MAD SCIENCE:
DISCOURSES OF 'SCHIZOPHRENIA' AND 'THERAPY' FOR HEARING VOICES

Michael John Wise

School of Psychology

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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.

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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.

CONTENTS

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.