1)(·hh)
6 Some[times ]
7 S: [”Yeah.”]
8 W: it can be a war: within y’self and you’re
9 fighting >and maybe other people don’t understand
10 what that< is (.) you know.
Walter’s renegotiation of potential madness (response D.) starts as a simile (“it’s like”, line 1), but the comparison becomes more ‘real’ with “it can be” (line 8) and “other people don’t understand what that is” (lines 9 to 10). Even though he does not directly implicate himself, his use of the word ‘you’ can be taken to include himself along with others in the same predicament.

In this account, the “baptism of fire” (line 1) is a trial which is put upon the person, by external forces and hence personal accountability is deflected with “you don’t want to be there but circumstances say that you are” (lines 1 to 2). The passivity included in this construction may suggest that a PATIENT identity is being invoked by Walter. The problem is even located internally at one point (“within y’self”, line 8). However, because his description is couched in terms of the afflictions of religion/fire (“baptism of fire”, line 1) and war (lines 5 to 9), rather than the ‘mental illness’ of a psychiatric patient, this positions Walter (and others in the same predicament) as NOT-MAD. The identity of EXPERT VOICE HEARER is not invoked, here, as there is no suggestion of Walter being an expert in dealing with the voices, despite the general implication of having experienced them on many occasions, and despite Walter indicating that he has experience in something which non-voice hearers do not understand. Indeed, in the context of this account, “other people don’t understand what that is” (lines 9 to 10) may refer to a lack of sympathy from others, rather than a non-voice hearer’s lack of detailed knowledge about hearing voices.

Personal agency and the responsibility to respond effectively to the “baptism of fire” (line 1) are not addressed directly in lines 1 to 3. The account then develops into a discourse of war (lines 5 to 9), with a possible solution/holding strategy being introduced which is located internally (“within y’self”, line 8) and is to do with personal agency (“you’re fighting”, line 9). In this turn, the use of “it can be” (line 8) also suggests that Walter may no longer be talking only about initial experiences of hearing
voices but is including ongoing experiences of the phenomena in his description. It is worth noting, however, that there is no clear distinction between a problem and a solution in this account; the battle may be both the problem and the solution, and it may be without resolution. Nevertheless, besides the internal, there are other social aspects to the problem/solution: “other people don’t understand” (line 9). That is, other people, those who have no personal experience of hearing distressing voices, perhaps also have some responsibility in this. Overall, then, in this renegotiation of the potential, ever-present accusation of madness, Walter is managing the tension in biopsychiatry, and especially clinical psychology, that people are not to blame for their ‘illness’ and are personally responsible for getting better.

Response D: “the storm that went through”

Below, Walter describes his experiencing of voices, again stressing the ineluctability of the experience, its externality and the persistence of his efforts to conduct his life constructively in spite of his torment:

Extract 7.19 (HVG, S4, MW, 54:44-56:05)

1 W: Well (.) I think sometimes e- (.) er (0.9) when ya
2 go to hospital with voices that can hasten the
3 (.) admission to hospital you know (0.4) Er I’ve
4 sort of got a path of destruction that’s been
5 there all that time an’ I- the only way (0.1) the
6 stress makes it worse you know?
7 M: ((cough))
8 W: When they did come on (with) the voices when I
9 first experienced them the stress was terrible to
10 be putting up with (0.5) things an’
11 [...] ((12s omitted in which W describes his way of
12 living being the only way that he has respite))
13 W: that’s the only way I can find (0.4) find (0.3)
14 hope or h- find a haven in whatever I’m doing
15 you know (0.3) [(_ hai]ving them) up there and
16 M: [Do y-]
17 W getting rid of (them) (.) the (. ) the destruction
18 they cause and going ba:ck and trying t’ ·hhh u:m
19 to rebuild it again >]you know what I mean<
20 rebuild li:fe again (.) after it’s been torn apart
21 by the (0.5) by the stor:m th’t went through (0.1)
22 you know.
M: Do you get a sense that you are finding (0.5)
M: [your]
W: [Er ] oh very [ s l o w ]ly very slowly (thing) I
M: [((cough))]
W: think (. ) (the) the voice[es are th]ere for a long
M: [°Righ:t.°]
W: time j’st-j’st (0.7) it j’st seems to revolve
around the cer:tain things I do and doesn’t seem
to get much better it just seems like the sun
shines on it an’ (0.2) it seems to sort of come on
and th’ th’ like (0.1) er (0.2) like a lot of erm
(0.5) different storms at the same time going on
and I- I’ve just got to wait ’til I ride the tide
and wait ’til it’s over °you know.°
M: Mm[m:]
W: [Th]at’s the only way I can do it [...]
Responses B & A: “it sent me mad”

The repeated stress on the importance of external factors in the precipitation of the participants into madness, rather than a bizarre and irrational individual problem, is further illustrated in the extract below. Once again, we have an account analogous to the ‘I was just doing X... when Y’ device in accounting for the rationality of madness. In essence, the argument claims that anyone faced with these circumstances would, understandably, sensibly, go mad. This time, the ‘paranormal’ or bizarre experience is not hearing voices (as in Extract 7.13A & B), or being ‘hit with a bible’ (as in Extract 7.17A & B) but rather the experience of an unwarranted, inexplicable, and devastating accusation as preface to going mad in toto. Stuart describes being sent mad by a (to him) bizarre happening, prefaced by a detailed - and utterly pedestrian - account of having lunch with relatives and thinking cogent, rational and unremarkable thoughts.

Extract 7.20 (HVG, S6, MW, 49:07-49:53)

1 S: [...] I was having lunch at my grandmother’s place
2 my mum’s mum’s (. ) place · hhhh and she c- s- ↑I
3 w’s sitting down all happy and thinking gee things
4 are getting brighter you know↑ (0.8) I might even
5 (0.1) buy myself some cigarettes (1.5) ↓you know
6 (.) coz that’s what I used to do (0.2) >er ya<
7 know (0.3) ↑an’ then she called me mad er (0.2)
8 e-er-ss:: (0.6) ↓the li’l gir- ya know th- er (.)
9 their daughter (0.1) friends of (. ) (1.5) m-y
10 grandmother (0.3) a:nd er (1.7) >sh- sai<- she
11 said ‘<↑He:’s ma::d>’ ((different voice)) (0.6)
12 ↓you know an’ I thought (0.5) · hhh
13 S?: ((cough))
14 S: ↑I though:t er (1.8) ↓you don’t really (0.6) e- e-
15 e- ((croaky)) and um (0.5) (↑t) (0.8) ↑it se:nt
16 me ma:d literally
17 R: Mm.
18 S: from there: on.

In this account, we have Stuart going about his mundane, everyday, business (X), essentially a denial of madness (response B.) by the invocation of a NOT-MAD identity (lines 1 to 6), when all of a sudden (in lines 10 & 11) there is a little girl saying that he
is mad (Y) (“she said ‘<\text{He}:’s ma:d>’”). It is of note that this phenomenon is made all the more real and bizarre by the use of direct reported speech and the provision of the fine-grained biographical details of the little girl. She is not just any little girl, she is the highly specific daughter of friends of his grandmother. Then, we have the extraordinary consequences (Y+, if you will): “\text{It se:nt me ma:d literally}” (lines 15 to 16).

One analytic reading of this extract, overall, is that Stuart is effecting a renegotiation of the nature of the offence as being due to social rather than biological causation (response D.; NOT-MAD). However, we may take the account as being to do with a mitigated admission of madness, as a fact of Stuart’s biography (response A.; MAD SELF (PAST)). Indeed, for Stuart, the onus appears to be on the girl who sent him mad (ie, the mitigating circumstances) rather than the great extent (response C.) or nature (response D.) of the madness, per se.\textsuperscript{15}

\textit{Responses E & A: “Charles Manson went mad”}

In a conversation about voices returning after a time of being without them and about a fear of feeling good, Stuart describes what it is like for him:

\textbf{Extract 7.21 (HVG, S7, MW, 7:17-8:00)}

1 \textbf{S:} \text{[...] it’s like the Beatles song the steeper you go the high:er you fall.} \\
2 \textbf{R:} \text{M[m. ]} \\
3 \textbf{S:} \text{[An’]} \text{I don’t know if you’ve heard Helter-Skelter.} \\
4 \textbf{M:} \text{No.} \\
5 \textbf{R:} \text{(Mmhmm.)} \\
6 \textbf{S:} \text{You know s- (0.5) and erm (0.6) you go ma:d >but I don’t listen to that song (.) b’cause<}

\textsuperscript{15} As an aside, it is interesting to note that the final “from there: on.” (line 18) renders Stuart’s sanity - which was once relatively unproblematic and routinely ordinary and which then became an extraordinary problem, caused by a extraordinary event - as routinely problematic; as both ordinary in terms of frequency and extraordinary in terms of being ‘problematic’.
Here, we see Harper’s ‘rationality trap’ in operation, as ever, in that Stuart (as NOT-MAD) is displaying expert knowledge (about the Beatles song, Helter-Skelter) and a rational concern with causality (linking listening to the song with going mad), whilst at the same time discussing his fear of being/becoming mad (again) (ie, MAD SELF (FUTURE)). The implication is that Stuart is talking from past experience (ie, MAD SELF (PAST)), so that there is a justifiable anxious anticipation of madness coming when his guard is lowered; even and especially when he is doing well. Nevertheless, Stuart’s demonstrated rationality and the fact that the events in the account are presented as potential, rather than explicitly having already happened to him, suggest that such events just might happen to anyone (ie, Stuart is NOT-MAD, just like everybody else).

In line 11, Charles Manson works as a well-known extreme case to prove Stuart’s point; his teetering between NOT-MAD and MAD PERSON. Manson also serves as a MAD OTHER (in line 11 and then in 28 to 29; response E.). This is not a simple redirection, given that Manson is blamed for waiting in the wings to “pop around and ↑bo:p” Stuart; something which might be taken as a metaphor for what causes Stuart’s
madness. However, the inclusion of a MAD OTHER (a madder other) deflects blame, at least, away from Stuart.

Overall, then, we may take this account to be a mitigated admission of madness (response A.), with the mitigating factor being that the madness is located in an indeterminate time-frame which does not include the present (ie, it involves the past and/or the future). In this implied past and feared future, Stuart constructs himself as something of a perpetual, potential MAD PERSON - there is a MAD SELF, ever-close, waiting to jump out from the shadows - no matter how NOT-MAD he appears to himself and others.

Section summary

In our third approach to sanism-in-action, we considered selected examples of voice hearer’s talk as situated, occasioned responses to an ever-present, potential negative evaluation of their rationality and sanity. We saw a number of different kinds of responses, which included the following identities: PATIENT, NOT-MAD, EXPERT VOICE HEARER, MAD SELF (PAST, PRESENT, &/or FUTURE), and MAD OTHER. We also saw more examples of voice hearer management of agency and responsibility. The number and variety of X when Y accounts attests to just how much the rationality and sanity of the voice hearers is at issue in these interactions. Much effort is put into being ordinary. Nevertheless, patienthood and madness are ever-relevant; they are always waiting in the wings.
SECTION 5. FURTHER UNDERSTANDINGS

Pasting-in voice hearers as NOT-MAD

Smith (1978) analyzes how an interviewee constructs her friend, K, as having a ‘mental illness’ through a process of ‘cutting-out’ K from the social group. Increasingly, the interviewee explicitly categorizes K as being ‘mentally ill’ and presents K’s behaviour as being objectively anomalous as opposed to being deviant but sharing a common rationality with ‘mentally well’ others. K is systematically excluded from those who know what is - she is excluded from those who know how to relate ‘rationally’ with the ‘real’ world.

It is my contention that, in the hearing voices data corpus, the voice hearers are categorized, by default, as severely mentally ill PATIENTS and thus, as being more or less mad. To counter this pervasive identity, much work is done by voice hearers to establish their membership in the category of rational CLIENTS and/or NOT-MAD people. This work - a ‘pasting-in’ of NOT-MAD as a cover identity to conceal a PATIENT whose sanity is in question - is essential to the conduct (and possible) success of the entire cognitive-behavioural therapeutic enterprise. That is to say, it approaches a logical impossibility to conduct cognitive-behavioural therapy with people who are defined not as simply having one or two irrational beliefs or ‘faulty cognitions’ (Garety, Fowler, & Kuipers, 2000) but rather who are, by virtue of their diagnosis, definitionally out of touch with the reality inhabited by the therapists. Thus, therapy must proceed under the cover of a co-constructed recipient identity as CLIENT and/or NOT-MAD person, as if the recipients are capable of rational thought, Socratic dialogue and so on. The tension which is created as a consequence of the adoption of the omni-relevant device-controlled interaction is live throughout the therapy transcripts. That is,
despite (or because of) this NOT-MAD cover, voice hearers and therapists still, when it suits the occasion, frequently construct voice hearers as being more or less mentally ill PATIENTS.

For these hearers of distressing voices, in these sessions, there is an ever-relevant, even if never manifested, possibility of being evaluated as, frankly, mad - with all the concomitant prejudice and discrimination. It is important to note, then, that the voice hearers’ work in the enterprise of being NOT-MAD can be still heard/read from the data as being relatively coherent, compared to their diagnosis of ‘severe mental illness’, and compared to the incoherencies which plague the management of the various professional identities. (We consider these professional incoherencies presently). That is, overall, the voice hearers - and it is Stuart, perhaps, who works at it the most - come across as being pretty much in touch with reality. Indeed, one might turn this consideration on its head and analyze the variety of ways in which the therapists and their techniques are shown by group members to be somewhat out of touch with ‘reality’, particularly with the ‘reality’ of the voice hearer’s experiences.\(^{16}\) In keeping with the ‘pasting-in’ notion, perhaps EXPERT VOICE HEARER (and NON-VOICE HEARER) can be seen as a typically opposed introduction of an entirely new kind of interactional ‘scene’, compared to the PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT RELATIONAL PAIRS.

**A hierarchy of identities**

Upon closer inspection of these extracts and the data corpus more generally, then, the invocation of PSYCHIATRIC STAFF, PATIENT, THERAPIST, and CLIENT

\(^{16}\) This perhaps controversial point may be considered in relation to the title and content of Boyle’s book “Schizophrenia”: A scientific delusion?” (2002b).
identities is clearly more frequent than the cover identities of the therapists as caring, NOT-STAFF conversationalists and voice hearers as their articulate, free-thinking, NOT-MAD interlocutors. That is, NOT-STAFF and NOT-MAD operate as cover identities; for a time, more or less, covering the underlying identities of PSYCHIATRIC STAFF or THERAPIST, and PATIENT or CLIENT, respectively.

However, the cover is frequently ‘blown’ to reveal two variants of the omni-relevant device in operation: PSYCHIATRIC STAFF + PATIENT or, in its kinder guise, THERAPIST + CLIENT, no matter how rational the voice hearers attempt to show themselves to be. This is patently not dialogue (which requires co-equals). A hierarchy of privilege is constructed and maintained from a ‘super-sane’ PSYCHIATRIC STAFF/THERAPIST, to a CLIENT, to a (mostly rational, but subservient) PATIENT, to a MAD SELF. Such a hierarchy is forged from pre-judged, but continuing to be upheld, sanism. It functions despite, or because of, the covering and partial undermining of these identities. The identity of EXPERT VOICE HEARER does not fit neatly into this hierarchy. EXPERT VOICE HEARER (and NON-VOICE HEARER) is a relatively fleeting, special case compared to the professional-led omni-relevant devices. Indeed, to be an EXPERT VOICE HEARER requires a repudiation of Mike and Richard as THERAPISTS; of the entire institutional structure within which the therapy occurs.

The contiguous extracts below are included as an example of several of these hierarchical identities, and EXPERT VOICE HEARER, operating in close proximity with each other. Before the extract begins, Stuart had been describing an occasion during the week when he heard a distressing voice whilst waiting for a bus. He explained that, to distract himself, he continued to go about his activities for the day. Stuart then asked whether the other voices hearers ever find that nothing helps with the voices on occasions, but Mike quickly steps in:

Extract 7.22A (HVG, S3, MW, 9:13-9:58 (A to C))
1 M:  (What) did you do at the ti:me="
Mike’s question is aimed squarely at the present: “(What) did you do at the ti:me=” (line 1). Stuart replies accordingly, with “=Told >it t’< get ↑lo:st” (line 2). In line 5, Mike invokes the identity of THERAPIST by providing a particular formulation of Stuart’s response. Mike’s formulation in terms of ‘confronting’ the voice is more formal (more ‘therapeutic’) than Stuart’s initial account and more in keeping with a therapeutic ‘coping’ response. Note the use of “okay” and “so” to indicate that this is indeed a professional formulation of events. With Mike at least partially as the THERAPIST, the implication is that Stuart is the CLIENT. The start of Stuart’s subsequent response, in line 9, does not come until two other voice hearers have begun to respond with laughter.

Mike’s questioning continues:
Before Mike has even finished asking Stuart about how he responded to the voice, Stuart begins to defend his own sanity status (lines 13 to 16). He does this with a denial of madness (ie, negative evaluation response B.) and, thus, identifies himself as an EXPERT VOICE HEARER. In line 15, Mike’s repeated utterance “IN YA HEAD in ya head” can be taken as defending his own position in that he constructs himself as: (a) knowledgeable enough about hearing voices to not make ludicrous comments about them, and (b) not accusing Stuart of being (completely) mad. However, Stuart continues to work at strengthening his claim to sanity through a contrast between himself as NOT-MAD (“I’ve actually walked with people”, line 19) and what is now a redirection of the accusation (ie, negative evaluation response E.) towards people who “keep on saying these mad things” (lines 19 to 20). This is something of which Stuart “actually” has first-hand, expert experience, as an EXPERT VOICE HEARER. That is, Stuart invokes the identity of MAD OTHER in contrast to his being a NOT-MAD person/EXPERT VOICE HEARER.

The interaction, however, continues with a negative evaluation of his sanity by Mike:

Extract 7.22C (HVG, S3, MW, 9:13-9:58 (A to C))

Mike: [Sounds complicated]

M: [t’ m(h)e (hh)]
Let us look at Mike’s formulation, “Sounds c(h)omplic(h)ated t’ m(h)e (hh)” (line 36), in some detail. The use of laughter and a confession of being nonplussed is to some extent compatible with Mike as NOT-STAFF (and Stuart as NOT-MAD/EXPERT VOICE HEARER). However, it can also be taken as invoking PSYCHIATRIC STAFF/ThERAPIST and at least partially alluding to Stuart’s MAD SELF. How is that so? What might be taken as a confession by Mike of his own shortcomings concerning knowledge about voices can also be taken as a veiled critical evaluation by a psychiatric professional of Stuart’s ability to have a rational understanding of reality. This implied evaluation clearly distinguishes between PSYCHIATRIC STAFF/ThERAPIST and PATIENT/CLIENT on the grounds of sanity.

Stuart’s response in line 40 confirms that a negative evaluation has indeed taken place. In his receipt of Mike’s turn, Stuart provides a reformulation of the events in question, countering the implied criticism by attesting to his ability to know how simple the situation really was. Mike then does a THERAPIST job of aligning the topic of conversation back with the present. His action is softened by his alignment with Stuart’s original phrasing of telling the voices to get lost (line 2 & 46).

We are now in more of a position to consider further how and to what ends some of these identities operate in the data corpus. Given that the patients are generally constructed as being in subordinate identities compared to therapists, the contrast - direct and implied - between a NOT-MAD/EXPERT VOICE HEARER and a MAD OTHER allows the patients to at least maintain their own sanity status as (having
always been and becoming more) rational, knowledgeable, in control of self, and knowing about what constitutes ‘real’ madness. Although they are in many ways opposites, NOT-MAD and EXPERT VOICE HEARER are identities which (as they are in this data at least) can slip away to permit the occasioned adoption of the highly subordinate identity of a PATIENT who is seeking professional help.

The distinction between PSYCHIATRIC STAFF / THERAPIST and PATIENT / CLIENT allows the therapists to maintain their dominant sanity status. At the same time, the voice hearers, as PATIENTS or as less subordinate CLIENTS, can be constructed as becoming more rational, knowledgeable, and in control of self. Constructing voice hearers, as EXPERT VOICE HEARERS - as being currently very much more independent and able than PATIENTS - undermines the therapists’ position as professionals. As PATIENTS and CLIENTS, the voice hearers’ improvements (past, present, and future) are constructed overall as being through the application of professional knowledge: the professionals are very much required. PATIENT, CLIENT, THERAPIST, and PSYCHIATRIC STAFF all involve a management of tensions in which the voice hearer varies from being somewhat agential and responsible for their own individual change to being barely so, but is always at least somewhat controlled by a therapist. EXPERT VOICE HEARER, such as it is in this data, is only a fleeting break away from such social control. Nevertheless, during an EXPERT VOICE HEARER’S moments of excluding professionals and their co-identities, it is more of a break away than NOT-MAD.

Two further identities are, on occasions, constructed by the voice hearers to occupy a similar position to MAD OTHER, below PSYCHIATRIC STAFF, THERAPIST, CLIENT, and PATIENT. These are MAD SELF (PAST) - certain constructions of the voice hearer’s self in the past - and MAD SELF (FUTURE) - certain constructions of the voice hearer’s self in future. These latter two identities are utilized when NOT-
MAD, etc, will not do the task at hand. Either kind of MAD SELF may be invoked, for example, by a patient to counteract a therapist’s construction of their problems with voices as being minimal. MAD SELF, then, may be seen as the voice hearer being constructed as an extremely ill PATIENT. On other occasions, MAD SELF may be invoked to evidence therapeutic change, as a contrast to a rational, present self. Even MAD SELF in the past, however, carries the penalty of implying the possibility of MAD SELF in the present and/or future: identities which have the lowest sanity status of all for the hearing voices group members.

**Normality-abnormality continua**

Perhaps it also makes sense to consider the sanist hierarchy as a normality-abnormality continuum in action, a quasi continuum. The hierarchy has the ‘them and us’ dichotomy between ‘normality’ and ‘abnormality’; it has the sliding between sometimes vaguely delineated identities; it is in many ways nonsensical; and yet it gets a lot of work - a lot of social control - done. The EXPERT VOICE HEARER identity, however, operates outside of the hierarchy; but it does not seem to hold much favour in this kind of hearing voices group.

**SECTION 6.  CHAPTER SUMMARY**

Now that we have started to look, this data is so much about hierarchy and identities on the basis of a person’s rationality and sanity; in many pervasive, sometimes subtle, yet powerful ways. From this perspective, the hearing voices group data concerns the invocation of the *negatively* evaluated identities of PATIENT, MAD SELF, and MAD OTHER. It concerns the *positively* evaluated identities of PSYCHIATRIC STAFF and THERAPIST. Then there are the identities, NOT-MAD and NOT-STAFF, and
EXPERT VOICE HEARER and NON-VOICE HEARER. These interactions are about the oppressive and counter-oppressive work which is done by these identities in and through talk, as much or more than they are about people talking towards achieving a personally integrated understanding of hearing voices experiences. This data shows sanist prejudice-in-action. Strangely though, even in this, it takes two to tango: PSYCHIATRIC STAFF/THERAPISTS require PATIENTS/CLIENTS, and vice versa.

I began the chapter by introducing the notion of sanism and omni-relevant devices and their pervasive distinction throughout the data in terms of constructions in-sanity and ir-rationality. We went on to analyze three prejudice-related issues: omni-relevant devices, not-so positive therapist actions, and negative evaluation responses. It was argued that two different collection K, omni-relevant devices operated in a tense union throughout the data. These were PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT, as demonstrated in sections 1 and 2. In the course of my analyses, I utilized topic-action and topic-presentation distinctions to assist in the analytic ascription of identities. We saw the functioning of each omni-relevant device when it was made pertinently absent and then reinstated by interlocutors.

On examination, it appears that the ‘unholy’ collection K ‘alliance’ between the identities of PSYCHIATRIC STAFF and THERAPIST entailed considerable problems for the therapists to coherently manage expounding the tenets of both professional disciplines. This is illustrated by the fact that, in my analyses, THERAPIST + CLIENT is both a cover for PSYCHIATRIC STAFF + PATIENT and an omni-relevant device. In theory there is a clear distinction between PSYCHIATRIC STAFF and THERAPIST identities, but in practice the distinction is far from clear. Indeed, the therapists present themselves as respecting the voice hearers as CLIENTS (in so far as that is supposed to include more respect in CBT, for the rationality and agency of the CLIENTS, than in psychiatry), but without directly challenging the tenets of orthodox psychiatry (that the
PATIENTS are, overall, irrational and that their problems are rooted in biology). This is not to say that clinical psychology does not carry such a tension intrinsically within the discipline itself (given its own foundations on the medical model) (see Boyle, 2002b), but that aspects of the data are made clearer by an analytic distinction between THERAPISTS and PSYCHIATRIC STAFF and between CLIENTS and PATIENTS.

Regardless of the distinction, however, it is concluded that these instances of collection K included professionals who, as they were bound by their available identities, were inadequate in the way that they met accounts of human distress with a dominant, formal approach. In contrast, EXPERT VOICE HEARER emerged as a voice hearer identity which fully - though all too briefly in the hearing voices group - departed from/breached the controlling omni-relevant devices. It did not fit the institutional-sanist mould; it escaped the ‘rationality trap’ (Harper, 1999). But, as such, it was not supported by the therapists and patients alike.

We also considered the not-so positive therapist actions of ‘not-so-normal-ization’ and ‘not-so-positive discrimination’. These were defined as occasions in the data when supposedly therapeutic actions turn out to support or at least to insufficiently challenge actions on the basis of the sanist, supposed normality-abnormality of people. Surely that is a counter-aim to therapy.

What I call ‘negative evaluation responses’, from voice hearers, were then examined, as a response to the ever-present sanism. In the data, we found examples of each of the five responses, in connection to sanism, which were first posited in relation to research on racism.

Finally, three further understandings of the data were added: (1) that the rationality of the voice hearers required pasting-in (ie, it is not a given as it is for others), (2) that the identities with which we have been concerned - besides EXPERT VOICE HEARER and NON-VOICE HEARER - operated within and furthered a sanist hierarchy, and (3)
that there was a normality-abnormality continuum in operation in the hearing voices group.

In this final data chapter of Part 2, and of this dissertation, I have tried to demonstrate sanist privilege and prejudice in psychiatry and psychology from a number of different perspectives. Each vantage point, I suggest, attests to the inequality of social power which was prevalent in the particular hearing voices therapy group that was studied. In the next chapter, we place this data in the context of the rest of this dissertation and in the context of changing to more positive practices.
CHAPTER 8. CONCLUSIONS

SECTION 1. VOICES THERAPY IN CONTEXT

Socrates in asylum?

Hearing voices experiences are predominantly constructed in contemporary Western society as ‘auditory hallucinations’: problematic at best, ‘schizophrenic’ at worst. Indeed, along with what psychiatry and psychology call ‘delusions’, hearing voices is widely described as a first-rank ‘symptom’ of ‘schizophrenia’ or a ‘symptom’ of some other ‘severe mental illness’. A large proportion of diagnosed people then remain designated as ‘ill’ and associated with ‘mental health’ systems for the greater part of their lives (Coleman, 1999; Thomas, 1997). Such voice hearers typically lose much of their autonomy to the care of family and professionals.

The Diagnostic and Statistical Manual of Mental Disorders (currently DSM-IV-TR, APA, 2000) is based on individualism and medicalization, including choosing to infer ‘mental illness’ from reported experiences and, more so, from observations of behaviour. The biopsychiatric sentiments behind the DSMs tend to dominate our descriptions of what constitutes a person’s distress and atypical behaviour. Social context and personal meaning are given little credence in affecting behaviour and, thus, in playing a causative role in relation to ‘symptoms’ (Crowe, 2000). Focusing on biological/medical/genetic factors may serve various functions, including undermining potential blame which may be levelled at the authorities, service users, their families, and society in general (Boyle, 2002b). This tendency in psychiatry and wider society
has continued despite the work of researchers such as Boyle (2002b), in criticizing the ‘concept’ of ‘schizophrenia’, and Romme and Escher (2000), who have done much to evidence the role of what they call traumatic life events in the onset of hearing voices. Diagnostic systems are prescriptive, restrictive, and morally evaluative of what they hold to constitute ‘normality’ and ‘abnormality’.

It is ironic that diagnoses of ‘mental health’ problems are generally on the increase, despite, or because of, the march of medical and pharmaceutical interests (Double, 2002). Yet blame is seldom levelled at the medicalization of distress and the role of institutional practices in the marginalization of people who report bizarre and/or distressing experiences, and exhibit ‘problem’ behaviour. Instead, the dominant discourse of psychiatry is seemingly softened, yet served, by increases in ‘user friendliness’ and ‘access to services’, desperate calls for more funding, and the ongoing promise of ‘better treatments’ which are ‘just around the corner’. Social control can thus be achieved (cf. Laing, 1967; Szasz, 1976; Gosden, 2001). It seems that Socrates, that brilliant philosopher from antiquity who reported hearing an unconventional, divine voice, may not have fared so well either in this ‘enlightened’ era of ‘progress’ and (post-)modernity.

I am not wanting to over-use the comparison between Socrates and the contemporary voice hearers in my data but it is worth highlighting, at this stage, the high levels of competence which are evidenced by the hearing voices group patients. Remember, these are people ‘in question’, those who ‘have’ ‘severe mental illness’ (whatever that may be).

This dissertation has examined different ways of representing experiences which are often known as ‘mental illness’. It is about whether it is tenable for reports of experiences, such as hearing voices, to be predominantly connected to a biological frame of reference, to be seen almost exclusively as ‘symptoms’ of ‘mental illness’. I
believe that my case in point - hearing voices and the ‘illness’ with which it is most commonly associated, ‘schizophrenia’ - is a strong case in showing that professional representations of phenomena related to human distress are, and always will be, hugely inadequate. So-called ‘delusions’ are perhaps a tougher case to crack, culturally, to sever the ties with orthodox psychiatry. However, most or all of the arguments relating to hearing voices also apply to ‘delusions’, just as many of the arguments pertain to all of the so-called ‘symptoms’ of ‘mental illness’. I have argued throughout this dissertation that to maintain a dominant biomedical view (or any dominant view) of understanding and dealing with people’s reported distress and bizarre behaviour misses too much of the personal and interpersonal aspects of people’s experiences/accounts. That, I hold, has been borne out in the data. I suggest also that this missing understanding applies to secondary consumers in addition to primary consumers.

This thesis has concerned the relationship and non-relationship between hearing voices and ‘schizophrenia’. I have also looked at aspects of a cognitive-behavioural therapy group for hearing voices. With a particular interest in hearing voices, critical assessments were conducted of psychiatry and ‘schizophrenia’; including those ‘mad scientist’ constructions, normality-abnormality continua. In Part 1 of the dissertation, a number of psychiatric and psychological texts about ‘schizophrenia’ and hearing voices (as a ‘symptom’ of ‘mental illness’, and otherwise) were summarized and analyzed. In Part 2, transcripts of talk from a therapy group for hearing distressing voices were analyzed. It is remarkable just how many of the issues raised in the psychiatric and other texts of Part 1 were played out in the talk-in-interaction of Part 2. I take this to be confirmation of my ‘findings’ rather than an indication of dubious methods.

Caution should be exercised in comparing different texts and different examples of talk-in-interaction. However, it is worth making some general comparisons, here, given the institutionality which is common throughout. The interaction in the hearing voices
group data represents an instantiation of the official psychiatric texts, and, in turn, the CBT for ‘psychosis’ manuals, which were analyzed in Part 1. The similarities between what my analyses have revealed as being performed in the theoretical therapy texts and in the actual interaction of the hearing voices group hold in terms of both general professional-patient relations and the minutiae of therapy practice. That is, according to my analyses, the therapists and the patients did what they were officially supposed to do: they enacted the provision and receipt of a professional service - a treatment - by the therapist to the patient. We have seen this treatment, cognitive-behavioural therapy, for ‘psychosis’, as a largely pre-formed, professional-led, far from perfect mix of psychiatry and psychology. It involves managing a tension between categorizations of voice hearers as passive or active, ‘abnormal’ or ‘normal’: it operates along sanist lines. Patients are deemed to be of questionable sanity a priori and they are treated accordingly.

One response to this thesis, then, might be to maintain that psychiatrists and cognitive-behavioural therapists are just doing what they are supposed to be doing, so why criticize them? On one level, the first part of this statement/question is correct, in so far as I explained, above. However, my reviews and analyses have shown that there are important, ungrounded, a priori assumptions - for example, concerning the ‘rightness’ of professionals, and the sanity of patients as questionable, in dealing with ‘symptoms’ and more generally - which are not made explicit in official texts or therapy practices. How can such actions - such duplicity, prejudice-in-action, and disregard for valid sources of information in relation to the people who report first-hand experience of the phenomena, the people being ‘assisted’ - how can this be to the long-term benefit of voice hearers and society? It cannot.

As a critique of ‘schizophrenia’ and ‘mental illness’, this study represents a data-based accompaniment to the works of Boyle (2002b), Johnstone (2000), and Gosden
(2001). Notwithstanding my focus on ‘schizophrenia’ and ‘mental illness’, and my closer presentation of data, this dissertation is also roughly modelled on Leudar and Thomas (2000): the initial grounding in history, the pre-eminence of accounts from first-hand experiencers, and the promotion of dialogue when representing hearing voices, distressing or otherwise.

I believe that my dissertation presents a valid version of an overall picture of problematic social events in the hearing voices group therapy sessions. That is not to say that other, more positive, pictures would not have also been valid. Similarly, in the first part of the dissertation, I believe that I have presented valid overall pictures of written representations of ‘schizophrenia’ and hearing voices: of the dominant, professional psychiatric position of ‘mental illness’ and of professional and voice hearer alternatives. We shall soon consider how these snap-shots inter-relate.

But why have I been so very critical in my consideration of psychiatry and psychology? By casting a critical eye and learning more about how negative interactions occur in ‘clinical’ encounters we are more likely to understand whether and how they might contribute to other negative actions and inactions; how they help to maintain economic and social inequities for people who hear voices and people with psychiatric diagnoses. We might also gain different understandings of how such interactions could be improved. As I have tried to show in this study, the way in which the phenomena in question are categorized seems to have a two-way bearing on how those who experience such phenomena - the people in question - are treated. That is, this can impact at both the macro-social and the micro-social level of human existence. For example, in Part 2, we saw some evidence of social inequities in interaction, examples which might add to negative experiences elsewhere to have a profound impact on the stigmatized person’s existence.
In addition to their other shortcomings and benefits, I have argued that medically-derived descriptions of ‘mental illness’ can only ever be based on assumptions of quasi-continua rather than the ‘true’, linear continua on which they are purported to be based. Conceptually, such representations involve an inescapable impossibility, since a ‘true’ continuum can only represent *quantitative variations* in a *single quality*. Nevertheless, normality-abnormality continua all enact a nonsensical overlaying of a *qualitative dichotomy* between ‘normal’ and ‘abnormal’ with a supposedly *quantitative continuum* between those qualities. Indeed, ‘normality’ and ‘abnormality’, generally, seem to be red herrings with ‘mental illness’, obscuring what boil down to moral, prior evaluations and subsequent evaluations-in-action. In this sense, the ‘problem’ with ‘schizophrenia’, the discrepancy, is more to do with establishing how to judge others and treat people differently, rather than some inherent ‘abnormality’. Unfortunately, such critical understandings do not yet seem to have restricted the psychiatric use of the biomedical when dealing with human distress.

**Representations in question**

Beginning with the examined psychiatric and psychological texts, I now compare representations of the phenomena in question from the first part of this dissertation with those described in the second part. The orthodox psychiatric texts were all found to contain implicit continua between ‘normality’ and ‘abnormality’, which uphold the medical model. I have further demonstrated that the views of professionals tended to be privileged over others, especially over those people who have the most direct experience of the phenomena in question. Normality-abnormality continua are conceptually nonsensical: they represent different qualities (whatever they may be) on the same quantitative continuum. Moreover, rather than simply helping, they add to
prejudice-in-action against those who are deemed to be never quite ‘normal’ in their behaviour, biochemistry, rationality, and rights.

In my analyses of hearing voices group data, I have explicated the operation of the omni-relevant device, PSYCHIATRIC STAFF + PATIENT. I have argued that this institutional device was frequently covered with the identities of THERAPIST + CLIENT (which was also institutional, also an omni-relevant device) and with NOT-MAD + NOT-STAFF (also institutional, but much less apparently so). Furthermore, those identities tended to eventually lapse into the PSYCHIATRIC STAFF + PATIENT default. Such chopping and changing of identities may be, at least in part, a consequence of the incoherencies involved in enacting a normality-abnormality continuum regarding rationality/sanity. I have also argued that the professional identities, the super-sane, if you like, were at the top of a sanist hierarchy. In this way, supposed rationality, as ‘normality’, was socially evaluated as being better than supposed irrationality. Thus, in practice, the cognitive-behavioural therapy group operated on much the same fuzzy, yet ultimately firm, divide as biopsychiatry.

How do the texts on CBT for ‘psychosis’, in their presentation of psychological theory and practice, compare to the orthodox psychiatric texts and the hearing voices group data? Overall, ‘psychosis’ was constructed in the CBT texts as being considerably more to do with ‘normal’ psychological processes than psychiatry-proper. In line with this, the CBT texts present ‘normalization’ and ‘Socratic’ questioning, overall, as positive and helpful practices. For example, even when cautions are added about Socratic questioning, that mainstay of cognitive therapy, there appears to be a general assumption that when the procedure is performed correctly then changing someone’s mind in such a way is a good thing. This belies the way in which such procedures are, more or less, prescribed and administered by the professional to the client. The contrived or selected examples of ‘normalization’ and Socratic questioning in the
textbooks, however, can be seen to present ‘clinical’ neatness and effectiveness, along with a presented respect for diversity of views. Moreover, ‘normalizing’ accounts of ‘psychosis’ serve to balance and conceal the pathologization which occurs, even in these psychological texts. Normality-abnormality continua are ever-present in these accounts.

On the surface, then, the official texts paint a generally rosy picture of help in the clinic. For example:

Generally, it is useful to be open and honest about what the therapist’s perspective is. However, the patient’s perspective needs to be respected, and the patient assured that they are not going to be pressured or bullied into accepting the therapist's viewpoint.

(Fowler et al., 1995: 78)

In contrast, issues of ‘leading the witness’, ‘positive’ discrimination, even oppression, were played out in the hearing voices group. These occasions might have involved professionals ‘listening’ to patients or engaging in ‘Socratic’ questioning, but they were shown clearly to be part of pedagogical sequences. This occurred in the overall ‘negotiation’ of experiences, as the professional view versus the personal view, especially between the therapists and Stuart. Here, the chops and changes of interaction were very much in evidence. For example, explicitly stated or implied beliefs sometimes varied on a move and counter-move, turn-by-turn basis. But there was also an often overbearing institutional asymmetry in action. The resulting competitive mish-mash tended to be quite unlike ‘clinical’ precision and ‘fair play’. The same was true for the analyzed example of not-so-positive normalization.

Of course, one might argue that the patients in the hearing voices group were all voluntary and seeking professional assistance/leadership. Perhaps also the therapeutic ‘medicine’ was worth it, because of its effectiveness or potential, regardless of what some might take to be the bitterness of the pill. However, there may be other ways in
which the same or better could be achieved. Without more lay-to-professional dialogue, and more interdisciplinary dialogue, we will never know.

In my analyses of official texts, I have described therapists as needing their patients to be sufficiently irrational and patient-like to warrant therapy (yet sufficiently calm and compliant to be ‘led’ by a professional and also sufficiently rational to ‘be’ a cognitive-behavioural therapy client). That is, therapists and patients are, in a sense, mutually constitutive (they are two sides of the same coin), just as I have shown ‘normality’ and ‘abnormality’ to be. In the hearing voices group data, we came upon the identities of PSYCHIATRIC STAFF + PATIENT, THERAPIST + CLIENT, and NOT-MAD + NOT-STAFF, according to the participants’ concerns-in-action. There was also the relationship between MAD SELF, NOT-MAD, and MAD OTHER. The co-identities of each pair can be considered to be ‘the other side of the coin’ for their respective co-identity. In my consideration of identities in therapy, I focused on (the sufficiently critical) actions of privilege and prejudice. These also are two sides of the same coin.

In Part 1, I began to suggest, in connection to the CBT manuals, that there exists a tension for therapists between utilizing the psychological model (ie, mentalism) and the medical model (ie, based on physical disease). However, it was argued that these two positions can largely co-exist, with their individualist assumptions and with psychological deficit standing in for, or alongside, disease. It was also argued that psychology is an addition to psychiatry and that, as an adjunct more than a challenge, it can function as a ‘nice’ shiny coating for orthodox psychiatric business. For example, according to Fowler and colleagues, the acceptance of psychotic illness, the finding of a ‘middle road’,

...may involve making adjustments to lifestyle and behaviour, taking medication, using the services of health professionals, while otherwise seeking to maximise independence
and maintain a personal identity separate from that of a person with chronic mental illness.

(Fowler et al., 1995: 27)

This characterizes Stuart in the hearing voices group very well. But what were the professionals in the group doing to really assist him to “maximize [his] independence and maintain a personal identity”? Rather, we saw many of these issues played out in the hearing voices group, with tense unisons within and between the omni-relevant devices of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT. Pathologizing psychiatric distinctions, rather than ‘normalizing’ psychological distinctions, were found to be the ‘bottom line’.

Turning to the critical alternatives to ‘schizophrenia’ and ‘mental illness’ which were reviewed, my hearing voices group data confirms that there is more than ‘a grain of truth’ to many of those approaches. Some of the critical alternatives from Part 1 were barely touched on in Part 2, but others appeared as the topic and/or the actions of talk. For example, issues of social control, the moral perspective, the spiritual/existential perspective, the importance of social context, voice hearer perspectives, and service delivery in practice were all raised in connection to the hearing voices group. Nevertheless, the explicit consideration, rather than the enaction, of such matters tended to be officially avoided.

I have criticized ‘normalization’ for the way in which it can form part of the control of talk towards professionally sanctioned ‘therapeutic’ matters, and serve as a ‘cover’ for biopsychiatry. It was also argued that examples of not-so-normal-ization can do even more in those directions. Such professional-led control is likely to reduce support for concepts such as radical self-autonomy, telepathy, or magic, which do not conform to officially sanctioned frames of reference.
Indeed, the more radical user groups and texts (as exemplified by the Hearing Voices Network), in contrast to ‘towing-the-line’ cognitive-behavioural practices, are perhaps the best sources of inspiration for improving on the PATIENT and NOT-MAD identities which appeared in my data (ie, for fostering sustained independence from being a passive PATIENT). Being listened to and supported under the guise of being NOT-MAD still has the drawback of a MAD PERSON/PATIENT identity beneath the cover. Whilst no identity can be a panacea for all concerns, being some other kind of MAD PERSON, an ORDINARY PERSON, or an emancipated EXPERT VOICE HEARER, would presumably be more desirable. Such autonomy need not be restricted to voice hearers alone. It can, of course, apply to other experiences; other groups of people.

Let us now revisit the review of discursive studies of ‘severe mental illness’. In my summary of Smith (1978), it was described how the interviewee (K’s friend) went through a process of ‘cutting-out’ K from ‘normality’. That is, initially K was constructed under an assumption that she was ‘one of us’ (ie, rational/sane by default). However, she became constructed increasingly as more like ‘one of them’ as the interview progressed. In relation to the hearing voices group data, it was posited that, in contrast to K, the hearing voices group patients required ‘pasting-in’. That is, they were constructed from the outset under an assumption of being one of ‘them’; irrational/insane by default. This may reflect a difference between the way in which ‘schizophrenia’ tends to be represented, compared to ‘less severe mental illnesses’.

We have also seen how Harper (1999) described a ‘rationality trap’ in which the people whose sanity was very much in question tended to work towards presenting themselves as hyper-rational which tended to result in drawing attention to the issue of their rationality, or lack thereof. This notion turned out to be extremely pertinent in my explication of how the hearing voices group patients were concerned with managing the
tensions between being a PATIENT, a CLIENT, and being NOT-MAD. These were to some extent mirrored in the tensions which are part-and-parcel of the therapists’ attempts to manage each of their respective therapist co-identities (ie, PSYCHIATRIC STAFF, THERAPIST, and NOT-STAFF).

Georgaca (2000) analyzed talk in which reality disjunctures could not be resolved without the denigration of one of the participants involved. Similarly, I have described the invocation of PSYCHIATRIC STAFF + PATIENT as a fall-back position for the general resolution of reality disjunctures, in which the latter party is denigrated.

Georgaca (2000) also found the patients in her data to be socially competent. This contrasted with Palmer’s (2000 and unpublished) psychiatrically skewed finding that the patients in his data evidenced systematic inadequacies in social interaction. In contrast to Palmer, and in keeping with Georgaca, the hearing voices group data demonstrated that the patients exhibited considerable social skills, under the often very trying social circumstances of systematically sanist, clinical interaction.

In my review of Palmer’s approach, I argued that what he took to be specific social incompetencies should, instead, be taken as patient non-conformity and its professional non-uptake. Similarly, in my hearing voices group, there was evidence of situated partial non-conformity through invocations of the NOT-MAD identity and, better still, the EXPERT VOICE HEARER identity. As with Palmer’s data, the professionals in the hearing voices group did not tend to take-up, but rather sometimes ‘played along’, with many of the issues raised as patient concerns. Professional messages about the ‘right’ and ‘wrong’ ways to deal with the phenomena in question - to behave generally, to be generally - dominated the interaction.

Palmer (2000) wrote about studying the actual practice of diagnostic procedures, although I claim that, in a sense, what he was studying is better considered to be diagnosis-maintaining actions on the basis of a largely prior (moral, social) diagnosis.
The same can be said for the sanism-in-action which was evidenced in my data: it occurs post-diagnosis (ie, it is an example of prejudice), it perpetuates the diagnosis, and both the diagnosis and its maintenance boil down to moral choices of ‘good’ versus ‘bad’.

Largely in connection to non-uptake, I also criticized Palmer and the professional in his data for tiptoeing around the subject of madness. Moreover, I claimed that their negatively evaluative practices were hidden behind social niceties and that both the evaluations and the niceties perpetuated what must surely have been some kind of prior diagnosis. In my analyses of the hearing voices group, such tiptoeing was considered in terms of not-so-positive discrimination; the hiding, in terms of cover identity/ies; and the whole interaction, in terms of the omni-relevant device of PSYCHIATRIC STAFF + PATIENT.

I have argued that analysts’ theoretical concerns may overshadow participants’ concerns. This was apparent with Sass’s use of phenomenology (though his was not a discursive study) and Palmer’s use of psychiatry. Am I guilty of such overshadowing practices, albeit that I am swayed more by critique of therapists than prescriptions for clients? I suggest not, despite my tendency to summarize findings before presenting data. One benefit of such summarizing or theorizing is that it speeds things along. One of the disadvantages is that the data can ‘fly by’ on the way to the pre-planned ‘destination’ (ie, it speeds certain selected ‘things’ along and into being). I have attempted to find a suitable trade-off between the two distinguishable but related positions (rigour and rhetoric), to suit my stated and, I consider, worthwhile purposes. Either approach may strike valid positions on what they look at, how they look, and what they find. That does not mean that anything goes: there is still rigour and rhetoric, rigour as rhetoric, and vice versa.
How else does each half of this dissertation relate to certain analytic methods and parts of the ‘central analytic record’? Collection K was very evident in the hearing voices group data. I have tried to show how the identity pairs of PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT were established on the basis of institutionalized sanism and not just in terms of areas of specialist knowledge, getting the helping job done, and the like. Otherwise, one would have thought that the voice hearers could have been recognized more fully for their specialist knowledge, as EXPERT VOICE HEARERS. If that had been so, then, on occasions at least, the expert plus non-expert pair might have been reversed in a sustainable way from PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT to EXPERT VOICE HEARERS + NON-VOICE HEARERS. Sacks’ membership categorization analysis, including his work on doing ‘being ordinary’, omni-relevant devices, and cover identities contributed greatly to my analyses in these areas.

Similarly, I argue that the hearing voices group interaction was not all under the auspices of the institution of ordinary conversation but that there were extra-institutional rules in operation (ie, the rules of doing ‘psychiatry’ and ‘psychological therapy’), the understanding of which was enhanced by the analytic/discursive use of cultural knowledge in addition to analyzing participant practices and concerns.

Let us consider certain aspects of data type and how that fits with choice of analytic method. The hearing voices group data is not the stuff of classic discourse analysis. For example, it is not the kind of data which Wetherell and Potter (1992) worked with; data from interviews where the researchers set the main topics of talk to match their interests. The data in Part 1, however, was set on the topics of interest by the authors of the various texts. The hearing voices group data topics were also set by the dominant participants (ie, the professionals, akin to the authors in Part 1) but this time there was some co-construction of topics with the patients, plus some patient topic selection. It
was both a potential drawback and a strength in this study that one of the dominant participants in the hearing voices group was the analyst in this dissertation.

The texts in the first half of the dissertation were, in some ways, analyzed as if they were turns in wider cultural and sub-cultural interactions. Thus, my analyses relied on a wider take on context, to make sense of what I took to be the performative aspects of the data. However, unlike CA, despite being informed by the kind of detailed analysis which CA provides, the analyses in Part 1 did not have the benefit (some would say, necessity) of the next turn proof procedure which comes with interactional data.

The hearing voices group data, unlike the data in the first half of the dissertation, was clearly interactional. Another point of difference is that the group data was ‘naturalistic’ (since it would have occurred even if it were not audio-recorded for study; see Potter, 2002, and Hepburn & Potter, 2003). The group data analyses, with their CA-style transcripts, were somewhat like CA in their rather more micro-social, turn-by-turn approach. However, a macro-social, cultural, critical context (á la Part 1) was very much invoked analytically to complement a more local understanding. Thus, CA-inspired DA and MCA were employed, to critical ends.

This dissertation demonstrates that there need not be a sharp divide between CA and DA. Rather, one can variously blend the two approaches, occasionedly. Each method has its general trade-offs and analyses should be judged within their local context and for the work that they do, rather than pre-judging one method to be better than another.

Finally for this discussion of representations, let us consider some of the items on the cutting room floor; in particular, the issue of discourse analytic interpretive repertoires (Wetherell & Potter, 1992; Antaki et al., 2003) in relation to voice hearer accounts of hearing voices. Voice hearer accounts were not a focus of this dissertation. Whilst being highly complementary to an understanding of professional representations, that would have opened up another expansive line of interest. However, some voice
hearer ‘discourse’ did appear in the group data. For example, there was a relatively encapsulated example of what could be termed ‘biomedical discourse’ (Extract 7.15A & B) and ‘storm discourse’ (Extract 7.19). If it had been a focus, I might have begun an investigation by collecting further examples of such hearing voices discourse and anchored my analysis in interaction, as is (now more then ever, it seems) encouraged by Antaki and colleagues.

**Methods of social change**

I am not wishing to undermine the (potential) social action contained within the overall direction of this dissertation, but will it be taken as more than ‘just words’? My thesis question involved the investigation of how professionals represent ‘schizophrenia’ and hearing voices in theoretical texts, and how that is played out in therapy practices. Along with the *explication* of representations, however, I have also been *critical*. Current dominant approaches to the phenomena in question are highly dismissive of the inter-personal, and much of the treatment which occurs in the name of psychiatry and psychology is oppressive and not in the long-term best interests of the people who are on the ‘receiving end’. This thesis, then, has also entailed a search for non-prescriptive alternatives, and, whilst it has been concluded that no single representation of the phenomena and those who experience them should prevail, respectful dialogue with the personally experienced and a consideration of the inter-personal have been advocated as important, typically missing, ingredients for how to proceed. But this is an ongoing thesis question, and what will become of it?

Conclusions, recommendations, and future directions will be discussed further in our final section. For now, let us discuss this prospect of social change a little more generally. What of the practical application of these methods for criticism; what might come of them? For example, is there much hope, at the level of personal change alone,
of largely reformed psychiatric interactants, of less prejudiced professionals and less
privileging by patients, following a reading of such critical works as this? In connection
to racism in New Zealand, Wetherell and Potter (1992) do not seem to hold high
expectations: “in the end we are not convinced that individual psychological change
generates economic and social change” (p. 217). They reach the same conclusion
regarding sexism:

Men are clearly guilty, who can deny that? But is it their weakness as human beings,
the unendearing traits and unpleasant little habits which cause the oppression of
women? Some would argue these failing are precisely the problem and a little painful
self-probing is exactly what is called for, and certainly these traits are constituted
through patriarchy. But can men be ‘reconstructed’ so easily without large-scale
changes in the social relations of gender? While self-critique, confession and soul
searching are important and make life better for individual men and women, do these
therapeutic practices overthrow patriarchy? Will the growth of a cadre of ‘new men’ or
cleansed Pākehā New Zealanders be sufficient in itself to change the lot of substantial
groups of women and men or substantial groups of Māori and Pākehā? From a different
perspective, it could be argued that, as with social mobility afforded the working class
within the educational system, a few can move ‘upwards’ but mobility is not possible
for the working class as a whole without radical change in social organization.

(Wetherell & Potter, 1992: 217-219; emphases added)

Similarly, with our data, the problem is not just within psychiatrists, therapists, their
patients, and their clients, or even within psychiatry and psychology more generally.
Studies such as mine merely highlight one arena in which the problem is played out and
one arena in which something can be done about it. But much needs to be done about
enacting respect for diversity. Much needs to be done about bringing to an end the
perpetuation of ‘schizophrenia’ and its continuing-to-be-pathologizing offspring. And
much needs to be done about re-evaluating and re-constructing what some take to be ‘mental illness’ and psychological ‘abnormality’; at all levels of social organization.

Wetherell and Potter (1992) caution about using prejudice-in-action to combat prejudice-in-action, thereby perpetuating problematic discursive moves (p. 218). This is something to which this dissertation comes perilously close. However, they also hold to the value of logical disputation (my words) with the actual practices of discourse at “those points of fracture and contradiction... [in which] there is scope for change and the redirection of argument” (p. 219).

The authors of *Mapping the Language of Racism* add one final leveller (but not a moderate one) to bring these aspects of social change together into “critique around local action around specific issues” (p. 220; my emphasis). I shall generalize their quotation of Gilroy (1987) to all programs of individual change with global ambitions towards utopia, towards

...harmony on a grand scale. Paul Gilroy (1987) has argued that, in contrast, the appropriate anti-racist strategy is both more extensive and more modest.

More modest because these struggles define themselves by their relationship to the everyday experience of their protagonists and the need to address and ameliorate concrete grievances at this level; more extensive because an elaborate and sophisticated critique of social structure and relations of contemporary capitalism has been a consistent if not a continuous feature of the ‘racial’ politics and culture from which these struggles have sprung. These two tendencies shape each other and their reciprocity dissolves the old distinction between reformist and revolutionary modes of political action. (1987, p. 116).

(Wetherell & Potter, 1992: 219-220)

There is also Potter’s own (not exactly Wetherell and Potter’s) description and criticism of anti-constructionist anti-criticism, his description and criticism of critical discourse analysis, and his arguments and dilemmas for criticizing fact constructions (1996: 218 ff.). Potter concludes with a celebration of the tension and debate between the various approaches as being productive in itself, although he acknowledges that such a conclusion, in itself, enacts a rather post-modern approach (p. 232). To take a stance,
one way or another, is inevitable, as I argued in my critique of Coulter on the myth of ‘schizophrenia’.

**Section summary**

In this dissertation, we have seen the phenomena in question appear in various guises, each more or less attested to by their proponents as the way the phenomena *are*. Besides conceptual criticism of many of these positions, we have also considered the various views as social action; social constructions. Most prevalent were the constructions of pathology and deficit; which we saw as, amongst other things, (co-)produced evaluative practices with prejudice-in-action. That is, we considered the phenomena not as inherent cognitive, biological, phenomenological, or social pathology, but rather as being constituted from and for situated, occasioned inter-action. Second, we have seen such phenomena being constructed as ordinary, ‘normal’ experiences. Third, they have been constructed as extraordinary and unusual; even supernatural. These various versions have been used in professional, patient, and service-survivor accounts in a three-way varying mix. Each of the three can be evaluated as ‘good’ or ‘bad’, etc, depending on requirements. Even pathology can be ‘good’ in action; that is, effective in terms of discursive use. With the tricks of construction, the same ‘thing’ can be either pathology, ordinary, or extraordinary; or such versions can be allotted to ‘different things’; to build a version of self- or other-in-reality. But some versions carry more social weight than others and some are used in an institutionalized perpetuation of social power asymmetries. Should any one kind of representation be allowed such domination over valid and useful views? Surely not.

How did these categorizations of ‘schizophrenia’, ‘mental illness’, and hearing voices fare in this study? A variety of analytic methods were employed; a critical, CA-inspired blend of DA and MCA. With these methods and with evaluations of ‘the
findings’, ‘schizophrenia’, ‘mental illness’, and even ‘hearing voices’ were all found wanting in one way or another. The use of critique was found wanting but worthwhile. Cultural knowledge for critical ends needed to be carefully managed so as not to offset its tension with empiricism. Overall, after careful and critical consideration of both the mainstream and alternatives, there is no compelling evidence to suggest that biopsychiatry should dominate, as it does, in this area of human experiences.

SECTION 2. BEYOND WORDS AND PAPER

We have examined reported phenomena which are taken to be the divine, the ordinary, mental pathology, and continua with normality. There are historical perspectives, conceptual perspectives, existential journeys, morality, and views of social control. There are contextual considerations, voice hearer experiences, practical applications in mental health services, reality negotiations, and sanism-in-action; a staggering array of options and actions.

We have seen aspects of the dominant psychiatric position and psychology, laid out: ‘what lies beneath?’. One might see this final chapter as concerning mostly ‘what lies beyond?’. What potentials lie beyond the words of this dissertation? Can there be a life, more or less ordinary, after biopsychiatric domination? If the changing tides of psychiatric and social history continue as they have done, then the answer is ‘yes’. And, as we have seen, there are various already tested, yet still prototypical, alternatives which can add to ways of dealing with human distress in a more inter-personal way.

Given the confusions which are apparent in professional versions of ‘schizophrenia’, our main conclusion, however, is surprisingly simple: we would do well to respectfully listen more to the first-hand experiencers of the phenomena in question. These
phenomena are sometimes ordinary, sometimes bizarre, but they typically remain somewhat perplexing for all.

Should professionals, of any ilk, be the experts to preside over human distress? And, even if professionals are to have a major role in coordinating the dialogue between positions on dealing with the phenomena in question, then why should they be medical professionals? Why should medical doctors dominate in helping people deal with such distress? As a budding mental health service clinical psychologist, I may be beginning to talk myself out of a job. According to my analyses and reviews, what professionals should be doing, if anything in this area, is not yet clear. But it is demonstrably clear that there should be less professional privilege and less prejudice concerning ‘patients’.

The Christian holy trinity may be considered a remarkable, unprovable reported belief which is in some ways akin to ‘schizophrenia’: they are both orthodox views that contain representations of multiple, simultaneous existences which ultimately are sustained by faith over proof (or rather the lack thereof). Both religion and psychiatry are dogmas. In psychiatry’s frame of reference, there is the dogmatic application of authoritative psychiatric texts, as there tends to be in religion. Faith and the dogmatic use of texts are all well and good but such matters are not goals for empirical enquiry, by definition. As a relativist, I am not suggesting that we ever settle for any dogma, since ‘better’ truthful versions will continue to be found, on any topic. Thus, unorthodox positions should be at least recognized as one view amongst many. Alternative views should be given a fair hearing, so that evidential pros and cons can be better judged. Orthodox belief systems should not remain privileged simply because; simply because they represent the most established and powerful position.
**Working with, not on**

What must dealing with all of this be like for the people in question? What must it be like for those who experience distressing and/or perplexing inter-personal events relating to ‘mental illness’, time and time again? How is it, to be treated as essentially questionable by (almost) everyone around, including those whose job it is to help you? Perhaps we should listen, dialogue, and listen some more. Here, the phrases ‘less is more’ and ‘the more I learn, the less I know’ seem to apply.

More generally, ‘working with’ would involve a shift in value focus from one which is dominated by *competitive comparison* (including pathology - supposedly what is wrong; deficit - supposedly what is missing; and striving for material quick fixes - the supposed solution). The shift would be to a focus on blending inter-personal *acceptance and equity* (including diversity, pragmatism, and getting to know oneself and others). More contextualized solutions might then be discovered, somewhat incidentally along the way.

These suggestions involve a far-reaching move, favouring inclusion over exclusion and mundane processes of change over professional-led processes of change. So long as an emphasis on dialogue, diversity, and equity operates within this proposed shift, then it would not entail merely the replacement of the current, rigid, domineering system of being with one another.

In the changed field of ‘mental health’ (or whatever it might become), medicine can then take its place, according to actual merit. In keeping with the relativist tenets introduced in my introductory chapter, there is a level of competition in this proposal. Besides matters such as criminality, decisions could be on the basis of benefits and costs for ‘patients’ (and, secondly, for family and society) rather than the privileging of medical professionals in the service of society and social control. Because ‘services’ and ‘customers’ have grown to rely on certain technologies (eg, biomedical discoveries,
medication, and psychological therapies) it does not mean that such approaches should be allowed to dominate our way of dealing with ‘mental illness’, our way of relating to people’s lives.

On occasions, this might require therapists to unilaterally change their practices in order to undermine prejudice and privilege. However, over the long-term, this may benefit both the professional and the ‘patient’. And would society not also gain from a diversity of views and actions, and from co-equal dialogue with those who are most experienced in the phenomena in question?

What again of the thesis question? In turning away from mixed normality-abnormality continua, are we all well (united we stand), are we all sick (united we fall), or are concerns over illness and wellness a red herring when it comes to psychological and/or inter-personal matters? It turns out that there is no satisfactory single answer for the question of how to best represent and deal with ‘mental illness’. That is the wrong question. One can simply ask the person directly. It is wrong to locate a person on the professional’s clinical examination table as the topic in question, to be discussed over by others as if the person is not all there, as if the context of their life is not all there. If a professional is to help at all then how can they, how can we, assist rather than ignore such immediate, pragmatic, and personal requirements? The answer (or non-answer), I suggest, is to hold more to the institution of conversation and practical help than professional institutions. (1) For professionals to acknowledge and seek to understand further the discursive practices of ‘ordinary conversation’ (by both lay people and professionals) in assisting people with their distress. (2) For professionals (and lay people) to deprofessionalize: to unlearn much of the socialization and training which goes towards being a ‘professional’ and to be more like ‘ordinary people’ (with whatever diversity and extraordinary ‘things’ that may eventuate). Thus, areas of professional specialist knowledge may be offered as ‘just another point of view’;
alongside knowledge from those who are most experienced with the phenomena in question. Note that the *phenomena* in question are still perplexing, but the *person* is no longer in question.

Of course, these conclusions may be considered to be little more than truisms. However, they are conclusions which, as we have seen in the data of this dissertation, have so many interests stacked against them; interests which should be served differently or not served at all (Boyle, 2002b; Gosden, 2001; Johnstone, 2000). The interests and approaches of those who are less power-wielding can hardly be overstated.

Returning more specifically to clinical interactions, Silverman (1997: 84) considers how “counsellors (and their clients) co-operatively produce and manage ‘delicacy’ and professional accounts of ‘empathy’”. He notes that “‘empathy’ between professional and client is a central concern of counselling texts” and quotes the following “highly respected definition” from Carl Rogers:

> [Empathy] means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in the other person... To be with another in this way means that, for the time being, you lay aside the views and values you hold for yourself in order to enter another’s world without prejudice.

> (1975: 4; cited by Silverman, 1997: 85)

So how can professionals be more empathic and less prejudiced in action, in addition to their actions being appropriate for the conversational and professional business at hand? Silverman goes on to point out how Rogers’ definition, and definitions from many other approaches, are based on the unacknowledged mentalist assumption (my words) that public communication behaviours can build a bridge between private consciousnesses. Instead, Silverman considers empathy - in line with his general approach and the
general approach of this dissertation - as the interplay of actions which make use of publicly available conversational resources. He states that there are no a priori right or wrong ways of responding to clients: what works has to be interactionally devised, on each occasion. Silverman concludes that the distinctive character of counselling comes from the systematic deployment of this publicly available apparatus.

Building on from Silverman, therapeutic approaches which impose a system of therapy on someone - approaches which subtly or blatantly privilege, a priori, professional accounts over client accounts - are missing much of the point. They are missing much of the value of publicly available communicative resources (between and within people).

How might this apply to the subject of ‘therapy’ for people who hear voices? In this dissertation, I have been highly critical of some of the practices of mental health professionals. Although, as a discourse analyst, it is important to maintain sufficiently unmotivated looking - so as not to presumptively categorize and bias the analysis from whatever the data may hold - it is important to not over-compromise methodology with diplomacy. And one should also explicitly acknowledge some of the ways in which analyses and discussions are constructed for their (potential) audience(s); how methodology-in-action depends on the occasion, on the task-at-hand.

Nevertheless, along with diplomacy, clinical psychologists, psychiatrists, and mental health workers have hard lessons to learn about how to improve their part in respectful communication and relationships. As I am learning with this dissertation, there are times and places for radical critique; the same for discretion. Respectful communication - inter-professional and lay-to-professional - includes conversationally appropriate listening and argument, between co-equals. The professional should not supersede the conversational.
Before we consider further the possible breadth of application of dialogue, let us recap on hearing voices. As we have seen, especially with the work of Leudar and colleagues, hearing voices may be constructed as many different things, historically, culturally, and dialogically. Voices do not equate to pathology. Recall the case of Peg, who, perhaps with the help of dialogue with a mental health worker about how voices relate to her life experiences, apparently came to develop a more integrated understanding of voices in her life (Davies, Thomas, & Leudar, 1999; Leudar & Thomas, 2000). The dialogue with Peg is described as not being therapy; it was not done by someone to someone. In relation to our discussion of Wetherell and Potter’s (1992) conclusions concerning social change, the dialogue with Peg may be seen as an example of locally applied, widely informed action, with both local and wider consequences and dissemination.

A number of studies have shown that a proportion of people in the non-psychiatric population hear voices and are not troubled enough by the voices to seek help (eg, Tien, 1991, cited by Romme & Escher, 2000). In line with these findings, Leudar and colleagues provide a contrast to the pathologizing of voices which occurs within classification systems of mental disorders, in the wider field of mental health, and in Western society on the whole. The traditional psychiatric approach largely ignores the content of what voices say and encourages voice hearers to do likewise - thereby typically invalidating the voice hearer’s lived experience. Instead, Leudar et al. (1997) took a pragmatic and dialogic approach to voices, investigating accounts of what voices can do with words and of how voices and voice hearers interact. Results were consistent with the position that hearing voices - in both psychiatric and non-psychiatric populations - may usefully seen as a genus of ordinary inner speech, with the rather odd and exaggerated characteristic of being not of the self.
The emphasis that *DSM-IV* places on the loosely specified criterion of “a voice keeping up a running commentary on the person’s behaviour or thoughts” (APA, 2000: 312) as a prime indication of active-phase ‘schizophrenia’ is especially alarming, given the commonality of often mundane comments by voices on a voice hearer’s thoughts and actions, as found by Leudar et al. (1997) in both university undergraduates and people with a diagnosis of ‘schizophrenia’. This may be taken as a problem with the construct of ‘schizophrenia’ rather than an indication that many people in the ‘normal’ population have ‘psychotic’ tendencies.

So how can therapists more respectfully contextualize hearing voices experiences? Surely the least professionals can do is to not promote psychological and medical models to the point of decontextualizing hearing voices phenomena, removing the voices from their relations with voice hearers. Otherwise, the hearing voices experiences are isolated from the potentially beneficial context of a personally and socially integrated life story.

Although doing ‘being ordinary’ (in the hearing voice group, NOT-MAD) seems promising on the face of it, such covering does not suffice for long because of the omni-relevant devices waiting in the wings (ie, PSYCHIATRIC STAFF + PATIENT and THERAPIST + CLIENT). Therefore, a more sustained EXPERT VOICE HEARER identity (or whatever independent from omni-relevant device identities might emerge) may have more long-term benefit. Indeed, considering what might have been, what might be, EXPERT VOICE HEARER + NON-VOICE HEARER could be an omni-relevant device operating in a group about hearing voices. Such a device, where the voice hearers are in a ‘dominant’ position, when the device is active, would not have the problem of subjugating personal accounts of human distress, since the voice hearers’ own reported experiences are the ever-present topics of interest, and since there is no claim of supreme rationality (beyond an expert understanding of the first-hand
experience of hearing voices), as there is with PSYCHIATRIC STAFF and THERAPISTS. At other times, when EXPERT VOICE HEARER + NON-VOICE HEARER is not active (but still, of course, relevant), then co-equal dialogue can be a vehicle for respect and exploration of the complexity of human lives, rather than over-reaching professional representations. Thus, dialogue is likely to enhance the enactment of more sustainable and beneficial social relations. It is important to note that respectful, co-equal dialogue does not mean a denial of differences and a negation of specialist knowledge, far from it. Dialogue allows for argument, agreement, disagreement, humour, and diplomacy.

Let us now discuss further the possibility of applying dialogue to experiences other than hearing voices. Perhaps what is most required from mental health workers in the field is profoundly simple. Perhaps it is the wider application of the kind of respectful dialogue which Leudar and colleagues raise in connection to voice hearers. That approach may include a pragmatic exploration of what voices do, have done, and can do, in the voice hearer’s life. Other experiences might be considered in a similar way.

But most of all - and rather unlike therapy approaches, even one such as narrative therapy - a dialogical approach is not a ‘therapy’ which is done to or even done with someone. Put another way, dialogue is more of an ‘a’ than a ‘the’. Beyond the deceptively simple enactment of respectful dialogue, a dialogical approach is not some ‘thing’ which is known about prior to the interaction and which is then simply done (ie, put into action). This distinction is akin to ethnomethodology and discourse analysis - and perhaps to a lesser extent, conversation analysis - being about a set of principles rather than a set of pre-defined methods. A dialogical approach (ie, dialogue) is not one of those more or less standardized, theorized, and manualized approaches which are abundant in psychological therapies and even psychotherapies. It is a dialogical interaction, between someone who has experienced something which is perplexing
and/or distressing and someone who has not. Such interaction may contribute to both people developing a more personally integrated view - and perhaps inner dialogue - in relation to the experiences in question. Perhaps a rather different kind of group to the one in the hearing voices group data corpus could assist in supporting such developments. The approaches of Coleman and Smith (1997) and Romme and Escher (2000), regarding voices, share this emphasis on respecting diversity in another’s behaviour, experiences, and points of view.

As was noted in my analysis of CBT manuals for ‘psychosis’, Fowler et al.’s (1995) references to rehabilitation and living with social disability suggest a view that people (‘psychotic’ people, at least) do not tend to make profound and lasting changes from psychological intervention. Leudar and colleagues’ dialogical approach may also be taken as a recognition that people do not often change in that way. However, the latter approach does not lock the person into medically derived frameworks, as CBT typically does. Rather, it opens up the availability and moral accountability of whatever understandings and resources fit more positively with the person’s life experiences. It also opens up the possibility of a more integrated understanding of the role of negative experiences. Society may be all the richer for it.

Or would so much dialoguing about a wide variety of experiences merely create confusion? Would such confusion act as a smokescreen for inappropriate actions? And would there be an increase in conflicts of interest? If the dialogue is sufficiently ‘open’ then the answer is ‘no’ to each of these questions. It is important for professionals to respect the point of view of the primary service user and of the family and of the wider community in their dialogue and other services, in relation to ‘mental illness’. However, besides criminal behaviour, the primary consumer should come first.

Some of the problems of a broadly dialogical approach might also be seen as its strengths: it is merely a broad recommendation; it is not therapy; the inter-personal can
do its job, without unnecessary interference. However, in keeping with Leudar and colleagues, although I am going further than them to argue for a wider application of a dialogical approach to all human distress, I am not advocating an overnight adoption of dialogue and the overnight abandoning of current psychiatric understandings and practices. Rather, I am suggesting a sustained ‘trying on for size’ of dialogue, of the various understandings which we have at present, and of the new understandings which dialogue will create.

**Inter-professional dialogue**

To consider dialogue between professionals a little further, let us turn briefly to Bracken and Thomas (2001) on postpsychiatry. It is worth noting that both Bracken and Thomas are consultant psychiatrists, amongst other roles: they have the critical benefits of being within the profession as well as without. Theirs is the task of trying to move beyond the conflict between psychiatry and anti-psychiatry with a more agreeable (though not entirely agreeable) opening up of the field to other perspectives which are currently less dominant but equally valid. They aim to put the voices of service users and survivors centre stage. Surely psychologists should move in the same direction, in word and deed. Surely both disciplines need to open up their shuttered, institutional windows. It is hoped that studies of therapy talk-in-interaction and discourse - including critical studies like my own - will further such moves.

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1 For a complementary, critical look at the problems and possibilities for mental health services, see Newnes, Dunn, and Holmes (1999; 2001).
Training with discursive findings

We now briefly consider the role of more diplomatic and perhaps accessible approaches, in their relation to the training of clinical professionals. Depending on one’s point of view, such applications might be chosen as a second line of action to radical critique, or it might be used in place of radical critique, or as a reparation of over-critique.

The training of interactants and potential interactants is not a common topic amongst discursive researchers. Nevertheless, here, I roughly distinguish between various types of studies for ‘training’, in terms of the directness of design for and/or contact with those receiving the ‘training’: (1) studies which are designed specifically to be used in active training programs for certain staff, ie, typically, the staff of the commissioning organization; (2) studies which are designed to provide or incidentally provide training aids to certain staff as a product of the study (eg, Potter & Hepburn, 2003); and (3) studies of clinical interactions where there is no direct training as a commissioned or incidental product of the study reported in the paper but where training (ie, knowledge and skills acquisition) may occur indirectly in those who happen to read the study (eg, presumably, Messari & Hallam, 2003; McCabe et al., 2002). Research in which training actually takes place in the interaction being studied might fall into either or none of these three categories.

Hepburn and Potter (2003) make it clear that they were, understandably, not looking to offend anyone in their work on calls to a National Society for the Prevention of Cruelty to Children (NSPCC) child protection helpline (see Potter & Hepburn, 2003; what I take to be a somewhat CA-orientated application of DA). Hepburn and Potter (2003) report that their work to-date with the NSPCC has resulted in “training aids” for staff. For example, staff members were able to hear and discuss recordings of their own helpline talk. Thus, any feedback to staff was relatively non-confrontational. The
authors note that, later on in the project, they may be able to latch audio fragments with analysis and practical suggestions for a more sophisticated training aid: “The aim of these kinds of practical interventions is not to tell the CPOs [Child Protection Officers] how to do their job better, but to provide one sort of resource that they can draw on in their training and practice and which is helpful” (Hepburn & Potter, 2003: 195).

Silverman (1998) is cited regarding the value of practical suggestions for staff.

Silverman (1997) is also pertinent, here, especially his chapter on “Implications for practice”. For example, somewhat similarly to Hepburn and Potter, Silverman states that

[a]s a sociologist rather than a counsellor, it is not for me to take a position on the therapeutic or health promotion implications of the practices I have identified. However, this is not to wash my hands of such practical matters. Instead, in the many workshops that have followed this research, my transcripts and findings have been offered to practitioners as a means to establish a dialogue about their practice and the constraints under which it operates.

(1997: 212)

What if Silverman had been a practitioner as well as a researcher? Might he have justifiably adopted a clinically informed position under such circumstances? My discussion on not allowing theory (including clinical theory) to pre-empt and dominate over an unfolding of the data is relevant to this debate. However, as I noted, the advantages of such moves should be acknowledged, as well as the disadvantages.

It is fair to say that Potter and Hepburn’s (2003) application of DA produced useful and widely uncontroversial findings and authorial discussion, as it was so-designed. The Hepburn and Potter paper (2003: especially pp. 194-195) discusses important considerations regarding the practical application of discourse analysis, with a focus on

2 I am working from an uncorrected proof of Hepburn and Potter (2003).
the Potter and Hepburn (2003) study, compared to standard, idealized, training materials.

Before we leave this topic, though (and this is not to be taken as a negative evaluation of any of the above studies), there is more to consider. On occasions, training may also need to target the unlearning of behaviours; behaviours which may be so advantageous and entrenched as to require direct challenges in order to promote positive change. Furthermore, both learning and unlearning is perhaps best evidenced through relatively direct assessments of behaviour change, ideally over the long-term and in a variety of suitable contexts. Few discursive studies are specifically geared towards the training of (potential) interactants and perhaps none have taken on the formidable task of combining such methodologies with either qualitative or quantitative outcome studies.

Reprise

In keeping with the theme edition of the British Medical Journal, entitled “Too much medicine?” (Moynihan & Smith, 2002), and in line with Double’s (2002) paper from that special issue, it is concluded that there is too much ‘mental illness’. Supposed matters of biomedical science and progress dominate contemporary psychiatry. But this is a very blinkered view of science and scientific domains. The acknowledgement and study of social and personal matters have been backgrounded, for largely unscientific reasons; for morality and social control in the serving of society, and for professional self-interest.

In this dissertation, in original analyses and in reviews of other studies, ‘schizophrenia’ and its progeny have been shown to be problematic on many counts. This study has supported, on this occasion from a discursive perspective, that which Boyle (2002a & b) made abundantly clear in evidentially supported conceptual terms.
And, even if ‘schizophrenia’ itself were a valid scientific concept, which it is not, then it would still not be valid as a biologically dominated ‘mental illness’, since constructions such as biomedical ‘mental illness’ subjugate too many other valid points of view; points of view which are incompatible with a medico-psychiatric model, according to the model’s own criteria.

Hearing voices, and other so-called ‘symptoms’ of ‘mental illness’, are not necessarily pathological. Much depends on where we choose to look and what we make of the ‘findings’. Discourse and rhetoric play an enormous and underrated role in the making and sense-making of all representations, including those of a person and ‘their’ features.

Discourse which focuses on the biomedical underplays the social, just as discourse which focuses on the professional underplays the personal. As has been demonstrated in numerous examples of talk and text in this dissertation, such work adds to the social power of some and subtracts from the social power of others. Through the social actions of discourse, the ‘normal’, the ‘sane’, and the ‘super-sane’ are privileged, and the ‘abnormal’, the ‘mentally ill’, and the ‘mad’ are subject to prejudice. One wonders just how therapeutic that can be.

Many important, socially orientated questions remain unanswered by privileging professional psychiatric and psychological points of view. What of dialogue between co-equals? What of diversity, freedom, and learning? And what of practical help in changing macro-social disadvantage? I have shown how discursive analyses can inform on some of these issues. I have shown how, in contrast to dominant psychiatry and much of Western society, some people dialogically and pragmatically deal with experiences such as hearing voices; with a sustained, respectful view towards the importance of inter-personal contexts. Perhaps Socrates’ fate would have been rather
different, in his own lifetime and beyond, had he been afforded such respect by the authorities.

Thus, lay-to-professional and inter-professional dialogue has been called for. But how are we to reduce the competition between discourses and increase the dialogue? According to the relativist, social constructionist tenets of this dissertation, words are (potential) actions but what will it take for these words to be seen as having been sufficiently enacted? It is our job (as cultural and subcultural members) to make sense of all this.

The current psychiatric and commonsense understanding of hearing voices or ‘delusional’ beliefs is that they are pathological ‘symptoms’ of ‘severe mental illness’. Thus, orthodox psychiatry pays no heed, at a local interactional level, to actual patient talk about the phenomena in question. With a biological focus, patients are deemed to be, on occasions, quite simply, out of touch with reality.

The postures of science and progress in biopsychiatry belie the fact that so little is known about the phenomena in question. Voices, like ‘delusions’, are increasingly seen as the result of dysfunctional neurotransmitters and, with a psychological gloss, as failures of reality-testing. Disruptions in automatic cognitive processes and maladaptive conscious appraisals - in the mind - are seen as leading to ‘psychotic symptoms’ (Garety et al., 2001). Although (once a diagnosis has been established) the content of delusions and voices are traditionally seen as irrelevant in medical psychiatry, they are increasingly seen as potentially fertile ground for cognitive-behavioural therapies (eg, Chadwick, Birchwood, & Trower, 1996), as an adjunct to pharmacological treatments.

Any approach which allows people to talk about their voices and which apparently leads to a reduction in voices-related distress would seem to be worthwhile and ‘empowering’. However, talking therapies can also be highly restrictive and prescriptive - a tool for the continuation of medico-professional domination. I have demonstrated
this empirically. The medical model is not far below the surface in clinical psychology. Other social actions - including social, educational, or vocational activities - tend to be seen as somewhat palliative, rather than curative or otherwise beneficial.

I have argued that psychiatric assumptions about hearing voices entail grossly pathologizing generalizations about complex issues which are, in practice, influenced by the constructing of accounts for social inter-action. To explore some of these more social concerns, Leudar and colleagues have begun to use a pragmatic and dialogical approach, without the assumption of pathology, to unpick reports of hearing voices (see Leudar & Thomas, 2000). When considered from such a position, even highly distressing voices may be seen as in some ways ordinary, though often still perplexing, experiences. We can then seek an understanding in terms of personal and interpersonal meaning, rather than as an individualized ‘mental illness’. Indeed, it is important for professionals and patients to understand that hearing voices may be positive rather than deeply distressing experiences and that many voice hearers never come to the attention of psychiatric services. Having examined the example of hearing voices, it is clear that such reported experiences can be so very many different ‘things’. Furthermore, it should be acknowledged just how much is at stake with these arguments, especially in relation to people who would be diagnosed with, and medically managed for, ‘schizophrenia’ or other ‘mental illnesses’.

It has been further suggested by Leudar and colleagues that some voice hearers might develop a more integrated personal understanding of their voices through a dialogical exploration relating voices to life experiences. Davies, Thomas, and Leudar (1999) describe the single case study of Peg, who seemed to benefit in this way. One aspect of this approach was the exploratory co-equal dialogue (more or less) between Peg and a mental health worker. This is taken by Davies and colleagues to stand in
contrast to a talking therapy intervention which is done, as somewhat packaged, by a professional to a patient/client.

This dissertation confirms, through analyzing actual therapy talk, that psychiatric patients are seriously underestimated in their ability to interact socially and in their purported cognitive abilities. In each of the study cases examined, clinical professionals, who are supposedly there to help, tended to make assumptions about ir-rationality - to discern ‘what really happened’ and ‘what really helps’ - on unacknowledged moral rather than empirical grounds. On the basis of these findings, in an extension of the work of Leudar, Thomas, and colleagues, it is recommended that respectful dialogue with those who have first-hand experience of questionable phenomena should be privileged over professional theory and therapy. On these grounds, let alone all their other inadequacies as biomedical ‘concepts’, ‘schizophrenia’ and ‘mental illness’ should be reified by science no longer.

But what is ‘schizophrenia’, then? What is it that has shaped psychiatry, so far away from the inter-personal?

This is the creature that has never been.
They never knew it, and yet, nonetheless,
they loved the way it moved, its suppleness,
its neck, its very gaze, mild and serene.
Not there, because they loved it, it behaved
as though it were. They always left some space.
And in the clear unpeopled space they saved
it lightly reared its head, with scarce a trace
of not being there. They fed it, not with corn,
but only with the possibility
of being. And that was able to confer
such strength, its brow put forth a horn. One horn.
Whitely it stole up to a maid, to be
within the silver mirror and in her.

(Rilke, 1949: 95; cited by Sarbin & Mancuso, 1980: 222-223; original emphasis)
APPENDIX A. TRANSCRIPTION SYMBOLS

[ ] Square brackets indicate overlap of utterance or a part of utterance.

= Equals sign indicates latching; no gap between the two lines.
(Note: my use within an utterance is unusual).

(0.0) Length of silence in seconds.
(Note: My transcripts would benefit from more consistency as to whom pauses are attributed).

(.) Micro pause; less than 0.1 seconds.

**Underlining** marks stress/emphasis.

: A colon indicates that the preceding sound is prolonged.

− A hyphen marks a cut-off; a word incompletion.

. A full-stop marks a stopping fall in tone.

, A comma indicates a continuing intonation.
(Note: Unfortunately, I omitted transcribing these from the start and so continued to omit them for consistency).

? A rising, questioning intonation.

¿ An inverted question mark indicates a partially questioning tone.
(Note: Unfortunately, I omitted transcribing these from the start and so continued to omit them for consistency).

↑↓ Marked shifts into higher or lower pitch. An up-arrow at the end of an utterance indicates a characteristically Australian intonation. (Note: I have transcribed only relatively large changes in tone, such as those between phrases, rather than
within words).

**WORD** Especially loud, relative to surrounding text.

(Note: Relative to same or surrounding speakers?).

° ° Bracketing by degree signs marks relative quietness.

> < Such bracketing indicates relatively faster speech.

< > Such bracketing indicates relatively lower speech.

· hh A dot preceding hs marks an in breath.

hh Hs without a dot marks an out breath.

w(h)ord A bracketed h indicates breathiness or laughter.

[^t] Marks a dental click; an unvoiced sound from an articulation which is often between tongue and teeth

( _) Indicates a syllable or word which is unrecognizable.

(word) Transcriber is not quite certain of what was said. The word in brackets is an educated guess.

(( )) Transcriber’s additional descriptions.

For several of these symbols, more than one symbol in a row indicates prolongation. For example, with colons, weir::d is a longer utterance than weir:d.

These symbols (or most of them) are derived from the work of Jefferson (eg, 1985). My transcripts are inspired by such conversation analytic work, although I am sure that both the transcripts, per se, and their match with the actual audio data would not meet the exactitudes of many a formally trained conversation analyst. The transcripts do, however, suit my CA-inspired, discourse analytic purpose. I have also sought consistency, within my work and with CA transcribers.
APPENDIX B. A WORD FROM THE BOOK

[BOOK:] There is a theory which states that if ever anyone discovers exactly what the Universe is for and why it is here, it will instantly disappear and be replaced by something even more bizarrely inexplicable... There is another theory which states that this has already happened...

(Brett, 1978, Hitchhiker’s Guide to the Galaxy, by Douglas Adams, BBC Radio 4; original ellipses)
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