Chapter 3: Constructions of Madness

> How can people who inhabit different and conflicting realities – worlds in which the "other" is discredited and demonized – sustain life together?
>
> (Gergen, 1999: 142)

This chapter is focussed around a central debate in psychiatry that was highlighted towards the end of the previous chapter, biological versus social determinism; a polarised dichotomy that is both misleading and naïve. Whilst this chapter explores the construct of schizophrenia and reassesses the evidence from both biological and social perspectives, my central argument is that madness, regardless of its aetiology, needs to be embedded in cultural and historical contexts, an objective of fundamental importance if we are to have a deeper understanding of it. Schizophrenia has been chosen to illustrate the biological/social polemic for two reasons. First, as argued previously, it is at the centre of scientific research, both genetic and neurological, thus this construct exemplifies how the relationship between psychiatry and its object, madness, is founded upon positivism, a scientific approach to the understanding of human nature. I shall argue that, whilst not denying the potential importance of a biological approach, there is at present little evidence to support the dominance of this perspective in our understanding of the phenomenon. Second, schizophrenia, and more generally psychosis, has been attributed to Margery Kempe and Mary Barnes, the authors of the narratives that constitute the analysis stage of this research. Examining the way in which schizophrenia has been construed from different perspectives illuminates the ways in which these narratives have been interpreted. The chapter begins with an examination of the evidence put forward in support of schizophrenia as a diagnostic

syndrome. I shall then address the use of phenomenology by psychiatry as a means of studying inner distress, examining the influence of Husserl and Heidegger. In the second part of this chapter, I shall examine alternative frameworks within which madness has been understood within social psychology, focussing particularly on social constructionism. I shall argue that social constructionism provides us with a contexualist framework within which to construe madness, one that places language and social relations central to the social aetiology of madness. The chapter concludes with a brief discussion of how such competing explanations can be reconciled.

Positivism and Psychiatry

Coulter wrote "the literature on mental disorders is quite out of proportion to the adequacy of our knowledge about them" (Coulter, 1973). Here Coulter explicitly points to the incongruity between the wealth of perceived knowledge not only in literature, but in different forms of texts in the Western world (Internet, newspapers, magazines, television, radio and so on) and our *actual* knowledge, what we can say with certainty about madness. However, as Ingleby highlights, it is not data or findings that are lacking, but a need to reassess our understandings of madness (Ingleby, 1981: 8). Ingleby goes on to argue that it is the scientific framework on which the common understanding of madness is based which needs deconstructing in order to make space for possible alternative explanations. Critics of psychiatry have traditionally attacked it for inappropriately basing itself on the medical model, with the dualistic analogy between the material body and the immaterial mind being fundamentally flawed. Ingleby takes this argument one step further contending that psychiatry is not based on medicine per se, but on the scientific basis of medicine; the positivist paradigm

(Ingleby, 1981: 25). Ingleby makes an important distinction here, highlighting psychiatry's role in humanity's quest to understand itself.

The mental framework that enshrouds psychiatry is based on the natural sciences and uses the mechanistic metaphor of natural science to construct mental illness. This metaphor construes human beings as machines without agency, their behaviour originating in deterministic forces external to the organism (Sarbin and Mancuso, 1980).[1] This positivistic, mechanistic paradigm has two pivotal underlying assumptions, which shall be examined in turn; first, that objective observations can be made that can be both measured and replicated; and second, that deterministic theories can be constructed from inferred causal relationships (Ingleby, 1981: 28). Within these assumptions is a radical separation between facts and values, objectivity and subjectivity (Sedgewick, 1982: 23). Examining the former assumption, scientific objectivity is central to the medical classification system on which diagnosis is based. Boyle argues that there are two further assumptions underlying the formation of a diagnosis (Boyle, 1999). First, the presence of a diagnosis assumes that a relationship has been identified between observed clusters of symptoms and, second, that a physical or psychological antecedent exists in relation to the identified symptoms. Boyle (1990b) presents a taut argument based on these two assumptions, which questions the scientific status of schizophrenia. Her line of reasoning rests on the status of schizophrenia as a hypothetical construct. Hypothetical constructs are inferred from unobservable phenomena such as intelligence, memory or attitudes. In order to infer a new hypothetical construct two processes need to take place. First, there needs to be

[1] Parker, Georgaca, Harper et al. (1994) argue that root metaphors such as the mechanistic metaphor, become taken-for-granted as they become culturally absorbed. It therefore becomes increasingly difficult to identify them as metaphors as they lose their 'as if' status and become literal, an argument I shall develop later in relation to communicating unusual experiences.

evidence of an observed group of regularities, which is the necessary condition for claiming validity of the construct. Second, hypothetical constructs should have the power to make predictions about events yet to be observed, in other words the antecedents to the observed clusters. To relate this to schizophrenia, a relationship has to be demonstrated between an observable (e.g. self-reports of voice hearing) and the inferred construct (schizophrenia). The predictive power of the construct relies on its ability to identify a further relationship between two observables (e.g. voice hearing and brain changes). Boyle cogently argues that schizophrenia does not meet the necessary and sufficient conditions needed to infer its status as a hypothetical construct, yet its validity as a hypothetical construct is regarded as an axiom within psychiatry, a central issue this chapter aims to extrapolate.

Engle and Davis (1963 in Boyle, 1990a: 5) proposed a hierarchical classification system based on levels of certainty (i.e. the certainty with which new cases may be recognized), reflecting the fact that some diagnostic categories are more robust than others. Schizophrenia is classified as a syndrome; a cluster of signs and symptoms whose antecedents are unknown and, as such, lies at the bottom of this hierarchical classification system. The diagnosis of schizophrenia is still based on Kraeplin's criteria for dementia praecox of 1896. Whilst Kraeplin claimed to have observed similar patterns in onset, course and outcome in dementia praecox, there is little evidence to suggest that any reliable pattern was observed. His writings are scattered with references to the "variability" of the condition, illnesses took "considerable different courses" and occurred "so imperceptibly and with such indefinite indications" to make onset both unobservable and unidentifiable (Kraeplin, 1896; 1899 in Boyle, 1990a: 9-11). Kraeplin's criteria were revised by Bleuler, who rejected the term

dementia praecox on the basis that deterioration (dementia) and onset in youth (praecox) were not defining features of the condition. Instead he named the illness (which is what he considered it to be) schizophrenia (Bentall, 2003: 23). Crucially, neither Kraeplin nor Bleuler made any attempt to justify why a particular behaviour was interpreted as a symptom of the described conditions. They were essentially at liberty to identify any phenomena as a symptom with little empirical evidence to support their constructs. Despite the uncertainty of its origins, Kraeplin's criteria formed the basis of Schneider's description of schizophrenia. Boyle argues that Schneider, like Kraeplin and Bleuler before him, takes the validity of the concept "schizophrenia" for granted with little supporting evidence, making the tautological claim that symptoms of schizophrenia were "frequently found and therefore a prominent feature of schizophrenia" (Schneider, 1959 in Boyle, 1990a: 14). Crucially, the premise of Schneider's diagnostic system rests on the core assumption that schizophrenia is an illness as opposed to a syndrome, whose "underlying morbid physical condition" would be proved in time, a view still upheld by psychiatry today (Johnstone, et al., 1999: 3). This conceptual slippage from syndrome to illness generated within the profession of psychiatry is problematic, as it gives the impression that schizophrenia exists as a recognisable phenomena. Moreover, in the wake of anti-psychiatry, there has been a resurgence of interest into biomedical explanations for the 'causes' of schizophrenia led by self-consciously styled 'neo-Kraepelinian' biopsychiatrists, whose research is hyper-empirical, easily measurable and computable (Brown, 1990: 390[144]).

The Diagnostic and Statistical Manual for Mental Disorders Fourth Edition (DSM-IV-TR) bases its descriptor on Schneider's criteria, which in turn is based on Kraepelin's description of dementia praecox. The DSM lists five characteristic symptoms of

schizophrenia; delusions, hallucinations, disorganized speech, disorganized/catatonic behaviour and negative symptoms (e.g. flattened emotional expression, lack of goal directed behaviour and diminution of thoughts manifested in poverty of speech) (American Psychiatric Association, 2000). Diagnosis also takes into account secondary symptoms related to reduced functioning in any daily activity, a diagnostic criteria that amounts to nothing more than a value judgement.[2]

The authors of DSM IV-TR acknowledge the difficulty in making a clear diagnosis of schizophrenia:

> No single symptom is pathognomonic of Schizophrenia; the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired occupational or social functioning. (APA, 2000: 299)

> negative symptoms are difficult to evaluate because they occur on a continuum with normality, are relatively non-specific and may be due to a variety of other factors. (ibid: 301)

Thus there are no identifiable signs of schizophrenia which are independent from personal report. DSM furnishes the reader with a description of what schizophrenia looks like, but cannot identify its defining feature (Rosenberg, 1984). The fundamental flaw underlying the DSM and other psychiatric classification systems is that it takes the validity of schizophrenia as a hypothetical construct for granted. Hempel (1961 in

[2] This said, DSM does explicitly argue for serious consideration of cultural differences where "socioeconomic or cultural situations are different from [clinicians] own" (APA, 2000: 281). However, this is a recent recommendation for psychiatry, with the majority of psychiatrists still subscribing to the positivistic model traditionally used (Jackson and Fulford, 1997: 88).

Boyle, 1990b) argues that as psychiatric concepts are not related to an agreed set of observed events, the constructs cannot be inferred, nor can operational definitions of constructs be made. However, this is precisely what happened; for example, in the eighth edition of the International Classification of Diseases (ICD 8) operational definitions were given for constructs whose validity could not be demonstrated. The epistemological flaw concerning psychiatric descriptions of symptoms is that they are not based on the science of observation but interpretation. For example, descriptors such as flatness of affect, aggressivity, lack of goal directed behaviour, can be applied to most people at some point. The ontological flaw is that the mind is not amenable to objective observation. The more we examine psychiatric symptom descriptors, the more absurd it seems that they are used to formulate diagnoses, as if they were externally measurable signs.[3] The classification of groups of behaviours is not discrete, there is no clear demarcation between their presence or absence, but rather they exist on a continuum. As DSM-IV-TR explicitly states, perhaps consciously pre-empting this very critique, any evaluation of a person's behaviour hinges on a subjective interpretation of comparing it to a situational and cultural norm. The DSM admits to being "atheoretical", some distress is judged to be sane (e.g. response to pain, appropriate bereavement) whilst other forms of distress are not (e.g. prolonged bereavement). As such, the authors describe it as a phenomenological approach, a claim that shall be addressed later in this chapter. Ingleby argues it is not that there are

[3] With increasing levels of knowledge and technology the boundaries of physical illness are also blurred. Even physical phenomena of what were once deemed absolute events, the beginning of life and death, are now ambiguous, so that they are determined more by technology than an organic process. Engel expressed it thus: "the boundaries between health and disease, between well and sick, are far from clear and never will be clear, for they are diffused by cultural, social, and psychological considerations" (Engel, 1977 in Roth and Kroll, 1986: 64).

no criteria for making psychiatric diagnoses, but that "the criteria are unstated ones, lying in the culture itself". (Ingleby, 1981: 32).[4]

Within the positivist paradigm, observed data should be both reliable and valid. Following the argument of there being a fundamental flaw with the idea of observing the mind, scientific concepts such as reliability and validity are negated. Reliability statistics usually relate to differential diagnosis, that is whether a case which has already been judged disordered can be classified according to the diagnostic system. In confirming psychiatric syndromes, inter-rater reliability is used in the absence of more robust reliability measures. International comparisons of assigning diagnosis have revealed a wide range of concordance, from 36% to 74% (Bentall, 2003). Spitzer's reanalysis of what were considered to be the best six international studies of psychiatric diagnosis indicated consistently lower levels of agreement than those claimed by the original authors (Spitzer and Fliess, 1974). Boyle (1990b) argues that where high levels of agreement are achieved, they are often over-valued. Reliability studies on DSM classification are widespread in the psychiatric literature and some have concluded that DSM IV has achieved "reasonably high rates" of inter-rater reliability and "on the whole, reasonable agreement can be achieved among trained staff that a patient does or does not conform to operational criteria for the diagnosis of schizophrenia" (Johnstone, Humphreys et al., 1999: 44). For Johnstone et al, writing from a biomedical perspective, there is no acknowledgement of the inherent cultural bias of inter-rater reliability. With raters being Western trained psychiatric professionals it is not surprising that reasonable rates of reliability are achieved, as agreement may be based on nothing more than "shared idiosyncratic beliefs" (Boyle, 1990b: 85). Consensus of

[4] It is unclear here whether Ingleby is referring to psychiatric culture or more general culture.

opinion is not a reliability measure, but rather it forms a social construction of behaviour, a social stereotype, which in itself is not problematic, but it becomes so if presented as science. As Jackson and Fulford argue, consensus, whilst important:

> cannot be the final, less the sole, criterion for the normal…It is, also, a potentially dangerous criterion, justifying as it does the tyranny of the one by the many. (Jackson and Fulford, 1997: 89)

Furthermore, reliability statistics do not take into account subjective interpretations or the situational context of the behaviour, nor do they say anything about the construct's validity. Rosenhan's classic experiment where all eight pseudopatients were diagnosed with a psychotic disorder despite ceasing to fake symptoms, powerfully questions both the reliability and validity of psychiatric diagnosis (Rosenhan, 1973).[5] All the hospital staff agreed that the sane pseudopatients were in fact insane, therefore high reliability does not equate with accuracy within the classification system. Moreover, Rosenhan's study highlights an issue that has been largely ignored by researchers and diagnostic manuals, which is the validity of diagnoses, as what was claimed to be detected (paranoid schizophrenia in seven cases, manic-depressive psychosis in the remaining case) was actually not. Achieving high degrees of inter-rater reliability is not difficult, but as in witch trials, validity cannot be inferred from a body of agreement (Brown, 1990). For a construct such as schizophrenia to be valid, meaningful clusters of observations have to be identified together with repeated demonstrations of the construct's predictive power, which Boyle argues has not been the case (Boyle, 1990a; 1990b; 1999). The authors of DSM take validity as a truism, being implicit in the

[5] See chapter two, footnote 12.

authority of the expert consensus (Sarbin, 1997). Psychiatry imputes validity from its correlation to other measures, such as diagnosis in medical records, but what psychiatry calls construct validity others have called "successful social hegemony" (Brown, 1990: 393[147]).

The second assumption underpinning the positivist paradigm is that deterministic theories can be constructed on the basis of inferred causal relationships. Three sources of evidence are used to support this assumption; genetic studies, physiological studies and physical treatments. To examine the first of these, inheritance studies, in particular twin studies, have been used to support a genetic factor in the prevalence of mental illnesses, especially psychoses such as schizophrenia and bi-polar disorder (Ingleby, 1981: 34). Concordance rates in separated identical twins are considered to be the strongest form of evidence, but are not without their methodological flaws. For example, zygosity of twins can be difficult to determine without genetic testing; samples are biased as diagnoses are not made "blind"; the term "separated" has a wide interpretation and takes no account of the similar cultural and socio-economic environments in which separated twins are placed, nor the degree of mental distress separation incurs. Taking into account the different forms of research in monozygotic twins, concordance rates range from at the highest 50% to as low as 14% (Moncrieff, 1999: 1498). Marshall (1990) purports that researchers have consistently chosen the method most likely to support the theory of inheritance of schizophrenia, arguing that the genetic determination of schizophrenia is treated as an axiom as opposed to a hypothesis. Whilst inheritance studies continue to be cited as evidence of the role of genetics in schizophrenia, similar methodological research which demonstrated different results is seldom referred to. For example, Heston's study of adopted children

of schizophrenics demonstrates how life circumstances can influence outcome. In his study, those adopted who were not diagnosed as mentally ill later in life, were found to have more artistic and creative occupations than a comparison sample (Heston, 1966). More recently, genetic studies have focussed on molecular research, but to date there is no convincing body of evidence.[6]

A second source of evidence is physiological studies. These have been particularly prevalent over the last forty years, partly because of improved technology, but also partly as a defensive response to the anti-psychiatry attacks of the late 1960s, "a way of securing unity in a disunified profession" (Brown, 1990). Much of this research is devoted to neurological and biochemical differences, the challenge being to discover a causal link between the brain and schizophrenia. However, establishing a causal link between observed physical differences and behaviour is a methodological minefield. First is the implicit and unchallenged assumption that diagnosis is a truism, with social and historical aetiology ignored. Second, if one were to accept diagnostic categorization, it is impossible to isolate causality from the intricacy that makes up a person's life, making it more likely that a complex interaction of physical, psychological and environmental factors influences a person's behaviour rather than a single determinant. Third, even if a relationship between the brain and schizophrenia was definitively established, direction of causality would be difficult to resolve between an anomalous brain scan and auditory hallucinations. Any psychological event is accompanied by a change in the neural structure of the brain. To give a light hearted example, London taxi drivers have been shown to develop an enlarged posterior

[6] It should be noted that the search for genetic explanations is not a harmless endeavour, but one saturated with moral and ethical dilemmas. Moncrieff, for example, cites a case where a couple, both of whom had been diagnosed with schizophrenia, were advised not to have children (Moncrieff, 1999: 1498).

hippocampus as a result of learning "the knowledge" (Maguire, Gadian, Johnsrude et al., 2000 in Bentall, 2003: 160). Even bio-medical texts on schizophrenia appear confused as to the relative success of recent studies. In their preface, Johnstone et al. (1999: xi) proclaim that "the challenge described by Weinberger (1995) of finding evidence that would implicate the brain in schizophrenia has been overcome" later referring to the "compelling evidence for the presence of specific structural and functional abnormalities associated with symptoms, signs and course of the condition" (ibid: 258). Yet elsewhere in their book the authors state "there is still no structural or functional abnormality of the brain which is reliably found in cases of schizophrenia *and not in other people*" (ibid: 146 emphasis added). So for example, whilst evidence has been put forward for enlarged cerebral ventricles in those diagnosed with schizophrenia, statistically findings are not significantly different from those patients with other mood disorders (Bentall, 2003: 158-9). The failure to establish a causal link between brain and behaviour judged to be schizophrenic is seen by medics and researchers to lie in the complexity of the brain, rather than in the inadequacy of the hypothetical construct. For example Karson et al. state that "the biochemical basis of the schizophrenic syndrome remains elusive", implying that it is present and there to be found (Karson, Kleinmand and Wyatt, 1986 in Boyle, 1990b). Thus the conventional publication style together with optimistic language used, obscures the paucity of supporting evidence (Boyle, 1990b; Sarbin, 1990).

A third form of evidence put forward is the efficacy of physical treatments. Historically these have been tried and tested on those identified mentally ill (Scull, 1991; Johnstone et al., 1999), in some instances diagnosis being made following the patient's response to treatment (Brown, 1990) . However, as Ingleby points out, there are two issues here.

First, *who* defines treatment as being effective? The treatment is only effective for as long as it is believed in either by the patient or the professional. Second, *how* do we define effective? ECT helps people to forget the pain of misery at the expense, in some cases, of gross memory impairment. Prozac helps to manage emotions by leaving no emotions to handle. As Ingleby states, "talk of a "cure" becomes rather ironical" (Ingleby, 1981: 37). He goes onto argue that even if a treatment is judged to have a real and positive effect, it does not automatically follow that the definitive cause was physical. Moreover, research focuses on the effectiveness of physical interventions, ignoring the number of people who do not respond to a particular treatment, which is usually greater than those that do (Boyle, 1990b).

Phenomenology and Psychiatry

Having deconstructed the evidence and mechanisms that support schizophrenia as a viable diagnostic construct, I want to move on to a more fundamental link between psychiatry and science, and that is psychiatry's basis in phenomenology. Bracken and Thomas argue that there are two fundamental assumptions underlying the phenomenological approach in contemporary psychiatry that have their foundations in positivistic methods. First, that psychological phenomena can be described, conceptualized and categorized in the same neutral, scientific way physical illnesses are, a point already discussed in this chapter.[7] Second, that psychological phenomena can be addressed as a separate entity to the meaningful contexts from which they emerge (Bracken and Thomas, 2005). So whilst the social, cultural and temporal context of a person's life is acknowledged, it is marginalized within this process in favour of the presenting symptoms. This, Bracken and Thomas argue, is a specific interpretation of

the word phenomenology based on the philosophical writings of Husserl (1859-1938).[8] Husserl is widely acknowledged as the founder of phenomenology, and there are three aspects of his work which are pivotal to the development of phenomenology in psychiatry. First, Husserl regarded philosophy as a science, but a science that seeks to establish universal laws through observation and description as opposed to causal explanations. Second, Husserl proposed there existed "intuitive truths", the highest form of knowledge which is self-evident, for example in mathematics (2+2=4) and in everyday experiences ("it is raining"). Intuitions are not irrational hunches, nor do they require verification, they are immediately known, an "immediate imitation of truth itself" (Husserl, 1970a in Moran, 2000: 95). Intuitions become central to phenomenology's object of study; subjectivity. Thus for Husserl, phenomenology is grounded in experiential, yet cognate knowledge, encompassing all conscious experiences. The central question with which Husserl grappled throughout his career was how consciousness acquired objective knowledge, or how objectivity is grounded in subjectivity. This leads to the third aspect of Husserl's philosophy which is relevant to phenomenology in psychiatry. As consciousness is ever present, Husserl believed it was obscured and distorted by the external, natural world; for example, by our cultural assumptions and our religious, technical and scientific knowledge. In order to isolate and access pure consciousness, Husserl suggested we put aside all our acquired knowledge via a "suspension of natural attitude" (Moran, 2000: 11). This could be achieved, he suggested, through a process of phenomenological or transcendental reduction, involving both intuiting and reflection. Husserl argued that phenomenological reflection enables us to access the original, previously unknown

[7] Social constructionists such as Gergen and psychiatrists like Bill Fulford, who trained as a philosopher, would argue that the description of physical illnesses is never value-free or neutral, obvious examples being AIDS, but less obviously cancer and heart disease (Gergen, 1999; Fulford, 1989).

evidence underlying the intuition, thereby accessing the a priori manner in which meanings are related together (Moran, 2000). This requires a shift from the contemplation of the "here-and-now" of an experience to the contemplation of its essence, by a stripping away or bracketing of our natural assumptions and theories of the world (Moran, 2000).[9] Husserl argues that it is only by accessing the essence of conscious experiences that universal principles can be claimed. Phenomenology therefore becomes the "science of origins" (Husserl, 1970b in Moran, 2000: 137).

The influence of Husserl's early writings on phenomenology is evident in Karl Jaspers' *General Psychopathology*. This classic text is a foundation stone for much contemporary psychiatric theory and practice, advocating the phenomenological approach as a means of accurately describing and identifying signs and symptoms of mental illness (Jaspers, 1963 in Bracken and Thomas, 2005). For Jaspers, phenomenology was a medical tool for use in the empirical science of psychopathology, rather than a philosophy as Husserl believed, with the aim being to provide scientific, generalisable and universal accounts of human behaviour. Phenomenology provides an objective framework within which the patient's subjectivity is dislocated from the body, the spatial and temporal world, and, of course, the psychiatrist. In other words, subjectivity is divorced from meaning. This is reflected in Jaspers' distinction between phenomenology and hermeneutics. For Jaspers, phenomenology describes the patient's subjectivity (form), whereas hermeneutics refers to understanding the meaning behind

[8] The account of both Husserl's and Heidegger's phenomenologies draws heavily from Dermot Moran's book *Introduction to Phenomenology* (2000, London: Routledge).

[9] In later works such as *The Crisis in European Sciences*, Husserl altered his position on the role of the natural world in the study of subjectivity. He claimed his Cartesian reductionism of conscious experiences made the ego "apparently empty of content" as it bypassed the complex ways in which subjectivity is embedded in the contextual world (Husserl, 1970b in Moran, 2000: 139). He uses the term "constitution" to reflect how the natural, social, cultural and temporal world is inextricably bound with consciousness, pre-empting the social constructionist movement of later years.

the patient's experiences (content) (Jaspers, 1963 in Bracken and Thomas, 2005). This could be viewed as a departure from Husserl, for whom the understanding of the inter-related meanings of subjective experiences was central to phenomenology. What Jaspers means by hermeneutics, however, is the *contextual* content of experiences, so this isolation of subjectivity from context is entirely in keeping with Husserl's separation of consciousness from the natural world. It is argued that this distinction and privileging of form over content persists to this day (Boyle, 1999; Bentall, 2003; Bracken and Thomas, 2005); for example, whether voices are in the third person or not is often of greater importance to clinicians than the meaning of the voices for the individual. Whilst Jaspers proposes a phenomenological approach in line with Husserl's thinking, this perspective can be critiqued as being philosophically flawed. How can phenomenology critique naturalism and positivism and yet still align itself with science? Whilst it does not look for causal explanations, it still holds the identification of universal laws as its primary purpose. From a social constructionist perspective it is nonsensical to infer universal principles from subjectivities. How do we know that what one person sees as red, another does not see as blue? Moreover, phenomenological reduction infers a Cartesian split in consciousness between the experiencing consciousness and the reflecting consciousness. How can consciousness be separated in this way? Which part is doing the experiencing and which the reflecting? Finally, and perhaps most importantly, how, as Husserl later acknowledged, can subjectivity be studied outside of the natural world?

These dilemmas are addressed by Husserl's one-time assistant Heidegger, a theorist widely regarded as one of the twentieth century's foremost philosophers. Heidegger (1889-1976) became deeply critical of his former mentor's phenomenological

philosophy in three key respects. First, Heidegger argues that it is impossible to achieve the complete reduction to the essence of experience as purported by Husserl, suggesting instead that we can only think back to our practical living experiences, what Heidegger termed *being-in-the–world.*[10] For Heidegger the pure essence is always inaccessible as reflection distorts the human experience. Second, he disagreed with isolating subjective experience from contextual and historical perspectives. Drawing on the influence of Dilthey, Heidegger places historicity or temporality central to understanding human experience. Human existence takes place in time "spread out between past and future and radically limited by death and so essentially incomplete" (Moran, 2000: 198). Third, he rejected Husserl's stance of phenomenology as pure description, arguing that all description is interpretation, thus embedding the hermeneutic circle within phenomenology. Our experiential understanding is embedded in Heidegger's *world* (see footnote 11), in particular the temporal world, and, as such, is interpretative from the start. For Heidegger, there is no linear time frame or a succession of "nows"; the present is not atemporal, being fixed or separate from the past or future, but is constantly engaging and contrasting with other temporal spaces (Heidegger, 1962 in Bracken and Thomas, 2005). In Heidegger's phenomenology, temporality is constitutive of being, what Heidegger refers to as *having-been-ness* (Leonard, 1994). Within this temporality, we are confronted with endless possibilities for engaging in different projects; however, such freedom of life choices is always situated, being bound by the historical, social and cultural contexts in which we live, what Heidegger terms as *thrownness* (Cooper, 1996). Human freedom is therefore constituted by the world of meanings in which we exist, but crucially, as Merleau-Ponty highlights, the significance

[10] *Being-in-the-world* refers to the total immersion and engagement of humans with the world and the hyphens reflect this "unitary phenomenon" (Cooper, 1996:25). The words *in-the* refer not to space or location (as in a pea in a pod or a person in a car), but rather they refer to our complete engagement with

of these meanings has already been chosen for us (Moran, 2000). Our world is therefore comprised of possibilities for what a person can and cannot become, an argument I shall return to in the next chapter, where I explore Bakhtin's concept of unfinalizability. Moreover, Heidegger contends that what we experience as meaningful is a collective experience that is socially embedded, a product of joint action (Bracken and Thomas, 2005). Our emotions, attitudes, understanding of the world and our use of language are all a shared participation in public understanding reflecting contemporary times and circumstances (Cooper, 1996). Meanings do not emerge from cognitions, but from our shared activities and engagement with the world.

The psychiatrist R.D. Laing drew on Heidegger's philosophy in his conception of *the self* in relation to psychosis (Laing, 1965). He employed Heidegger's term *being-in-the-world* to explore how someone's *being* could be disrupted by psychiatry. Laing argues that the technical discourse used by psychiatry effectively splits or isolates the person (being) from their world. He goes on to contend that unless we understand that a person does not live without their world, nor does their world exist without them, the study of schizophrenia will continue to reflect the experiential split of the person's *being-in-the-world* (Laing, 1965: 19-20). For Laing, whilst *being* can be understood from different viewpoints, it should always be understood within the totality of the person's world. What a person holds as significant may change with context, thus revealing different understandings of their experience. Bracken and Thomas support Laing in this respect, arguing that psychiatry would be better served by being grounded in Heidegger's approach to phenomenology as opposed to Husserl's. In their account of post psychiatry, Bracken and Thomas envisage a new direction for psychiatry based on

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the world (as a jockey is in the world of horse racing). In this way we get a sense of the world "holding

Heidegger's philosophy; one which takes account of the social, cultural and temporal contexts of human experience, for it is only in such contexts that what a person values or finds significant is apparent; one which gives precedence to the understanding of content and meaning, as opposed to biology; and one where diagnosis becomes an equitable process of exploration between professional and patient, where professional knowledge is not privileged over the patient's knowledge (Bracken and Thomas, 2005: 133-4).

To summarise, thus far this chapter has questioned the concept of schizophrenia as a hypothetical construct and critiqued the scientific basis underpinning psychiatry, both in terms of traditional, empirical research and phenomenology, both of which viewed schizophrenia as the basis for objective science. Science, Leonard contends "limits our imaginative ability to generate questions, and, further, limits the answers we can generate for those questions that we do manage to pose" (Leonard, 1994: 45). However, to engage in a critique of terms such as mental illness and schizophrenia is not to deny the existence of individuals' experiences and behaviours. It is clear that some people struggle with very disturbing and distressing phenomenon. What is under dispute is the interpretation of these experiences and the appropriateness of constructing them within a dominant scientific paradigm at the expense of sidelining more contextual explanations. Causal relationships may be suitable for physics, but to use such explanations for human behaviour is extremely problematic. Whilst I am not arguing that a positivist or biological approach has no place in the study of madness, I am cautioning against a simplistic biological reductionism. Kraeplin's paradigm persists as the dominant diagnostic model in psychiatry, despite empirically and conceptually

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together" in some way.

based arguments to the contrary. One of the key difficulties of such a diagnostic classification system is that it becomes unquestioned and culturally accepted, which reflects the overwhelming difficulty of finding an alternative framework within which to construct people's inner experiences (Bentall, 2003; Boyle, 1990b). Bentall argues that;

> We should abandon psychiatric diagnoses altogether and instead try to explain and understand the actual experiences and behaviours of psychotic people. (Bentall, 2003: 141)

The world of philosophy provides us with an alternative way in which to interpret human behaviour, so rather than looking for *causes* we should be looking for the *meanings* of illness. What is needed is an understanding of the way an individual attempts to construe their experiences and circumstances. The arguments of Bracken and Thomas, based on the philosophy of Heidegger, have provided us with a vision of what the future of psychiatry could look like. In the next section of this chapter I shall explicate some of the philosophical and theoretical underpinnings of this contextualist position using the works of Kenneth Gergen and Theodore Sarbin.

Social Constructionism and Schizophrenia

In beginning this section, I want to stress that its aim is not to expose mental illness as a "myth" (Szasz, 1967),[11] nor to ascribe it purely to a social process of labelling (Scheff, 1999). Kovel argues that such positions "are empirically false and philosophically shallow" (Kovel, 1988). Nor, as stated previously, am I arguing against potential

biological factors. Rather I shall present a social constructionist perspective of madness, namely that it is an emergent product of social relations and their discourses. Using the work of Gergen and Sarbin, I shall argue that language, metaphor and context are central to both experience and the communication of this experience to the other.

As outlined in the previous section, observations in psychiatry are inextricably related to language and discourse, with the common assumption being that language provides access to the mind. For some, language reifies inner experiences, describing them, for example, as schizophrenia, addiction or anxiety. However, Gergen states that to frame such concepts within this realist view is problematic (Gergen, 1990; 1999). Gergen's argument draws heavily on Wittgenstien's philosophy, which questions the assumption that we can use language to talk about our internal world in the same way we do the external world (Wittgenstein, 1967 in Bracken and Thomas, 2005). Gergen highlights five philosophical difficulties with this assumption. First, how can consciousness be turned in on itself to identify its own states? Which part of the mind is observing and which part is observed? Second, what criteria do we use to identify mental states and how can we be certain that such states have been correctly identified? How do we identify anxiety for example? Is it through physiological signs such as increased breathing or raised pulse? Why do these signs indicate anxiety as opposed to love or fear? Third, how do we know that subjective experiences resemble one another? How can we be certain that what I name anxiety is not the same as what another person calls love or yet another calls anger? Fourth, many concepts describing mental states have fallen out of use (e.g. neuralgia, hysteria, melancholy) and more recently homosexuality has been removed from DSM classification; does this mean that the subjective

[11] When Szasz referred to mental illness as a myth, he was not disputing the psychological distress

experience described by these words has disappeared? Fifth, how do we account for the different psychological language used in different cultures? For example, for the Ukta Eskimos there is no recognition or word to represent what Western society calls "anger" (Wetherell and Maybin, 1996). The fact that we rarely question the ontological status of our inner world demonstrates how embedded language and its linguistic devices (e.g. metaphors) are in our conceptualisation and articulation of our subjectivities.[12] It also highlights how we place our subjectivities in an epistemologically privileged position, treated as "unverifiable facts" (a deliberate oxymoron – they are unverifiable, yet we accept them as truths) that cannot be disproved. Language is not a mere reflection of an inner state, it is an integral element of social relationships that acquires its meaning and significance from the way it is used in human interaction in a particular context (Gergen, 1990).

By not questioning the use of psychological language to frame experiences, we accept the ontology of mental illness, ignoring the multiple functions the concept serves in the social world. First, the language used has to be translated from the cultural commonplace to the terminology of the expert, embedding it within medical discourse. This maintains the illusion of similarity between psychiatry and medicine, which in turn upholds the credibility and expert status of the profession. The psychological vocabulary used also contributes to the institutionalization of treatment, so that the experience is taken out of its social context and redefined in the professional sphere, which may, for some individuals, offer some reassurance that their experiences are not unique; that they are taken seriously and will be understood and addressed. Gergen

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experienced by individuals, rather he was arguing that the metaphor of illness had acquired a real status, analogous to the myth of witchcraft in the sixteenth century.

(1990) argues that by awarding concepts such as schizophrenia scientific status it transforms the experience into a problem solving activity, inducing a sense of optimism for professionals, for many disturbed individuals and for the lay population. For the lay population, such conceptions are not illegitimate reifications, but an "objective fixed point on a terrain of uncertainty" (Bury, 1982: 179). Whilst this may be useful in the short-term, for example in getting time off work, in the long term it can lead to a passive role in relation to the ascribed illness (Bracken and Thomas, 2005). Gergen contends that the deterministic and essentialist nature of psychological language effectively reduces people's behaviours to an inherent deficit, which cannot be overcome without professional help, thus binding the individual to the expert, which may decrease their capacity to generate their own solutions (Gergen, 1990). Second, the idea of schizophrenia as a disease distances us from disturbed individuals, making a distinct boundary between self and other, us and them. For both professional and lay people, this distinction, even if viewed sympathetically, relationally positions us as superior to the disturbed other, creating implicit hierarchies. As described in the previous chapter, whilst this division has historically emerged over the centuries, Gergen contends that as the language of psychological deficit has grown, so have our hierarchies of discrimination, making culture progressively incapacitated (Gergen, 1990). Many mental health professionals and organizations such as SANE[13] believe they are serving a positive function by aligning mental phenomena to physical illness, that somehow equating the term "schizophrenia" with "diabetes" can shift societal attitudes. However, as Sarbin and Mancuso suggest, the potential usefulness of illness as a value-free metaphor was lost as the term mental illness gained its "mythic status" (as a real

[12] Mark Johnson (1987) argues that metaphor is not a device of language, but an embodied imaginative capacity that enables language, an argument I shall return to later in this chapter in relation to Sarbin's work on metaphoric intent.
[13] Schizophrenia A National Emergency.

disease) and its negative valuations (Sarbin and Mancuso, 1980).[14] Historically, psychiatry has labelled those that society has rejected, therefore the diagnostic label of "schizophrenia" will never compare with that of "diabetes", as it is, in its essence, a symbol of rejection (Bracken and Thomas, 2005). Moreover, the extent to which the disease model has been appropriated by lay people is questionable, as they continue to use what Bakhtin describes as *Great-time words*, that is words which are sustained across cultures and histories; for example, crackpot, lunatic and schizo (the meaning of which is different to schizophrenic, referring to 'the two faces of madness' or split 'personality'). This said, the distinction between self and other created by the metaphor of mental illness serves to strengthen our belief in a stable and orderly world, fostering our sense of safety. This may seem at odds with lay fears of the violent and unpredictable nature of people labelled schizophrenic, but the grouping and categorising of disturbed behaviours enables the public to formulate predictions and take action (e.g. involuntary admission, medication, risk management strategies, governmental policies). Aligning disturbed behaviour within a medical framework explains the inexplicable, rendering the alien familiar and consequently makes it less threatening. Thus in the case of schizophrenia, a bizarre form of comfort is taken from the fact behaviour may stem from an incurable brain disease! Moreover, accepting a disease aetiology absolves the "victim", their family and society from responsibility in relation to disturbed behaviour (Boyle, 1990b). Some of the difficulty with constructing alternative, more contextual accounts of bizarre behaviour is that it removes the notion of blamelessness and increases the feeling of threat. To challenge a disease model is to challenge ourselves.

[14] Foucault argues that this negative valuation was inherited as part of the leper legacy (see chapter two).

One of the central features of constructing schizophrenia as a relational product is the process of diagnosis-making (Kovel, 1988). Diagnosis positions the parameters of normality and abnormality, and demarcates professional and institutional boundaries, bestowing psychiatry with the power to label and manage people on behalf of the wider society (Brown, 1990). Brown states that "psychiatric diagnosis is the social representation of psychiatric knowledge" (Brown, 1990: 389). For many critics, mental disorders do not exist without the process of diagnosis-making (Gergen, 1990; Sarbin, 1990; Kovel, 1988; Brown, 1990). The language used in this social interaction both names and constructs what it perceives to be the psychological processes of people's experiences. Diagnosis is also a location of struggle, where lay and professional, supporters and critics, fight over the functions of diagnoses (Brown, 1990). The use of diagnosis and its attendant manuals represents a "power linguistic approach" in which an individual's subjective experience is forfeited for clinical objectivity (Brown, 1990). It exists therefore not for the object (the disturbed individual) but for the subject (the clinician), with the objectifying gaze replacing the intersubjective dialogue (Kovel, 1988). This reflects Husserl's and Jaspers' writings on phenomenology, where the phenomenological gaze is objective, scientific, rational and neutral-free, seeking only to observe, describe and interpret (Jaspers, 1963 in Bracken and Thomas, 2005). Using Husserl's terminology, the social, cultural and scientific assumptions of the psychiatrist can be bracketed so there is a "suspension of natural attitude" (Husserl, 1983 in Moran, 2000: 136). This bracketing-off of subjectivity and exclusion of meaning is endemic in psychiatric practice (Corin and Lauzon, 1992). However, as Laing points out, such objectivity is impossible, as "to see 'signs' of 'disease' is not to see neutrally" (Laing, 1965: 31). To see a patient as someone with signs of schizophrenia and to see him/her simply as a human being are radically different constructions (Laing, 1965). Kovel

argues that the objectifying gaze used in the diagnostic process transforms an essentially subjective experience into an impersonal object "and so it violates its essence" (Kovel, 1988:134). Being treated in such a way when one's being is in a precarious state, is enough to challenge and threaten one's very own existence or, as Laing describes it, one's *ontological security* (Laing, 1965). To talk therefore of an objectifying gaze is not to consider it a passive feature in the social relationship of diagnosis. Nor should the power within the physician/patient relationship be viewed as merely repressive or silencing. Rather power is used positively to reconstruct the patient's experiences. Foucault argued that discourse both constructs and regulates the performance of the self, whilst simultaneously restricting other discourses. Thus, power becomes a central feature of discourse, forming what Foucault refers to as power/knowledge complexes, whereby power is an emergent property from forms of knowledge, institutions and their discourses (Foucault, 1979). Foucault would argue therefore that power is present in all discourse, including oppressed discourse, which manifests its power through resistance. It could be argued however that resistance is disabled by using medicine as an explanatory framework, as it removes the individual's experiences from the social context in which they occurred, thereby stripping them of meaning. Bracken and Thomas (2005) argue that this profoundly affects all concerned (the individual, their family and professionals) as the search for meaning is abandoned. Moreover, diagnosis, once conferred, positions the disturbed individual in an altered social narrative, that of the patient (Sarbin, 1990).

Corin and Lauzon suggest that rather than behaviours being interpreted as symptoms of a pathological process, they should be accepted and interpreted as signs that express an experience from which meaning can emerge (Corin and Lauzon, 1992: 268). Moreover,

redefining disturbed behaviour to a homogeneous diagnostic category obscures the heterogeneous nature of individuals' experiences, the meaning of which Sarbin argues can only be constructed from "detailed knowledge of self-narratives" (Sarbin, 1990: 261). In his analysis of schizophrenia as a social construction, Sarbin purports that hallucinations are no more than self-reported imaginings which have two intractable elements. First, serious talk by an individual of apparent counterfactual entities such as spirits or apparitions, and, second, the labelling and discrediting of such talk by another as heedless or foolish (Sarbin and Juhasz, 1978). The first person (actor) is therefore judged by the second person (observer) as being incapable of evaluating the truth of his experience (i.e. that he is hallucinating).[15] Some may judge the actor's reports as meaningless, others may not dispute they have meaning for the actor, but that this meaning is misplaced or simply wrong. Laing concurs with Sarbin's position stating that "*sanity or psychosis is tested by the degree of conjunction or disjunction between two persons where the one is sane by common consent*" (Laing, 1965: 36, emphasis in original). Husserl argues that such naturalistic, positivistic positions are absurd and "counter-sensical (*ein Widersinn*)", as they deny the reality of consciousness, whilst simultaneously assuming the existence of consciousness to give rise to the descriptions in the first place (Husserl in Moran, 2000: 143). Bracken and Thomas (2005) highlight the unethical nature of such positions. What the observer does is place a negative valuation on the actor's experiences, effectively excluding and degrading them (Goffman, 1961; Sarbin and Juhasz, 1978). This negative valuation is an essential feature of the concept "hallucination". Without it, reported imaginings would be named more neutrally (e.g. fantasies or daydreams). Thus the concept hallucination is only used as a result of the interaction between the individual reporting his/her imaginings

[15] For ease of reading, I shall use the symbolic interactionist terms of actor and observer to refer to the

and the person empowered with the authority to pass judgements on these imaginings (Sarbin, 1990). Within this social relationship, hallucinations are traditionally perceived as intrapsychic phenomenon, which, by bypassing the interpersonal features, makes it easier to frame within a scientific paradigm.

The negative valuation placed on the term "hallucination" is absent in some sub-cultures (e.g. spiritualist religions) and self-reported imaginings (e.g. "I could feel Jesus enter my body" or reports of communications with the dead) are given special status, affording the individual a powerful position as they are seen to fulfil an important social function (Sarbin, 1990). Sarbin argues that the concept "hallucination" has acquired its negative status in many Western, secular cultures because of the widespread belief that another person cannot legitimately occupy another perspective from our own whilst appearing to share the same spatio-temporal context (Sarbin and Juhasz, 1978). The social context in which imaginings are reported is therefore pivotal to the construction of the concept hallucination. Language, Sarbin argues, plays a crucial part in this, in particular metaphor. Johnson defines metaphor as, "a process of human understanding by which we can achieve meaningful experience that which we can make sense of" (Johnson, 1987: 15). Johnson goes onto suggest that an understanding of metaphor is imperative if the observer is to grasp the meaning within the actor's speech (ibid: 5). Meaning, he argues, is grounded in figurative patterns that cannot be reduced to literal concepts. As he warns, "we must not mistake our mode of description for the things described" (ibid: 4). Johnson's argument has important implications for those trying to communicate unusual experiences. The person reporting his imaginings literally may be unaware of the norms regarding language constraints when talking about imaginings.

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person reporting unusual experiences and the person receiving these reports.

For example, an individual might state "It was as if Jesus entered my body". Using the linguistic device "as if" is an attempt to get the observer to share the actor's perspective. However, the actor may feel this translation of the event did not convey the strength of feeling attached to the experience. The simile "as if" is therefore replaced with the metaphor; "Jesus entered my body", a metaphor that employs our physical experience of containment (being *in a room*) to express an abstract concept (Johnson, 1987: 30-1). In his later work, Sarbin argues that:

> when people claim that their imaginings are real, they are probably deeply involved in *as if* behaviour, behaviour that may be described as being lively, forceful and vivid – words that connote the bodily effects of emotional life.
>
> (Sarbin and Keen, 1998: 66-7, original emphasis)

For Sarbin therefore, the higher degree of organismic (emotional, cognitive and physiological) involvement in the experience, the more likely the actor will interpret their imaginings as equivalent to verifiable perceptions, a factor, as I shall outline in my analysis of Margery Kempe's narrative, central to the experiences of mysticism. However, when interpreting this self-report, the observer might mistake the metaphoric intent of the speaker (Sarbin and Juhasz, 1970).[16] As Laing points out, delusions contain existential truths, which are "to be understood as statements that are literally true *within the terms of reference of the individual who makes them*" (Laing, 1965: 149

[16] I go on to explore the relationship between experience and metaphor further in the next chapter, where I argue that metaphor is draw upon to describe 'indescribable' experiences.

emphasis added). The seemingly senseless therefore becomes a metaphoric and meaningful way in which to communicate one's sense of being.[17]

This confusion in communication can be further complicated by the social context in which private imaginings are made public. The medical consultation may put such pressure on an individual to make their imaginings coherent, that the metaphoric meaning behind the utterance is lost (Sarbin and Juhasz, 1978). These confusions "are not just signs of ignorance or lack of knowledge, but a predictable result of the metaphorical language when employed to communicate imaginings" (Sarbin and Juhasz, 1970: 66-7). Heidegger, described by Moran, makes a similar point stating that due to the nature of discourse, any verbal act can be:

> 'passed along' in such a manner that the original power of the revelation of the utterance gets covered up or distorted and congeals into an everyday sense which loses its urgency and its power to stimulate. (Moran, 2000: 230)

Sarbin suggests that in order to overcome such difficulties, the observer needs to give legitimacy to the actor's imaginings, which means taking the perspective of the other, including the social and temporal contexts in which imaginings occur, thereby making a genuine attempt to understand the meanings underlying the experiences (Sarbin and Juhasz, 1978). This understanding is not purely an intellectual process, but an empathic reaching-out to the other whilst recognizing "all the time his distinctiveness and differentness, his separateness and loneliness and despair" (Laing, 1965: 38). This last quote from Laing is important, as it reflects the fact that whilst Laing and Sarbin argue

[17] Daniel Schreber a high ranking German judge whose career and marriage were destroyed by madness,

for a phenomenological and social constructionist approach to schizophrenia respectively, neither theorist disputes the devastation such experiences can cause to an individual's life. Rather than a breakdown of an organic machine as positivism suggests, the breakdown ascribed to schizophrenia could be described as "a rupture in the patient's ability to negotiate the world" (Leonard, 1994: 53).[18,] The absence of health or well-being therefore brings our *being-in-the-world* into sharp focus.

Whilst Sarbin describes himself as a social constructionist, his argument on the role of conflicting discourses and communicative confusions is reflective of the symbolic interactionist perspective, a perspective dominated by the writings of George Herbert Mead. According to Mead, in order to communicate, an individual must take the role of the other, that is see from the other's perspective through a process of genuine interaction (Mead, 1934). Rosenberg (1984) argues that disturbed behaviour is deemed pathological because of a failure of the observer to take the role of the actor. Attaching a label of madness or sanity does not depend on the presentation of the actor, but the comprehensibility of their experience to the observer. Attribution is central to Rosenberg's argument. He contends that if attribution is internal, for example the observer identifies his/her own lack of knowledge as an obstacle to understanding the actor, then insanity will not be attributed. This occurs if the observer judges the behaviour to part of an alien culture or subculture of which s/he has little knowledge, for example African shaman or the Spiritualist Church. If however attribution is external, for example the actor has unverifiable beliefs both false and incomprehensible to the observer, then insanity is attributed to that person (Rosenberg, 1984). However

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speaks directly of employing metaphors to describe his ineffable experiences; "To make myself comprehensible I shall have to speak much in images and similes" (Schreber, 1955/2000: 16)

[18] Leonard's quote actually refers to all illness, not just schizophrenia.

as Sarbin argues, attribution is not only situated in culture, it is also situated in time. The attribution can become redundant when the behaviour loses its status as a social threat and the wider moral belief system of society shifts, as for example in the case of unmarried mothers and homosexuality (Sarbin and Mancuso, 1980). One of the difficulties Rosenberg highlights in the case of attributing insanity is the power relationship between the actor and observer. He argues that first, the more remote the role connection between observer and actor, the less likely the observer will understand the actor's perspective; and second, when people of a similar status are more willing to take each other's perspective, this consensual opinion weakens the actor's position still further. Whilst Rosenberg and Sarbin both focus on the social relationship as a central feature of the concept schizophrenia, there is a fundamental ontological difference between their perspectives. Sarbin sees "schizophrenia" as a social construction, an emergent property of the social world, a label for deviant behaviour. Rosenberg, on the other hand, takes an essentialist view, construing schizophrenia as a property of the individual. This take on Rosenberg's analysis may seem at odds with his previously described work, but whilst he presents psychosis as an interactional concept, he goes on to argue that mental disorder does exist and can be eliminated through therapeutic intervention. So whilst Rosenberg contends that psychosis is a failure of the observer to understand the actor's perspective, he counter-argues that in many cases the observer's perspective is the "true" perspective. His argument therefore should be centred around the actor's inability to understand the observer's perspective and conform to society's norms, as he states:

> Symbolic interactionism concurs with the psychiatric view that people are ill and require treatment…what symbolic interactionism contributes is an

> understanding of what the therapist is trying to accomplish: eliminating that behaviour that *other* people cannot understand, and replacing it with behaviour that other people can understand.
>
> (Rosenberg, 1984: 299, emphasis in original)

Rosenberg's argument is not based, I believe, on symbolic interactionism, but on cognitivism. Whilst he talks of failure in role-taking, he concludes that the actor's experience is due to an internal factor which can be rectified by "reason" (the position of the observer) or physiological intervention, a position aligned to the cognitivist perspective:

> Cognitivism holds patients to a moral imperative; their view of the world, their understanding of themselves is at fault. They must rectify their faulty thinking processes, their errant reasoning. (Bracken and Thomas, 2005; 161)

Such an individualist, essentialist position, Bracken and Thomas argue, detracts from the social context in which voices are experienced and generated. Significantly, as argued by Sarbin, it ignores the metaphorical significance of voices for the individual, which may be pivotal to their ability to cope.

I want to draw this chapter to a close by introducing what will be the main focus for the remainder of this thesis: the role of narrative as a means of communicating meaning. Sarbin argues that disturbed behaviours such as atypical beliefs, bizarre speech or unusual imaginings are a means of solving existential and identity problems, of preserving a precariously structured being through the use of storied constructions or

narratives (Sarbin, 1990). The use of the narrative structure to shape biography as a means to understanding emerges from contextualism, a perspective based on the historical act as its root metaphor and one that is anchored around the integral concepts of change and novelty (Sarbin and Mancuso, 1980; Sarbin and Keen, 1998). Its premise is that the world, as experienced by the individual, is constantly changing as a result of newly acquired knowledge (Sarbin and Mancuso, 1980). The concept of temporal space is central to contextualism; to be human is to be constantly engaged in the past, present and future. This reflects Heidegger's philosophy of existing in a temporal sense as a continuous person. Contextualism also construes the individual as an agent in the social world, performing intentional actions, whereby rather than voice hearing being symptomatic of a disease, it is an adaptive act or strategy related to their self-defining narrative and their social world (Sarbin, 1997). According to Sarbin, when this person's narrative departs from conventional plot lines, s/he is described as hallucinating. What then happens, is a mutual exclusion of the each other's frame of reference. With actors' stories conflicting with observers', equilibrium has to be restored in order to reduce internal strain and sustain the relationship. This is unequivocally demonstrated in psychiatry's translation of the patient's historical narrative into a mechanistic narrative, making it comprehensible for the observer (psychiatrist), but not necessarily for the actor (patient) (Sarbin, 1997). The dominance of the mechanistic, scientific narrative in psychiatry detracts attention away from the narrative content of behaviour, leading instead to the uncritical acceptance of diagnosis and treatment (Sarbin, 1997). Sarbin's contextualist account of voice hearing has much in common with both Heidegger's phenomenological philosophy and Wittgenstein's theory of language. Heidegger used the term "being-in-the-world" to refer to our complex activity in our worlds. In essence his proposition was that we construe the worlds we live in by our very presence, which

is in itself an action. Language is a central feature of this structured activity, as it not only names but constructs our realties (Heidegger, 1962 in Bracken and Thomas, 2005). In a similar philosophical vein, Wittgenstein argues that it is inappropriate and misplaced to describe the inner world as if it were the external world; for example, psychiatry's use of signs, symptoms and indicators, as the inner world is both unobservable and unverifiable (Wittgenstein, 1967 in Bracken and Thomas, 2005). In order to increase another's understanding of our inner experience, the social contexts in which utterances are made must be central. As is seen in everyday life and psychiatry, "uncoupling language and speech from the social contexts in which it takes place can be seriously misleading" (Bracken and Thomas, 2005: 152). For Wittgenstein, there is no inner world without the outer world; the ever changing social, cultural and temporal contexts in which human activity is bound. Bracken and Thomas in their writings on postpsychiatry make a strong and persuasive argument for the widespread assimilation of this contextualist approach in general psychiatry, whereby the "webs of meaning" and the "interdependent networks of references" can be explored (Bracken and Thomas, 2005). According to them, understanding each other's inner world is possible only through hearing each other's stories. Narrative psychology, which I shall go onto explore in the following chapters, provides a framework for this story telling.

Reconciliation

This chapter has critiqued the positivist perspective of the concept schizophrenia, providing instead alternative explanations from the related fields of social constructionism and philosophy. Yet can such different explanations be reconciled and if so, how? As Taylor argues, "frameworks today are problematic" (1989: 17), the implication being no one framework is shared by everyone. This is reflected in the

different social and political positions people occupy. Perspectives such as the biochemical and social constructionist may assert themselves as offering the primary explanation, with other perspectives "filling the gaps". Therefore what may be contested and defended by the different perspectives is what is "real" (Sapsford, 1996; Devalle, 1996; Wetherell and Still, 1996). The question should therefore be; does any one perspective hold the key to truth or are there multiple realities within which human behaviour can be understood? I believe the way forward with this argument is to accept that there can never be an ultimate reality amenable to objective, empirical investigation, yet neither are human experiences complete constructions. To align oneself at either end of this dichotomy does not serve the best interests of the person undergoing what may be distressing experiences. Perspectives should not be considered as supplementary, but complementary to each other, so that together they can be considered as partial truths or visions, which are amenable to some level of integration. If we accept that perspectives offer a partial vision of phenomena such as schizophrenia, there needs to be a common reality that perspectives can agree upon if integration is to be viable. This common reality could be a model of integration that perspectives find workable. Such a model needs to incorporate oppositional factors, such as biological determinism/free-will, allowing for a fuller, more meaningful integration of perspectives. Barrett predicts that biology will find a more modest place within a pluralist model, as understandings about the psychological and cultural factors of people's experiences and the ways they are treated become more sophisticated (Barrett, 1998: 490).

Csordas offers one solution for disengaging with the longstanding dichotomy of biological versus social determinism. He argues that what is crucially missing from

both accounts is "the analysis of the embodied, speaking person taking up an existential position in the world" (Csordas, 1994: 287). The errors he argues, apply to each discipline with both biology and the social treated as objective. In biological determinism meaning is superimposed on the body, whilst in cultural relativism the body is a tabula rasa upon which meaning is inscribed. Csordas argues beyond the simplistic assertion that both culture and biology are mutually deterministic in the illness experience, suggesting that what is needed is a "cultural phenomenology of embodied experience that allows us to question the difference between biology and culture, thereby transforming our understanding of both" (Csordas, 1994: 288). The medical anthropologist Daniel Moerman offers a means of negotiating this biological-cultural dualism (Moerman, 2002 in Bracken and Thomas, 2005: 220-225). Moerman argues that all medical interventions be it making a diagnosis, giving an injection, writing a prescription or psychotherapy are imbued with meaning and cultural significance:

> Much of the meaning of medicine, of the meaning response (and in the narrowest sense, the placebo effect), is a cultural phenomenology engaged in a complex interplay on the meanings of disease and illness.
>
> (Moerman, 2002: 70 in Bracken and Thomas, 2005: 222)

Building on Foucault's position that knowledge and power are embodied in the discourse, space and discursive actions of medicine (Foucault 2000a; 2000b), Moerman highlights how biology is imbued with cultural meaning, history and tradition. Reflecting on Moerman's work, Bracken and Thomas suggest that rather than biology and culture being an epistemological dualism, they are better envisaged within a

hermeneutic phenomenology that sees human experiences as being intrinsically related to culture and narrative, temporality and embodiment. The research presented in this thesis attempts to engage with Bracken and Thomas' hermeneutic phenomenology by returning to the original expert accounts of madness, those written in the first-person, and in doing so engage with the cultural and historical meanings of madness both before and after the emergence of the hegemonic discourse of psychiatry. When using contexualism as a search for meaning, Sarbin (1990) advocates researchers return to the individual as a social agent, to explore the meanings behind behaviours, asking questions such as "what is the person trying to do or say?" or "what story is he/she trying to tell?"

> Persons are perceived as agents trying – sometimes with poorly developed skills – to maintain their self-narratives in the face of a complex, unpredictable and confusing world. (Sarbin, 1990: 279-80)

In order to understand the existential and inter-personal themes of a person's narrative, medical discourse and psychological language has to be abandoned in favour of the language of social relationships and subjectivities (Sarbin, 1990). It is these subjectivities expressed through the medium of narrative that are central to the next chapter, which moves away from the professional and academic-as-expert narratives explored in this chapter, to patient-as-expert narratives.