Unchained Minds: Self-Accounts of Madness

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Abstract

This thesis explores the connection between the historical and social construction of madness in relation to how society currently views madness and schizophrenia. The anti-psychiatry movement has been outlined using the work of anti-psychiatrists David Cooper, R. D. Laing and Franco Basaglia. Foucault's work regarding madness and the asylum is also reviewed to give an overarching analysis of madness, including analysis of its creation. With the help of Basaglia, madness as class warfare and social disease are explored. By connecting this analysis to the medicalization of schizophrenia and the use of counter-narratives, this thesis uses the work of Deleuze and Guattari to illustrate how mental illness can be redefined through deterritorialization, reterritorialization and lines of flight. Specifically, this thesis uses a Foucauldian textual analysis to examine self-narratives of schizophrenia including, the films *A Beautiful Mind* and *The Best of Youth*, and the books *Two Accounts of a Journey Through Madness*, *The Center Cannot Hold* and *Living With Voices*. These self-narratives illustrate the importance of considering an individual's voice when determining treatment options for mental illness. Overall, a shift in thinking is needed. The findings suggest self-help groups are not enough on their own and should be combined with medical intervention. Self-narratives are an important step in the recovery process as it allows one to come to terms with their voice hearing experiences. As well, self-narratives are useful in the treatment process as a tool that can help to redefine dominant conceptualizations of schizophrenia and mental illness today.

CHAPTER ONE: REVIEW OF LITERATURE

In the following literature review, a historical examination of the anti-psychiatry movement is presented, as well as many of the major theories used to disrupt the language of psychiatric evaluation and medicalization.

The Anti-Psychiatry Movement: An Introduction

Late in the 18th century, psychiatry emerged as a field of medicine created to treat those mentally disturbed individuals who were viewed as living without reason. Originally, the goal of psychiatry was to treat these individuals with techniques like living in the country, which was believed to give patients convalescence (Berlim, Fleck, & Short, 2003; Foucault, 1959). However, as psychiatry continued to grow and expand through the 19th century, physical restraints as well as less humane and more invasive treatment methods began to be used. In response, criticisms of the negative aspects of these treatments emerged. In fact, Berlim et al. (2003) pointed out that the first people to raise critical questions regarding the practice of psychiatry were laypeople. As Dain (1989) discussed, throughout the 19th century former mental hospital patients began to speak out about their treatment. Those who wanted their stories to be heard, however, lost credibility due to their marginalized status as psychiatric patients. Thus, many individuals were unable to openly share their experiences and were unable to directly confront and challenge the psychiatric establishment.

In the latter half of the 20th century, members of the psychiatry field finally began to criticize these prevailing practices. The criticisms gained force when the use of psychiatric drugs became popular. These drugs produced many negative side effects and became another form of control over patients. With the advances being made in the

psychopharmacological field, many psychiatrists began to ignore the psychological side of treatment, focusing solely on drug therapy (Berlim et al., 2003). Many groups began to consider the techniques used on mental health patients as harmful and inhumane, thus aligning to challenge psychiatry's fundamental assumptions and practices.

In 1967, David Cooper coined the term anti-psychiatry. Anti-psychiatry became known as "a social movement that questioned not only the legal privilege of psychiatrists to detain and treat individuals with mental disorders, especially in a compulsory manner, but also the medicalization of madness" (Berlim et al., 2003, p. 61). Double (2002) suggested the medicalization of madness led to everyday problems being medicalized by psychiatry. Furthermore, Double proposed psychiatry should not be forced on anyone. He viewed it as directly related to social control, where the legitimacy of professional power is brought into question. Indeed, Berlim et al. (2003) showed that the anti-psychiatry movement questioned the very existence of mental disorders.

Cooper, (1978) described anti-psychiatry as:

1. Reversing the rules of the psychiatric game; countering medical power as embodied in the diagnosis, the principal way of not leaving the other in the humiliation ceremonial of psychiatric interrogation

2. Abolition of hierarchical authority structure, recognizing that the madman may express the central authority

3. Alternative non-interference aimed at the opening up of experience rather than it's closing down. This means the abolition of all forms of shock treatment. (p. 130-131)

Cooper (1967) discussed anti-psychiatry as a perspective which sees mental illness differently: psychiatry is a tool which labels mental illness as deviant and controls this

deviance through social and political tools within society. Those who opposed psychiatric

practices believed such practices were an "illegitimate form of social control and

psychiatrists' power to lock people up must be abolished along with the institution itself"

(Berlim et al., 2003, p. 63).

During the 1960s, the anti-psychiatry movement engaged a number of different

groups mostly internal to the mental hospital that merged to combat the contradictions

within treatments and patients' rights (Berlim et al., 2003). Not only was psychiatry

criticized for its practices, but it was also criticized for its ideological categories and its

oppressive nature. Berlim et al. discuss anti-psychiatry's rejection of the medical model

where the consensus of theorists was that a "mental disorder is simply a reflection of what

society considers unacceptable behaviour" (p.62). Anti-psychiatry disagreed with the

institutional practices within the asylum, as well as newer therapies such as

psychopharmacology. This opened the field to alternative therapies which could be

created and implemented.

Key figures in the anti-psychiatric alternatives include David Cooper, R.D. Laing,

Franco Basaglia, Felix Guattari, and Michel Foucault; each with differing views and ideals,

but all equally important. The theories and beliefs of the above psychiatrists and social

theorists will be discussed further throughout this work. At this juncture, and particularly

in light of their direct involvement in the anti-psychiatry movement, I consider the first

three theorists—Cooper, Laing and Basaglia.

Cooper (1967) believed madness and mental health were created and based on

social norms. Cooper also proposed that social problems are labeled as deviant from

interactions that show they are violations of social norms and expectations. These social

norms and expectations can be viewed as a form of control created and maintained through the language we use to communicate, which will be discussed further in the coming sections. Similar to Cooper, Berlim et al. (2003) discuss that Laing also viewed madness as a social construction. Specifically, he believed those diagnosed as schizophrenic were forced to act in such a way due to overwhelming social pressures in a "mad world" (Berlim et al., 2003, p. 63). Laing believed schizophrenia was a natural process used by individuals as a survival strategy (Berlim et al., 2003). In other words, Laing viewed schizophrenia as a way to escape social pressures that could potentially affect anyone. He saw schizophrenia as the point where "the light began to break through the cracks in our all-too closed minds" (Laing, 1967, as cited in Berlim et al., 2003, p.64). Laing not only disagreed with psychiatry's definition of schizophrenia, he also disagreed with the treatment process. In fact, as Berlim et al. state, Laing did not even see the need for professional help when dealing with the mentally ill. Instead, Laing felt the best type of treatment was for patients to be able to "go through their process of madness" (Berlim et al., 2003, p. 64) with supportive care and with medication taken voluntarily and when needed. Along with Cooper, Laing was one of the founders of over 20 therapeutic communities where he supervised approximately 113 patients (Guattari, 1996). Kingsley Hall, where patients and physicians lived together equally, presented an alternative to traditional psychiatric institutionalization (Barnes & Berke, 1991). In fact, Berlim et al. (2003) note that patients at Kingsley Hall had just as much say, if not more, in their treatment process as psychiatrists. Moreover, this allowed Kingsley Hall to move away from all forms of conventional treatment in hopes of restoring unrestricted freedom to its patients.

Basaglia also saw unequal power distribution as problematic within the psychiatric institution. Basaglia made a stand against psychiatry in order to address the power struggles faced by the mentally ill both within institutions and society at large (Berlim et al., 2003). Basaglia saw the mental institutions as oppressive forces which were based on social violence and exclusion rather than biological or psychological factors. He mobilized to have psychiatric hospitals in Italy closed and to eliminate treatments such as electroconvulsive therapy, seclusion and restraint. He believed these techniques were merely used to control deviant members of society. Berlim et al. point out that Basaglia believed for patients to be cured, they must realize their exclusion due to their mental illness and refuse to accept it. Basaglia believed it necessary to look at psychiatry's role from a larger perspective, (i.e., beyond the asylum and in society as a whole). This analysis is required in the societal standards defining behaviour as normal or abnormal, as well as in the class system as it was those from the lower classes who seemed to have the most psychiatric cases.

As illustrated above, Cooper, Laing and Basaglia have similar views regarding mental illness. Specifically, they believed mental illnesses were not necessarily products of nature, but rather labels assigned to people as a form of control (Berlim et al., 2003). The language used to define these individuals is oppressive and creates negative stigma as they are seen as deviating from socially constructed norms. In the coming sections, language will be discussed in relation to the role it plays in creating and maintaining conceptions of mental illness. Furthermore, this will be connected to Foucault's and Basaglia's work surrounding the anti-psychiatry movement. Laing's work at Kingsley Hall and Guattari's views will be discussed as well.

Language and Knowledge

Deleuze and Guattari (1987) state "language is not life; it gives life orders" (p.76). Language is not something to be believed, it is something to be obeyed and, further, it demands obedience. Language can be defined and interpreted in many ways[1]. As such, language plays a major role in the construction and maintenance of knowledge and discursive practices. Contrary to our popular view of language, Deleuze and Guattari have suggested language does not communicate information that conveys factual information. Language, for Deleuze and Guattari, is not only a tool for communication, but it is a tool to keep society in order. Language, in this regard, can be directly related to discourse in that "discourses can be seen as sets of statements that construct objects and an array of subject positions" (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smither, 1995, p.39). Through the language used to describe and position them, individuals are subject to the categories that describe them; certain places are marked for them and specific behaviours are expected from them (Parker et al., 1995). From this, we might infer that through the discourses used to structure society, dominant notions are created and maintained. As Parker et al. (1995) illustrate, "identification and categorization of others is at least dependent on if not entirely created within language" (p.57). Furthermore, Foucault (1972) following Deleuze and Guattari, stated that "language is neither informational nor communicational. It is not the communication of information but something quite different: The transmission of order words" (p.79). It is through language and order words that 'norms' and binary categories such as normal/abnormal, man/woman, adult/child, and ability/disability are created. This leaves us constrained by the language used to define and

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[1] Here, it is defined as any form of communication whether it be verbal, (e.g., speech), written, or nonverbal (e.g., facial expressions and body language)

describe us to the degree that such descriptions function seamlessly. One pertinent

example is how the medicalization of madness creates rule and hierarchy through binary

systems of categorization. As such, psychiatry nomenclature defines roles of dominance

and rule that create certain subjects as purveyors of the dominant logic of discipline and

control, thus giving force to certain subjects who classify other subjects as 'different' or

'dangerous'. Specifically of interest in this thesis are those classified as psychiatrists and

those classified as 'mad'.

The purpose of this thesis is to investigate the role language plays in constructing

dominant discourses in society. How does language create knowledge? How does language

create and maintain binary categories? What has happened historically to set these ideals

in place? What effects does being categorized in an either/or way have on those in the

subordinate categories, especially those classified as mad? What can be done to break free

of these binary notions? What role did the anti-psychiatry movement play in how madness

is viewed today? What is in the best interests of those considered mad? As noted above,

this thesis will seek to examine these questions to illustrate the connection between the

historical construction of madness and how madness can be treated and viewed differently

in society today by looking at the anti-psychiatry movement and self-accounts of madness.

Historical Views of Madness

In the following sections, a historical analysis of different views of madness will be

put forward to demonstrate how social factors govern and define what is considered mad

behavior.

Binary Discourses of Madness

In order to consider how dominant discourses have been created and maintained in society, we need to investigate the concept of the norm. According to Davis (2006) the concept of the norm did not appear in history until the 1840s. Since that time, it has played a major role in creating forms of knowledge about social subjects that have become a main feature of society. Davis traces the historical genesis of the norm as centred around an ideal body, or the body of God. This body was established as an ideal that everyone should seek, but none could obtain. Although this ideal body had many effects on subordinated populations such as women, people of colour, labouring bodies, queer bodies, among others, I would like to examine the idea of a norm in psychiatric terminology. The ideal body is a linguistic construct that orders subjects in the way suggested by Deleuze and Guattari above. In terms of madness, "psychiatric language constitutes the very pathological phenomena it seeks to explain" (Parker et al., 1995, p.93). Therefore, these terms are created specifically to define certain behaviours and characteristics of mental illness. As Foucault (1959) believed, scientific truths are created and maintained through language. In this process, the empowerment of some and marginalization of others is produced, especially those who deviate from the norm. As such, those who are labeled with a psychiatric illness, such as schizophrenia, are an example of a category that deviates from the norm.

Foucault (1959) discussed how scientific truths place the problem of madness within the individual and, therefore, remove the burden from society; however, without the concept of the norm, there is nothing with which to compare madness or abnormality. Through scientific truths and psychiatric language, individuals demonstrating symptoms of

madness are labeled as deviating from the norm and thus used as examples for others to stay in check. Foucault (1975) further illustrated these ideas in *Discipline and Punish* where he described how the prison became a strong tool for discipline, not only within the confines of the prison but in society in general. Individuals were expected to follow laws in order to avoid being incarcerated. This was not accomplished through violence and force, but rather through observation. The Panopticon illustrates the strong effect observation has on individuals within society. Although one is never certain they are being watched, it is the possibility that they might be or, in Foucault's words, that they are being watched by an unequal gaze which causes individuals to internalize the discipline: they are thus less likely to break laws when they believe they are being watched (Foucault, 1975). Linking this to psychiatry and its effects, we can see how those who deviate from the norm are placed under constant observation in schools, families and work places and then designated as abnormal and isolated for treatment and/or incarceration. This stigmatization and negative social sanctions function to keep other subjects in check. Clearly, then, the idea of the norm emerges with the idea of deviance and vice versa. In turn, deviating from the norm may lead to criminalization, which creates fear in society and the conditions for institutionalization in asylums for those unable to contribute to society. For Foucault (1959), hiding and excluding the abnormal created the concept of normalcy, which eventually led to the birth of the asylum.

Foucault: The Creation of Madness and the Asylum

Foucault (1959) described one way social deviants were separated from society in the 15th century. Deviants were placed on a ship named the Ship of Fools that set sail to remove the mad from society and ensure the public's safety. Once the ship of fools was no

longer used to segregate the mad, those labeled as such were driven from town to the

outskirts to live isolated from society (Foucault, 1959). As war began to ravage the

countryside, people were forced into the city where beggars and squatters became a major

issue. At this time, morality was a main factor as those not working were viewed as

morally inferior and laws were passed that made being poor a crime (Foucault, 1959). As

society began to develop and move into an industrialized state, working and contributing

to society were valued and exclusionary tools were used to separate these idle individuals

by placing them in asylums. The cause of such a shift in thinking was, as Foucault (1959)

pointed out, that madmen began to be viewed as not possessing reason.

Skott-Myhre (2008) further discussed how madness is constructed as a deviant

margin that enables society to have a disciplinary hold on individuals through the

proliferation of the panoptic gaze. Again, this is a form of discipline that operates from

within each individual who, in turn, fears the asylum and, therefore, continues to construct

madness as a foreign, distant issue. Those perceived as unable to use their reason are

placed within the walls of the asylum. Charlton (2006) discussed the institutionalized

rejection of difference where

> We have all been programmed to respond to the human differences between us with
>
> fear and loathing and to handle that difference in one of three ways: ignore it, and if
>
> that is not possible, copy it if we think it is dominant or destroy it if we think it is
>
> subordinate. (p.219)

Basaglia (1987) illustrated how the dominant class uses spontaneous consent which

he states is "given by the great masses of the population to the general direction imposed

on social life by the dominant fundamental group" where the "apparatus of state coercive

power 'legally' enforces discipline on those groups who do not 'consent' either actively or

passively" (p.143). Therefore, those in society who did not conform to the dominant

group's agenda must be disciplined, which was done through the asylum. This is one reason

Basaglia fought so hard in the 1960s for a deinstitutionalization movement, which will be

discussed further in the coming pages. The dominant class made it seem as though the

asylum was therapeutic and created to help rehabilitate; however, I will argue this was not

the case. Instead, I will propose that the asylum was used to control and segregate those

seen as deviant or, in other words, those who were not considered part of the norm

(Basaglia, 1987). Furthermore, the majority of individuals in the asylum were part of the

underclass, as society was made to believe by the bourgeois that these individuals needed

to be isolated because they were not contributing to society.

Parker et al. (1995) demonstrated that once social deviants began to be confined,

madmen were labeled and began to be treated differently. Madness elicited fear in society,

as it was never known how a madman would behave. Foucault (1959) stated that a major

factor in the management of patients in an asylum was, in fact, fear. Basaglia (1987) also

made note that individuals labeled as mad were locked up, not necessarily due to the fact

they had done something wrong, but rather because of the threat that they might do

something to cause harm to others. This was problematic as behind the asylum walls,

therapy techniques included electro-shock, psychosurgery and hydrotherapy (Skott-Myhre,

2008). Furthermore, the practices of the asylum failed to respect the human dignity of the

patient. This led to the inhumane use of restraint and lack of consideration of human

hygiene. Skott-Myhre (2008) reviewed Basaglia's reasoning for wanting to change the

abysmal state of the asylum during the anti-psychiatry movement, not only due to the poor

treatment of the patient but in order to "return what he called subjectivity to the patients whom he felt had lost any sense of themselves through their incarceration" (p.27) Again, this can be linked to the anti-psychiatry movement where a consensus was that asylums took away patients' individuality and potential. Basaglia felt patients were not suffering from a psychiatric illness, but rather from the "brutalizing socio-economic system amplified by the institutional effects of the asylum itself" (p.27).

The hospital and asylum were made to seem like institutions created to benefit those in need, but they were in fact used by the dominant class to benefit the economy (Basaglia, 1987). That is, the dominant class used society as pawns or, as Charlton (2006) states, 'surplus people' where the needs of human beings were put aside. Instead, economic demands drove these institutions to continue to benefit the dominant class and keep the deviant in subordinate positions and under control. Overall, the asylum allowed physicians and professionals to exercise their power by segregating those without economic and social resources who are seen as interfering with society's needs.

Basaglia: Madness as Class Warfare

Basaglia argued for an economic, Marxist reading of madness as class warfare. He suggests that the incarceration of madness was a result of economic conditions and the poor were overrepresented in the asylum. Those individuals who were unable to contribute to society or viewed as idle were confined in institutions that, as Basaglia (1987) stated, "shatter[s] the economic logic whereby every response to a need means an organization that lives and prospers on an expansion of the very needs it should be satisfying"(p.150). O'Connor (1973) as cited by Charlton (2006) asserted that those who have been labeled outside the norm are part of the "surplus population" (p. 218) where

they are poor and powerless due entirely to the economy. A person's class is directly

related to their economic production; therefore, those who are part of the lower and under

classes do not contribute to the economy in the way society expects and needs. Institutions

like asylums would appear to be created for those in need of these services; however, this

was not the case. Those unable to fully contribute to society were locked up, not to

rehabilitate them, rather because they were idle. In order to be cured in society, one must

accept the goals and expectations set by the dominant class, which means teaching

individuals not to stand up for what they believe and instead means adapting to society.

Basaglia (1987) discussed, "the progression of a disease…can vary according to the

patient's social class, we can no longer accept the division between science and politics, and

the fact that physicians and nurses have become the guardians of this division" (p.180).

Clearly a person's class affects how they are viewed and treated by society, thus the social

ramifications of madness require attention.

Madness as a Social Disease

Skott-Myhre (2008) reviewed how the flow of patients into the asylum is much

greater than the flow of patients who have been rehabilitated and released. This illustrates

the importance and need for the anti-psychiatry movement. Skott-Myhre (2008)

elaborated on Basaglia's notion and view of the asylum as being responsible for "the

absorption of the force of life"(p.45). Here, it is evident that once a patient was placed

within the asylum, they lost their originality and were grouped within a label. This label

dictated how patients were always treated by physicians and psychologists through the

lens of the disease model. Patients were diagnosed according to the disease model and

made to believe their madness was an internal issue; however, those involved in the anti-

psychiatry movement did not believe madness stemmed from within, but instead saw

madness as a social disease. Moreover, despite being grouped together by diagnosis, not all

cases are identical which shows why it is essential to hear different accounts of madness to

best accommodate those defined as mad. Again, this coincides with the overall belief of

anti-psychiatry theorists who see how patients lost their individuality within the asylum.

Although mental health institutions have improved immensely since the 15th

century, Basaglia (1987) believed the psychiatric institution creates "crazy people".

Foucault (1959) also viewed madness as a disease of civilization where people do not go

mad on their own, but are driven mad due to how they are positioned in society and the

associated social pressures. Parker et al. (1995) discussed Laing's understanding that, "a

person who retreats into schizophrenia does so because the threats to their existence as a

person necessitate that retreat" (p.24). Laing believed the causes behind anxiety were the

feeling of engulfment where one feels as though they are losing their identity, as well as an

implosion where the world destroys the self, all of which can be caused by the demands

society places on a person. Failure to meet these demands can lead to the marginalization

of the self as dangerous and perverse. As Basaglia (1987) stated,

> The disease is incurable and incomprehensible; its chief symptom is dangerousness
>
> and obscenity and the only scientific answer is the asylum where it can be
>
> safeguarded and controlled. Rules represent efficiency and productivity and
>
> whoever does not obey them must be relegated to a space from which he or she
>
> cannot interfere with the rhythm of society. (p.158)

Again, the asylum was created due to the dominant discourses surrounding madness. To

investigate this further, the medical model will be discussed.

Medicalization of Schizophrenia

Today the first way individuals view and approach madness is frequently through the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (Maj, 1998). Maj argues the DSM-IV-TR is sometimes the only source of information available about schizophrenia in North America. This is problematic for many reasons; one is the DSM-IV-TR consists of information strictly from psychiatrists and does not include any firsthand experiences of the disease. Brown (1995) discussed the social construction of diagnosis and illness, which is important to consider as social understanding often stems from dominant discourses like the biomedical model of disease. Again, by examining "how social forces shape our understanding of and actions toward health, illness and healing" (Brown, 1995, p.34), we are able to make changes to the negative connotations attached to such diagnoses through processes of deconstruction.

Schizophrenia is characterized in the DSM-IV-TR as consisting of a combination of positive, negative and cognitive symptoms, which must cause severe disruption in cognitive and emotional functioning in areas such as language, thought, perception and sense of self (Maj, 1998). The DSM-IV-TR lists the criteria that must be met in order for one to receive a diagnosis of schizophrenia (American Psychiatric Association, 2000). These include meeting requirements from symptomatological criteria or characteristic symptoms where two or more of the following symptoms must be present: delusions, hallucinations, disorganized speech, disorganized or catatonic behaviour, as well as negative symptoms (APA, 2000). A positive symptom is one that is an excess to normal behaviour, such as hallucinations, whereas a negative symptom is classified as a diminution or loss of functioning such as memory problems and confusion (Maj, 1998). The next category is

social or occupational dysfunction where these symptoms must be present from the onset

of the disorder with a significant impact on daily functioning (APA, 2000). Third, Maj

(1998) discusses the functional criterion where there must be a disturbance in functioning

present for the majority of time since the onset of the disorder evident in more than one

area of the individual's life. Finally, the signs of the above disturbances must be present for

at least six months (APA, 2000). Furthermore, the DSM-IV-TR also includes subtypes of

schizophrenia which include paranoid, disorganized, catatonic, undifferentiated and

residual types. The process of diagnosis can be difficult as there are many criteria that must

be met for classification as having schizophrenia, while, at the same time, these criteria can

also be met by other psychopathologies, causing additional convolutions in the procedure

of diagnosis (Maj, 1998).

Brown (1995) argues the diagnosing process is vital to the practice and theory

behind medicine because it "represents the time and location where medical professionals

and other parties determine the existence and legitimacy of a condition" (p.38). This is

evident as medical and social views of mental illness have changed over time and been

redefined by professionals. Although having a diagnosis and being labeled may bring

personal and emotional relief to the patient, it also allows medical professionals to control

the situation with their knowledge of the problem (Brown, 1995). Many patients know very

little about their diagnosis from a medical perspective, but are able to share their

experiences. This is where self-accounts can be helpful as individuals suffering from

schizophrenia are able to share their personal experiences about the disorder and shed

new light on dominant notions of schizophrenia as counter narratives.

Counter Narratives and the Anti-Psychiatry Movement

The anti-psychiatry movement in the early 1960s revealed the relationship between psychiatry and other forms of repression (Guattari, 1996). Specifically, the anti-psychiatry movement's purpose was to dismantle the fundamental practice of mainstream psychiatry. Guattari (1996) believed the only way to force change was through the end goal of "depsychiatrization of madness" (p.4). In other words, there is a need to move away from both the physical and chemical aspects of institutionalization. Guattari pointed out repression was, and still is present in the absence of hospitals where a "neuroleptic or chemical straight jacket replaces a physical straight jacket" (p.4). Guattari (1996) aimed to show the alternatives to psychiatry and by pointing out the traditional political organizations and the problems with how those deemed mentally ill were treated, as well as how social alienation affects them. Moreover, Guattari (1996) sought to dismantle the social alienation faced by the mentally ill as he believed this "denie[d] and suppresse[d] the specificity of madness, and evade[d] the trap of familialism which in turn denie[d], by excluding, extra familial or social factors" (p.4).

Linking the above to Foucault (1959), Foucault believed it was reason that silenced madness by distracting from the truth and the role social order plays. As illustrated previously, psychiatry was a tool for social control, which began with physical punishment and constraint and moved to oppressive internal restraints. Like Basaglia, Guattari (1996) did not believe psychiatric staff were treating patients well. In fact, Guattari saw the staff as deprived of the means to do so. Furthermore, Guattari (1996) cites Basaglia as being focused more on the modernization of society as the beginning of the decline of care. This decline in care was due to fewer beds and more patients per physician, an increase in the

size of institutions, a focus on professionalization and remuneration of physicians and nurses. The question that then arises is: "Was the hospital's goal to provide a good environment for individuals who do not have reason and who are seen as having an internal conflict?"

Was the hospital's purpose ever to rehabilitate the mad? As Guattari (1996) stated, "the true scandal is the existence of incarcerative structures which literally exterminate the mentally ill and the personnel who work there" (p.11-12). With the state of the hospitals as they were, other physicians became interested in alternatives to psychiatry. Like Foucault, Laing believed society was responsible for the creation of psychosis (Guattari, 1996). He was one of the founders of Kingsley Hall where patients and physicians were considered equal, medication was not prescribed by any physician on site and was only taken voluntarily by patients. Kingsley Hall was a place for the mentally ill to take a 'trip' through madness, which Laing recommended. In short, Laing saw mental institutions as playing a role in the maintenance of social repression. He felt psychosis could have healing potential and be emotionally liberating, instead of strictly oppressive like mental institutions (Barnes, & Berke, 1991).

Patients at Kingsley Hall were able to immerse themselves in their psychosis. As Guattari (1996) discusses, the leaders of the anti-psychiatry movement alongside the patients, who they say made a "career of schizophrenia" (p.63) and explored the world of madness in an unconventional way. This was "not the madness of the mental hospital, but the madness that dwells in each of us, a madness they proposed to liberate in order to release inhibitions and symptoms of every kind" (p.46). Mary Barnes was one of the patients who let herself go on this journey through madness, which proved challenging for

all those around her. Guattari described her journey and regression into childhood that left

her, on many occasions, close to death, specifically during her 'down periods'. This also

proved to be controversial as others would panic, unsure of whether to take her to the

hospital, a path that clearly went against the agreed upon treatment. Additionally, Barnes

and Berke (1991) stress that Mary was unwilling to receive treatment from the hospital.

Despite this, there were many instances where her well-being was in question and the

decision to seek further medical help was difficult for Berke and Laing to make.

Even during her better times or 'up periods,' Mary showed the challenge in dealing

with one in her state. She regressed into childhood and only listened to Laing and Berke.

She behaved like a small baby, needing to be bottle-fed and was not potty trained (Guattari,

1996). Berke compared the family of Kingsley Hall to a dysfunctional family, an interesting

comparison as one of Kingsley Hall's purposes was to dismantle the social relations of a

dysfunctional family; instead, they created one. For Mary, much of her psychosis

surrounded the family. Throughout her life, she was constantly creating familial territories

in all aspects of life. This was evident in her interactions with Anna Freud. Mary felt the

need to search for alternative therapy for herself and her brother Peter, also diagnosed

with schizophrenia. He, however, did not agree with the philosophies of Kingsley Hall and

much preferred the hospital (Barnes & Berke, 1991). Mary described in detail her ideas and

feelings about Anna. She wanted her help in more ways than one. She wanted Anna to

analyze Peter and her and allow them to move in with her, so Peter and Mary could become

her children. She also felt this deep connection with Berke and fantasized about being his

child. Guattari (1996) discussed familialism, which "consists in magically denying social

reality, and avoiding all connections with real fluxes. There remain only the possibilities of

the dream and the infernal locked-door of the conjugal-familial system" (p.49). This describes how Mary functioned in all aspects of her life, especially during her time at Kingsley Hall. She was not only a 'militant of madness' but also a professional and missionary of Laing's therapy (Guattari, 1996).

Guattari (1996) described the three processes of psychoanalytic therapy. First is interpretation, which shows "a thing must always signify something other than itself" (p.49) and never searches for the truth within the thing itself, but rather through signifying clues. Guattari goes on to discuss familialism, which through these signifying clues, point towards the familial representations and consists of the individual regressing into childhood in order to rediscover a memory. Finally, transference is to have "desire reinstalled in a cramped space" (Guattari, 1996, p.49) such as the couch of the analyst sifting interpretively through what the patient has revealed. Everything that is presented must be interpreted, which is usually done by the analyst in a silent fashion. These three methods were shown to not operate well with the mad, as the mad differed substantially from the socially dominant. At Kingsley Hall, Laing sought to use interpretation in other ways. As such, interpretation went from being an individually silent process to a collective and boisterous process that involved objects, gestures and interactions of forces. As illustrated by Barnes and Berke (1991), Mary interpreted every single interaction with anyone or anything as therapy to her. Guattari (1996) goes on to state that everyone at Kingsley Hall did become a psychoanalyst, although there was almost no psychoanalysis at all because " 'the partial objects', followed their own lines of force without being haunted by systems of interpretation, and duly codified by the social grids of the 'dominant reality'"

(p. 52). For Mary, she was the real analyst of Kingsley Hall as she fully immersed herself in the neurotic forces of her Kingsley Hall parents.

In what follows, Deleuze and Guattari's (1987) theories will be applied to illustrate how Kingsley Hall has impacted the field of psychiatry and the ramifications this sitation brought forward for others experiencing madness.

Deconstruction, the Body without Organs and Rhizomes

Another way anti-psychiatry investigated the question of breakdown, madness and schizophrenia is through Deleuze and Guattari's (1987) concept of the body without organs. Gibson (2006) states a body without organs "is a dismantling of the self in order to prepare it, make it open for intensities to pass over it. It is not a subject that lacks but a relay on the plane of consistency where desire is free flowing" (p. 190). For Deleuze and Guattari (1987), desire is not a want; a want limits desire. Instead desire is a positive productive force that leads one towards a new becoming (Gibson, 2006). Like deconstruction, the body without organs allows one to open themselves entirely to allow new experiences and new collisions with other bodies. Through these processes, it is possible to dismantle binary categories like normal/abnormal, ability/disability, physician/patient and move towards a more rhizomatic way of thinking.

The rhizome, which can give us a new understanding of madness and schizophrenia, is another term coined by Deleuze and Guattari (1987) that challenges dominant ways of thinking. Like the body without organs which gives one "the potential for unlimited transgressive possibilities" (Gibson, 2006, p.192), a rhizome "has neither beginning nor end, but always a middle from which it grows and which it overspills" (Deleuze & Guattari, 1987, p.21) and allows for multiple collisions with other bodies to occur. Deleuze and

Guattari argued that contemporary society is organized as a root-tree system based on binary logic where hierarchies and power are created and distributed and through which all individuals are expected to pass, inhibiting anyone from deviating from these norms. When one does not follow these norms, as in the case of those diagnosed with a mental disorder, they are labeled as different and contained. Additionally, a mental institution where physicians have full control over patients can be viewed as a root-tree system in that patients are expected to follow strict guidelines set by physicians and professionals, who are considered experts in the field, and rarely have much say in their treatment plans. The rhizome, however, "pertains to a map that must be produced, constructed, a map that is always detachable, connectable, reversible, modifiable, and has multiple entryways and exits" (Deleuze & Guattari, 1987, p.21). The rhizome is not a tracing at all, but a map that has infinite possibilities which allows those labeled as mad and other oppressed groups to exert their creative force.

Foucault (1972) offered us a way to think about the creative force of oppressed groups in his work through subjugated knowledges, which are "those blocs of historical knowledge which were present but disguised within the body of functionalist and systematizing theory and which criticism has been able to reveal" (p.82). These are knowledges that have been labeled as inadequate and are thus disqualified due to the fact they are lacking in professional expertise and scientific backing. Foucault argues it is through disqualified knowledges "that criticism performs its work" (p.82). Rhizomatic thinking re-surfaces these disqualified knowledges and shows that even though a certain type of knowledge is not a dominant knowledge, it is still a viable source of information. Self-accounts are particularly important in this regard.

An example of a rhizome is Kingsley Hall, where individuals labeled as mentally ill were able to live in a community in which they had full control over their lives and 'therapy'. Additionally, they were able to interact with physicians and other inhabitants of Kingsley Hall on an equal level, as there were no hierarchical systems of power since the physician/patient hierarchy was abolished (Guattari, 1996). Currently, groups such as the *Hearing Voices Network* and *Intervoice* provide new ways of thinking and viewing auditory hallucinations, which have historically been treated solely through medication. Goggins (2009) describes the *Hearing Voices Network* as a self-help group created by those who experience auditory hallucinations and who feel their needs have not been met by the mental health system. In an article for the Centre for Addiction and Mental Health, Goggins (2009) discusses that in the past nurses were advised not to interact with clients about the voices they were hearing; however, it is now believed this is exactly what they should be doing. Carey (2011) describes one interaction between a physician and his patient who had been diagnosed with a form of schizophrenia who insisted there were large holes in her brain. In order to dismantle this belief, the physician showed his patient brain scans and asked her to point the holes out to him, which she was unable to do, thus eliminating the patient's anxiety surrounding this delusion (Carey, 2011). Again, this illustrates how rhizomatic thinking can be beneficial and assist in deterritorialization and reterritorialization of current discourses. As the previous example illustrates, the physician used a technique not widely practiced to alleviate the patient's anxiety surrounding a delusion that would allow her to move beyond it. Again making reference to Kingsley Hall, Guattari (1996) stated:

Anti-psychiatry had at its disposal its own surface of inscription, a kind of body

without organs in which every corner of the house – cellar, roof, kitchen, staircase,

chapel – and each episode in the life of the collectivity, functioned like the gears of a

big collective machine, drawing each person out of their immediate self and their

own little problems, either to put themselves at the service of others, or to descend

into themselves in a sometimes vertiginous process of regression. (p.46)

This quote illustrates how places such as Kingsley Hall function as a body without organs

or rhizome. Specifically, Deleuze and Guattari (1987) described the rhizome as a way

everyone can be connected to any other body allowing for connection and extension, rather

than separation and closure, as seen in the binary and medical model approaches.

Blocking the Rhizome

Of course, rhizomes, subjugated knowledges, lines of flight, and acts of resistance

can be blocked, and frequently are. Referring to Freud's famous case, Deleuze and Guattari

(1987) illustrated this best with a quote about Little Hans saying "they kept on BREAKING

HIS RHIZOME and BLOTCHING HIS MAP, setting it straight for him, blocking his every way

out" (p.14). This example can be linked to the asylum and dominant notions of mental

illness where individuals must follow a strict regimen prescribed by physicians following a

root-tree system and often have little say in their treatment regime. Skott-Myhre (2008)

describes the lives of those in the asylum and the agony they face due to the "pain of an

immense blockage that seeks, without hope, a release" (p.36) where these individuals'

creative force has been blocked, stolen or channeled into the system that disregards their

needs. Although medication can be useful in many cases, it is also important to listen to the

patient's experiences to devise the best treatment combination possible. In Kingsley Hall

individuals were able to interact freely with others as well as with their environment, despite the stigma from previous labels. In terms of hallucinations and delusions, some individuals seek alternative approaches to medication, which almost always inhibit these experiences and change the person as a whole. Carey (2011) discusses the experiences and struggles of Joe Holt who has been diagnosed with schizophrenia. Joe has successfully worked with physicians and therapists "to build core skills from the ground up, through trial and repeated error" and only relies on medication in situations of extended episodes. This example shows it is possible for individuals to live free of the restraints found in psychiatry. For Joe, learning to cope without medication means releasing what was blocking his rhizome and opening himself to new possibilities inhibited previously by medication.

Releasing the Blocks

From the vantage point of dominant notions and norms embedded in society, all marginalized groups are seen as lacking in some way. As Deleuze and Guattari (1987) said through the processes of deconstruction, deterritorialization and reterritorialization, it is possible for new definitions or lines of flight to be created and new ways of thinking to emerge. Skott-Myhre (2008) defines lines of flight as "escape routes from the structuring effects of dominant social forms" (p.11). As such, Laing's Kingsley Hall living community was a representation of a different way of thinking and viewing mental illness where the binary category of patient/physician have been eliminated and all individuals living under the same roof were viewed as equals (Guattari, 1996). This illustrates how, through deconstruction, negative conceptualizations can be reconceptualized where the body without organs is able to open up to allow for new intensities and experiences to occur. As

well, through this process new conceptualizations of people, madness and society can be created.

These new conceptualizations can be helpful in that each situation and person is unique. Carey (2011) illustrates this point through a comment by a professor of psychiatry who has struggled with schizophrenia, "if you're going to focus on recovery, you might want to ask those who've actually recovered what it is they're doing." Physicians have always been considered the experts when it comes to disease and illness; however, in the case of mental illness, most physicians do not have first hand experience. Laing (1961) discussed this when he states, "self does not experience the experiences of other directly. The facts about other available to self are actions of other experienced by self" (p. 5). The physician does not truly understand the patient's experiences because they do not personally experience them. Furthermore, Laing (1961) went on to say, "if we agree that you do not experience my experience, we agree that we rely on our communications to give us our clues as to how or what we are thinking, feeling, imagining, dreaming, and so forth" (p. 13). The physician may use the individual's experiences to diagnose them; however, they can never truly know the patient's experience. In this sense, the physician can only be aware of his/her experience of the patient but not the patient's experience directly. Each individual has their own idiosyncrasies; each individual's experiences impact how they interact with the world and their surroundings. As well, all those grouped into the category of schizophrenic have different experiences, hear different voices, see different things they believe to be true and thus may be impacted differently by various treatments.

Basaglia (1987) stated "every contradiction that is revealed calls for the end of an ideology that would define and classify it, but it carries within itself a future contradiction"

(p.154). Caputo (1997) points out how binary oppositions have been present in society dating back to classical times. As humans in society who highly value money and material goods, everything is organized according to worth and value. Furthermore, Basaglia (1987) pointed out that these binary categories and 'truths' are based on scientific knowledge created by the dominant class with only the needs of the dominant class in mind. In a capitalist society, the hospital does not exist for the patients who are sick and in need of treatment, but rather for the physicians and nurses to work and stay in a position of power (Basaglia, 1987). Another important factor to consider is the value placed on the appearance and behaviours of others. This clearly shows that it will be extremely difficult to reconceptualize dominant discourses in society as certain appearances and behaviours have negative stigma attached to them; however, it is not impossible.

Again, although it will be difficult to have everyone begin to think in new terms, it is through these terms that change can happen. Becoming is a Deleuzoguattarian term used to describe an "identity-in-motion rather than a fixed being" (Gibson, 2006, p.190). Through the process of becoming, we can shed binary categories by opening up to new transgressive possibilities. By doing so, we will be able to abandon these binary categories and dominant discourses about madness and other problematic notions. By producing lines of flight, the dominant notions will be challenged and we will move away from the either/or and towards a both/and mentality where power relations are shed and what matters is the different creative capacities exerted by all forms of human life. Self-narratives of madness illustrate this point clearly and well.

Self-accounts of Madness

Self-accounts allow for the potential of one's creative force to be released, as those who were once locked in asylums without a voice are now able to share their stories and experiences. Something has changed over time to allow for the voices of the oppressed to begin to be written and read by society, which means there has been a shift in the idea of who is allowed to speak and with what authority. Through deconstruction, one is able to deterritorialize the molar lines or binary categories and reterritorialize oneself by breaking free of the discursive practices that have been ascribed to them (Deleuze & Guattari, 1987).

Self-accounts are a viable resource for shedding light into the lives of those labeled as mad. It is clear that language plays a major role in organizing and maintaining structure and control in society. Through this, certain groups are placed at a disadvantage and are oppressed by the language used to define them. So far, this thesis has shown how language is used to create different definitions that have been a main structure of society to constrain groups of people who deviate from the norm (i.e., those labeled as mad). As well, it is clear language restricts many groups in society; however, as illustrated throughout this thesis, we can reconceptualize dominant notions in ways that all individuals will be considered equal. This shift allows for these currently oppressed groups to be released from the linguistic restrictions used to define them. Although this process will be long and difficult, it is possible because throughout time some changes have been made to dominant discourses and practices. Derrida believed language is fluid enough to make change (Caputo, 1997). Change can be accomplished through using first-hand accounts from individuals who have been labeled as mad and who have or have not experienced different mental health services. Furthermore, those services that may not be considered by psychiatrists, such as Kingsley Hall, are also options and examples of lines of flight, or ways

to break down dominant discourses surrounding the view and treatment of madness in society.

Again, as illustrated above, language can also be used to reconceptualize these notions in society through the process of deconstruction, lines of flight and becoming. By deconstructing the binary categories that view everyone in an either/or sense, it is possible to open these categories to a both/and mentality through lines of flight where molar lines can be challenged with deconstruction and deterritorialization with the use of self-accounts of madness. So instead of constraining certain groups of people as Deleuze and Guattari (1987) believed the root-tree does, a rhizomatic way of thinking is more like a map that allows them to enter a state of becoming that has no limitations and only endless possibilities for being. This means moving away from an either/or state such as the binary categories discussed earlier. Instead moving towards a both/and mentality will allow everyone to be considered equal and where language can be used inclusively. One way this can be done is by focusing on the things a patient can accomplish, instead of using negative conceptualizations of mental illness. This process will be illustrated using various self-accounts of madness. I will show the powerful message self-accounts have and demonstrate how they challenge dominant discourses surrounding madness.

CHAPTER TWO: METHODOLOGY

The main purpose of this thesis is to examine the lives of individuals with

schizophrenia. To accomplish this, I analyzed different self-accounts of people who have

been diagnosed with schizophrenia. First, I chose to use the film *The Best of Youth* which

follows the life of two young brothers who meet a young institutionalized girl named

Giorga along their journey. Although this is a fictional account, Giorga's story is riveting as

the movie takes place during the late 1960s when Italy was in a time of political upheaval

and was embracing a deinstitutionalization movement. The film *A Beautiful Mind* was also

analyzed as it follows the life of John Nash, a paranoid schizophrenic who defied all odds

and went on to win a Nobel Prize. Both films are fictional accounts based on true events.

Although they are not firsthand accounts, the films accurately illustrate the struggles faced

by those diagnosed with schizophrenia. Second, I used *Two Accounts of A Journey Through*

Madness by Mary Barnes and Joseph Berke. Mary Barnes was diagnosed with schizophrenia

and entered Kingsley Hall for treatment in 1965. She was a trained nurse and worked for

the army and later as a full-time nurse in London (Barnes & Berke, 1991). During her time

in Kingsley Hall, Mary discovered through her recovery that she was a talented artist. She

was able to use art as an outlet and continued making art after completing her therapy. Her

book was chosen because she was diagnosed at a time when institutionalization was

recommended; however, she did not feel the hospital or institution was the right treatment

for her. She defied all odds and became a successful artist, which goes against everything

society has told us about what a person with schizophrenia is and are capable of. Although

her journey through madness was trying, she illustrated in her book that alternative

treatments could be successful. I also used Elyn Saks' *The Center Cannot Hold*. This is an

autobiographical book recounting her long struggle with schizophrenia. Saks is currently a

professor at the prestigious University of Southern California Gould School of Law. Again, I

chose to use Saks' book as it is an illustration of how one can overcome such disorders with

treatments other than institutionalization and antipsychotic medications. Finally, a

collection of recovery stories titled *Living with Voices* was used as further examples of the

different struggles individuals with schizophrenia have faced and overcome. This text

illustrated the different experiences of those who have struggled with mental health and

the stigma of being labeled. As well, many of these personal stories show it is possible to

overcome these disorders and continue to live a normal life without being institutionalized.

I chose to use this book as it shows how self-accounts are a viable source of information

pertaining to schizophrenia and other mental health issues.   Each account and experience

is unique and although there may be similarities, the differences are the important focus

for seeing how vital the individual's voice is in devising successful treatment plans.

        The research measure approach known as content analysis was used to analyze the

above texts, specifically through a Foucauldian textual analysis. Individuals in society

communicate in many different ways, such as through speech, as well as writing and

through video. As Fairclough (2003) discusses, it is difficult to obtain a true understanding

of the social effects discourse has on people without looking at the things they say and

write. This is important to consider when dealing with individuals who do not have a voice

in society and have been spoken for by those who exercise power over them. By analyzing

text they have written, we are able to gain access to an area that has yet to be discovered

and give a true representation of their experiences and feelings. As well, it is important to

note as Fairclough (2003) states, "a language defines a certain potential, certain

possibilities, and excludes others" (p. 24) which is evident when a person with schizophrenia is not taken seriously due to the fact they have been labeled. Analyzing the texts and experiences of individuals with schizophrenia allows us to see from their perspective and illustrates how they have learned to cope with, and recovered from schizophrenia. Their voices are finally able to be heard.

As Perakyla (2005) points out, critical discourse analysis investigates how the power and power inequalities are reproduced in society through the texts analyzed. In the case of the self-accounts of individuals who have been oppressed, their experiences as an oppressed group will be valuable and as stated earlier, we will gain insight into their experiences first hand rather than through dominant discourses. Furthermore, Kellner (1995) describes qualitative textual analysis as a means of discovering how different cultural texts produce meanings within society. As well, by looking at different cultural objects it is possible to obtain central meanings, values and ideologies within a specific text. Self-accounts of schizophrenia have not always been available to read and, therefore, there is considerable valuable information that can be extracted from these texts. Also, as Kellner (1995) states, many cultural meanings can be found encoded in texts through language, especially in terms of the dominant discourse and culture. As well, it is important to look at the history of the texts being analyzed as this can have a direct impact on their writing and the specific meanings embedded within them.

A historical discourse analysis looks at the subject through a Foucauldian lens of archeology and genealogy of the texts. As Prado (2000) states, "Foucault's basic strategy in both archaeology and genealogy is to retell the history of a discipline or institution or practice" (p. 25). Archaeology is the process of analyzing discourses or, systems of

knowledge, which are usually present within the dominant culture in society. Furthermore,

Prado discusses how archaeology is interested in further investigating how particular

systems of knowledge emerged by taking a critical stance towards the discursive practices

found within society at the time of study. This encompasses looking into who makes these

claims of knowledge and enforces them within society and, therefore, justifying these

systems of knowledge amongst those living in society. Genealogy, on the other hand, looks

at the power relations found within discourse and the impact this plays on exercising

power to shape the behaviour of others. Whereas archaeology is the specific object being

studied, genealogy is the ideas and concepts that have formed from this object. Mahon

(1992) further describes the goal of genealogy as a way of showing the historical

conditions of a particular object. This means discovering what events created differences

and therefore led to the discourses that are considered valuable and surround society

today.

       To specifically analyze the self-accounts listed above, I used the steps listed by

Foucault (1972) for a textual analysis from his book *The Archeology of Knowledge*,

1. Determine the conditions needed for the object to become a discourse, as well as

   how the object, in this case self-account texts, first appeared as a discourse. What

   had to occur in history to allow for the emergence of self-accounts? What had to

   happen socially to now have people with schizophrenia writing and making

   videos?

2. Determine what institutions and social processes influence the narratives. In this

   case, what institutions are associated with schizophrenia? These institutions

   surround and define the narrative; however, they are not operating from the

centre of the narrative. What is happening around and outside that allows for

the appearance of the narrative? In other words, what types of relationships are

evident between the narrative and that which surrounds it?

3. Determine who gets to speak and with what authority. As well, determine what

relationships are created amongst institutions, social processes and behavioural

patterns in which the discourse itself becomes a practice. What has occurred to

allow for schizophrenia narratives to develop in society? What has happened to

allow these works to be written and to be analyzed?

From here, as Foucault (1972) states, "we can now complete the analysis and see to what

extent it fulfils, and to what extent it modifies, the initial project" (p. 46). By using the steps

listed above, I took a critical stance towards the texts being analyzed to determine the

factors present in their creation and society's beliefs about them.

To start, I analyzed the films *The Best of Youth* and *A Beautiful Mind* using Foucault's

textual analysis. While watching these films, I took notes to use later in my analysis to

compare and contrast with dominant discourses found within the literature. Many events

have happened historically to allow for such films to be created and available for us to

watch. I considered the fact that throughout the history of schizophrenia and the DSM, the

diagnostic criteria have changed immensely. As Brown (1995) discusses, a social

constructivist perspective views how a particular phenomenon was identified and dealt

with by others. As illustrated previously, individuals diagnosed with schizophrenia were

placed in institutions and treated with techniques such as psychosurgery and electric shock

therapy (Skott-Myhre, 2008). Romme, Escher, Dillon, Corstens, and Morris (2009) illustrate

these techniques had long-lasting negative effects on these individuals and inhibited them

from sharing their experiences with us. Another factor very important that I considered is

how deinstitutionalization has directly impacted the self-account texts we see today in a

number of ways. Naturally, individuals were released from institutions, thus giving them

more freedom to express themselves in ways not thought possible. In other words,

deinstitutionalization made self-expression possible.

Next, I looked at the books *Two Accounts of a Journey Through Madness* by Mary

Barnes and Joseph Berke and *The Center Cannot Hold* by Elyn Saks using Foucault's

guidelines for a textual analysis. Again, while reading these books I took notes to compare

with the dominant literature as well with the previous pieces being analyzed, as they

challenge dominant culture. These books have been written by individuals who have

directly experienced schizophrenia. What has happened in society for books such as this

one to be written and published? Looking back in history, books about people with

schizophrenia usually depict them in a negative light. As well, self-accounts have not always

been available; however, recently we have seen more becoming available. Throughout

time, it has always been that those in positions of authority speak for those who are seen as

incapable of speaking. This silence creates a problem of having physicians, teachers, and

parents speaking on behalf of those individuals with schizophrenia. Finally, it is interesting

to note that there is a demand in society for fictional accounts of mental health, so what has

occurred to cause this attraction? One thing that was considered here is the rise in

prevalence rates of different mental health issues.

Finally, I analyzed the book *Living With Voices*, which is a collection of recovery

stories discussing individuals' struggles with mental health and how they have overcome

the obstacles caused by their illness, where I again used the steps of Foucault's guidelines

for a textual analysis. While reading these stories, I took notes to compare the themes within these stories with those found in the literature and discourse that surrounds schizophrenia and mental health. As well, I considered the institutions that are directly related to and have an impact on schizophrenia. This means I looked at medical discourses as well as explored the treatment practices used in psychiatry and psychology. Furthermore, it was important for me to determine how institutions, such as schools, therapy centers, and the media, had a direct impact on individuals with schizophrenia. This also means I looked at the power relations between these individuals and their teachers and physicians. As well, it was important for me to keep in mind that these institutions surround and define discourse and discursive practices; however, they are not operating from the centre of the narrative. In other words, institutions create discourses we use to define people and separate them into different groups, but these definitions in most cases do not represent those who are being defined. Therefore, looking at self-accounts from anyone who is considered as deviating from the norm can demonstrate that they have been defined by institutions all their lives. Finally, their voices are being heard. I considered that in many cases those labeled with schizophrenia are impacted by the discourse surrounding their disorder. As Williams and Collins (2002) discuss, many individuals diagnosed with schizophrenia "expressed fears about what society and the local community believed about the mentally ill" (p.302). This may impact whether an individual decides to share their story with others.

In summary, I used a textual analysis to delve into the different self-accounts listed above. I began with the films *The Best of Youth* and *A Beautiful Mind* using Foucault's steps for a textual analysis, and then moved to the books listed above. While reading the books

and watching the videos, I took notes and considered key themes present throughout. From

here, I compared and contrasted the notes I took with dominant literature that supports

the discourses surrounding schizophrenia today according to Foucault's guidelines for a

textual analysis. Overall, I hoped to gain insight into the lives of these individuals who have

been diagnosed with schizophrenia through their self-accounts. As well, I hoped to show

the differences between how dominant discourses describe schizophrenia and how those

who are labeled with schizophrenia describe their experiences.

CHAPTER THREE: ANALYSIS

This analysis applies Foucault's steps for a textual analysis to the various self-accounts to shed light on the experiences of those diagnosed with schizophrenia or who have experienced auditory hallucinations. To begin, I will apply Foucault's steps to the films *The Best of Youth* and *A Beautiful Mind.* Next, I will look at the books *Two Accounts of a Journey Through Madness* and *The Center Cannot Hold*. Finally, I will discuss the book *Living with Voices*. These texts all describe or depict the authors' first-hand experiences through giving a detailed account of their journey through mental hospitals, medication, and struggles with their inner self while learning to manage illness.

The Best of Youth & A Beautiful Mind

In what follows, I will present a textual analysis of the two filmic texts to show how mental illness, generally, and schizophrenia, specifically, are constructed and dominated by prevalent social discourses.

The Conditions Needed for the Object to Become a Discourse

A major factor that contributed to the fictional accounts, *The Best of Youth* (2003) and *A Beautiful Mind* (2001), both of which give an inside view of the asylum, is the deinstitutionalization movement. The deinstitutionalization movement paved the way for the individuals followed in both films to begin living outside of the asylum walls and integrate back in society. In the film *The Best of Youth* (2003), the deinstitutionalization movement in Italy depicted and portrayed the asylum as a place that gave poor treatment to patients. Basaglia was directly involved in this movement within Italy. In the first few scenes of the film, Italy is shown as in a state of unrest and revolt in the 1960s. Basaglia's work focused on the power struggles within the asylum between the physicians and

patients. Furthermore, Basaglia viewed the asylum as a social tool used to control deviant

members. He also believed these individuals should not be segregated in the asylum, but

rather integrated in society. Del Giudice (1998) points out between 1971 to 1974 how

Basaglia made efforts to change the logic and practice that ruled the asylum. He directly

challenged the hierarchy found within the asylum between physicians and patients.

Basaglia's goals included "changing the relations between operators and patients, inventing

new relations, spaces and opportunities, and restoring freedom and rights to the inmates"

(Del Giudice, 1998, p. 2). When Nicola and Matteo found a young girl, Giorgia, in an asylum,

the film illustrated the negative repercussions of asylum treatment. They could not believe

such a young, beautiful girl was subject to such poor treatment; they tried to have her

removed from the asylum and returned to her family. Unbeknownst to them, Giorgia was

returned to the institution because her father believed it would 'cure' her through electro-

shock therapy. Years later, Nicola and Matteo, whilst on a variety of tours of institutions

across Italy to ensure proper treatment of patients, found Giorgia along with other patients

in the disgusting basement of an institution where they were restrained and left in their

own filth. This scene of the film shows how many patients were treated within the

institution and helped sparked the anti-psychiatry movement. This portrayal especially

provided fuel for Basaglia's motivation to change the asylum system. Although Basaglia's

work was based out of Italy, it had such an impact on the deinstitutionalization and anti-

psychiatry movement worldwide. Del Giudice (1998) states that

> In the hospital in transformation, guardianship is replaced by care, institutional
>
> abandonment by the full assumption of responsibility for the patient and his
>
> condition, while the negation of the individual through the concept of illness-danger

is substituted by the conferring of value and importance to individual life histories.

Shock therapy and any form of physical containment is suppressed, the mesh

barriers which enclose the wards are removed, gates and doors are opened,

compulsory committals become voluntary and definitive ones are revoked, thereby

restoring civil and political rights to patients. (p. 2)

The Best of Youth (2003) illustrates this while following Giorgia on her journey through the

institution. Again, Basaglia's work in Italy had a substantial impact on the

deinstitutionalization movement and "has restored full rights to the mentally ill person,

given him access to social citizenship, and multiplied possibilities and opportunities for

him" (Del Giudice, 1998, p. 6). Without Basaglia's work, first hand accounts of mental

illness and the struggle faced by many in the institution would not be available today.

A Beautiful Mind (2001) is an academy-award-winning film based on the life of John

Nash, a mathematician with schizophrenia. The film follows Nash through his academic and

professional career. Along his journey, we see the struggles he faces when he develops

schizophrenia and how he is able to overcome and cope with this mental illness. In a

similar fashion to *The Best of Youth* (2003), the deinstitutionalization movement affected

the main character of the film. If Nash had been institutionalized, he would have been kept

within the confines of the abysmal state of the asylum, medicated and restrained as was the

case with Giorgia. Furthermore, Nash's creative capacities would have been inhibited. He

certainly would not have made such influential breakthroughs in the mathematics field for

which he won a Nobel Prize in 1994. Additionally, those who were confined lost all

individuality, as well as the resources to be successful. Being institutionalized would have

meant Nash was deprived of his academic experiences. His academic training contributed

immensely to Nash's success as he was given the resources to make breakthroughs in the

math field.

This film was released many years after the events it depicts as Nash was born in

1928. So what exactly sparked interest in Nash's story? Nash's Nobel Prize was awarded to

him in 1994, which obviously contributed to the increased interest in his story.

Additionally, Nash avoided pharmaceutical drugs, which are the main form of treatment for

schizophrenia. This also is of interest to society as pharmaceutical companies not only play

a major role in treatment, but also because drugs are prescribed by physicians who receive

benefits for doing so. Some of these benefits include payments, gifts and trips. Wilson

(2010) points out federal investigators have found these types of bonuses are given to

physicians who, in return, play down drug side effects while prescribing the drugs to their

patients. Pharmaceutical drugs began to be the main form of treatment for many mental

illnesses after their advent in the 1950s and continue to be used today despite their

negative side effects. Wilson also states that many patients, who began drug treatment

when antipsychotics were introduced, stopped taking the drugs directly because of

negative side effects, including involuntary body movements, tics and restlessness.

Recognizing this potential for damage, Nash stopped taking his medication against his

physician's orders. Importantly, however, the film *A Beautiful Mind* (2001) does not depict

this aspect of Nash's life (PBS, 2002). Instead, in the film Nash continues to take

antipsychotic medication throughout. Whitaker (2002) discusses the film in a newspaper

article about the use of medication by pointing out how the film strays from the original

story quite substantially. In the film after receiving his award, Nash mentions newer

medications he is taking. Furthermore, *The National Alliance for the Mentally Ill* has praised

the film's director, Ron Howard, for showing the "vital role of medication' in Nash's

recovery" (Whitaker, 2002); although, in reality, this was not the case. In fact, Nash stopped

taking his medication in the 1970s due to the side effects that may have inhibited his

intellectual accomplishments. PBS (2002) discusses Nash's experiences with his auditory

hallucinations which, despite being off medication, began to taper off organically. Nash

began to ignore the voices and decided to stop listening to them, which can be seen in the

documentary by PBS entitled, *A Brilliant Madness.*

Because Nash was a mathematical genius and incredibly successful, his narrative

created interest within the rest of society where others became interested in him and his

life, especially, his struggle with schizophrenia. This interest sparked a Hollywood story

and an award winning film was created. Although this is a fictional account of Nash's life

and may stray from the original story, it illustrates the possibilities individuals have when

not institutionalized and heavily medicated. Furthermore, although the prevalence rates of

schizophrenia are not alarmingly high or on the rise, it is a mental illness that many do not

understand.

Although the above films are inspired by true events, they are still fictional accounts

of stories modified for the big screen. More importantly, however, these films are evocative

accounts where the characters give accurate portrayals of individuals diagnosed with

schizophrenia, where the similarities between these fictional accounts and the first-hand

accounts that will be discussed later become apparent. Additionally, at the effect of the

story require our focus, rather than the origin. Although the writer and director of the films

do not have schizophrenia, they have provocatively portrayed the lives of two such

individuals. In Nash's story, he finds great success in his educational achievement and

contribution to society, as well as in his family life. This story is so evocative because everyone wants to read and hear stories about extraordinary individuals who have defied the odds and overcome their disabilities. Although these characters do not necessarily conquer schizophrenia, they are able to live freely outside an institution. Nash was able to find success in the academic field, as well as in his personal life. The general public wants to see success stories, as shown by the praise and reviews the film received, including four academy awards.

Another impact deinstitutionalization had is it allowed for individuals to live in society away from the constraints of the institution, thus receiving therapy in other ways. This means jobs were created in community living centres and for therapists outside of the institution. As well, more individuals were interacting with people such as Giorgia and John. Often, the news depicts those with schizophrenia in a negative light and there is an interest in society to learn more about the illness. This sparks ideas for fictional movies and books, especially when the story is like John's. There are many books available about various mental illnesses; however, they are all written by professionals. Very few are in the words of the person diagnosed. Although these films are not first-hand accounts, they create awareness and interest in society where self-accounts of schizophrenia have now been published.

Determine What Institutions and Social Processes Influence the Narratives

In Giorgia's case, her family played a major role in her life while in the asylum. In one scene when Nicola and Matteo take her from the asylum to her father, he comments that she must stay in the hospital because it will cure her. If her family had been more willing and able to care for her, she would not have been subject to the poor treatment

within the asylum. Although dominant beliefs at the time were that people like Giorgia

belonged in an institution, the asylum was also believed to rehabilitative. As previously

illustrated, it is clear the asylum was not rehabilitating at all. The institution itself, including

Giorgia's physicians and nurses, influenced her as well as her family. The physicians with

scientific knowledge had an impact on how her family and her father, especially, viewed the

asylum as a whole. As well, this scientific knowledge affected her father's views on the

Giorgia's hospital and the "healing" procedures she was receiving. Furthermore, the

physicians were responsible for her diagnosis and treatment regime, which included

electro-shock therapy. When Nicola and Matteo find her in the asylum for the second time,

her therapy was clearly having a negative impact on her. Giorgia was lethargic and not as

lively as during their first meeting. Finally, the nurses working in the hospital who left the

patients restrained in the basement clearly had a negative impact on all the patients in the

hospital; whether they received instruction from physicians or the hospital did not have

the resources is beside the point. Nicola and Matteo played a major role in helping Giorgia

move out of the asylum and into a new living facility. Although the film does not follow

Giorgia any further, we can assume this facility allowed Giorgia to live more unrestrictedly.

For Nash, the school played a major role in his success. Through the different

academic institutions he participated in, he was able to work, learn and accomplish highly

recognized work in mathematics. His wife was supportive through his time struggling with

his hallucinations and stuck by him in his decision to not use medication. The hospital also

influenced Nash as he did not agree with their way of dealing with mental illness.

Consequently, he decided to work on learning to live with his hallucinations without

medication. Finally, the voices Nash heard, although not real to others, were very real to

him. One voice he heard was that of a secret agent named Parcher, who Nash believed was

connected to the government. Nash, like many other Americans in the 1950s, was fearful of

events overseas. This fear can be understood in a broader sense where many individuals in

the United States during the 1950s were full of fear and suspicion surrounding the Cold

War and possible Soviet nuclear missile attacks (PBS, 2002). Furthermore, Nash was fearful

of being drafted into the military himself. As the war developed, so did Nash's fears, which

became delusions as his schizophrenia developed (PBS, 2002). The height of his fear and

delusions occurred in 1953 when some of his colleagues at M.I.T. were investigated for

having connections with the Communist Party. Nash's fears and hysteria were not an

isolated incident; the hysteria and suspicion brought on by the Cold War continued to

linger throughout America for years later, although they affected Nash dramatically. The

voice of the secret agent Parcher affected Nash negatively to the point of his belief he was

being persecuted by the Soviets and was in fear of his life, as well as his family's. The voice

of Charles and his niece, however, impacted Nash in a more positive fashion. Once Nash

realized Charles and his niece, Marcee, were merely part of his imagination, he says

goodbye to them. As he is doing so, he tells Charles he has been a good friend and thanks

him for all his support. For Nash, Charles was his college roommate. This meant they

shared many experiences together which, although not reality for others, were very vivid

and meaningful for Nash.

Finally, Nash's experiences take place in the 1950s when the Cold War hysteria was

at its peak. The film was not released until 2001. So, what was happening socially to allow

this film to be created? With the anti-psychiatry movement, awareness was brought to

society and other films were released prior to *A Beautiful Mind* that caused interest in

society to continue to grow. Furthermore, mental illness has negative stigma in society.

Mental illness is traditionally met with social fear and a view of the mentally ill as

dangerous (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). One factor is these

individuals are seen as missing characteristics that are distinctly human, such as rationality

and free will. In addition, Link et al. (1999) found most people want to keep their distance

from the mentally ill due to these beliefs and fears of danger. Often in the media, we only

hear stories that denote violence in the mentally ill, thus further contributing to this fear.

Although there are instances in *A Beautiful Mind* (2001) where Nash may have been

considered dangerous, the overall story shows Nash's success and brilliance in

mathematics. Again, the interest in his story may also be attributed to his Nobel prize.

Determine Who Gets to Speak and with What Authority

The film *The Best of Youth* (2003) is an accurate example of the little say those

deemed to be mentally ill had when it came to living arrangements and treatment. In

Giorgia's case, her father and physicians did not give her a say in her situation. The

psychiatrist's higher standing affected how Giorgia's father viewed the situation. This

further illustrates the power imbalances found within institutions, which Basaglia worked

to dismantle. Psychiatrists and psychologists are viewed as knowing more than the average

citizen because they have scientific knowledge; often, this knowledge and its use of power

goes unquestioned. In the film, it took Nicola and Matteo to give Giorgia the chance to get

out of the asylum. These brothers worked closely in the mental health field with Nicola

pursuing a career in psychiatry and Matteo working as a support worker who took mental

health patients for walks. This is how the brothers initially met Giorgia and became

interested in helping her. They were able to give Giorgia the confidence to move on from

the only life she ever knew. The final scene of the movie with Giorgia shows Nicola

dropping her off at her new living facility. At first, she is hesitant, but with Nicola's

encouragement, she goes inside.

As for Nash, in *A Beautiful Mind* (2001), being part of academia made resources

available to him, thus giving him the opportunity to not only do amazing work in the

mathematics field, but also in the sense that because of his standing, he was able to avoid

long stays in the hospital and refuse to take medication. Also, due to his standing in

academia, he received more interest from others in society who could see it is possible for

an individual diagnosed with schizophrenia to be successful with proper resources and a

support system. Additionally, having the strong support from his wife, Nash was able to

refuse taking medication and overcome his auditory hallucinations in other ways. PBS

(2002) and Whitaker (2002) stress that Nash 'overcame' his schizophrenia. The idea of

overcoming schizophrenia is consistent with the medical emphasis on a cure. Despite this,

the film was an illustration of what living with schizophrenia could be like. One touching

scene in the film was where near the end Nash was being interviewed for the Nobel Prize.

Nash recognized the man interviewing him was trying to decide if Nash was 'crazy' and if

he may embarrass the institution upon receiving the award. Nash bluntly admitted he was

crazy; however, he told the man he chooses not to indulge in that part of his life any

further. During this conversation, professors all around the room began to bring Nash their

pens, a symbol of great success, honour and a lifetime of achievement. This scene illustrates

how Nash's credibility was in question prior to this event, but with the respect of his peers

and colleagues, Nash receives the award.

Again, it is important to consider Whitaker's (2002) article here where he discusses the fact that the film does not portray Nash's story accurately. As mentioned previously, *The National Alliance for the Mentally Ill* even praises the director for depicting the importance medication plays in the recovery process, although studies have shown this is not always true. Pharmaceutical companies, along with physicians, possess the power and authority to have these drugs prescribed despite the negative outcomes often associated with their use. Furthermore, Whitaker (2002) states that

> Most Americans are unaware that the World Health Organization (WHO) has repeatedly found that long-term schizophrenia outcomes are much worse in the USA and other "developed" countries than in poor ones such as India and Nigeria, where relatively few patients are on anti-psychotic medications.

Even still, looking back historically, a psychologist reported a third of the inpatients hospitalized in Vermont State Hospital with schizophrenia were released and deemed "fully recovered" in the 1950s with one thing in common, all were weaned off antipsychotic medication (Whitaker, 2002). With pharmaceutical companies gaining power over time, medication has dominated the treatment modalities chosen for the mentally ill. With other support, John Nash has been able to recover and live in society, something that may not have been possible if he had continued long-term use of anti-psychotic medication. It is a shame the film strays from the truth in relation to medication. Whitaker (2002) argues that Nash's story should inspire society to reconsider the use of anti-psychotic medication and the treatment of the mentally ill. As well, this illustrates the importance of looking further into certain dominant discourses. Here, a film based on a true story twists the truth in favour of pharmaceutical companies.

Two Accounts of a Journey Through Madness & The Center Cannot Hold

In what follows, I will present a textual analysis of the two texts to again, show how mental illness, generally, and schizophrenia, specifically, are constructed and dominated by prevalent social discourses.

Determine the Conditions Needed for the Object to Become a Discourse

Two Accounts of a Journey Through Madness, written by Mary Barnes and Joseph Berke, is the story of Mary' struggle with schizophrenia. She recalls memories from her childhood, where risk factors of developing schizophrenia were present. Essentially, this book literally recounts Mary's journey through madness before, after and during her time at Kingsley Hall.

The Center Cannot Hold is Elyn Saks' account of her life with schizophrenia. Her book outlines her experiences during university when she began to struggle significantly with her illness. Elyn recounts her feelings and interactions with mental health professionals, family, friends and academic peers throughout her lifetime leading up to where she is today.

For both Mary Barnes and Elyn Saks, deinstitutionalization played a major role in allowing these books to emerge as a discourse. Neither woman would have had the experiences or collisions with other bodies such as their peers and therapists if they were institutionalized, thus dampening their creative force and ability to write and publish a book telling their personal stories. Specifically, if they had been institutionalized for a long period of time, medication and restraints would have been used, thus restricting them greatly. This unfortunately was reality for Elyn during her time at law school, during which she was medicated and held against her will in an institution. This type of treatment fully

inhibits the creative capacities of the patient and would have restricted both women from

what they accomplished and produced throughout their lives. Looking back to Basaglia

(1987), the dominant class made others believe the asylum was therapeutic and healing. As

we have seen, the asylum and later the hospital were used to control and segregate those

labeled as mad, deviant and unable to contribute to society. Clearly, those individuals who

would have been institutionalized have thus been given more opportunities than they

would have had if they been locked up.

       During Mary's struggle with schizophrenia, the deinstitutionalization and anti-

psychiatry movements were in full swing. Her brother was hospitalized for schizophrenia

and Mary witnessed the treatment he received. She did not want the same for herself.

Instead she actively sought out alternative treatments as she did not agree with the

hospitals way of dealing with the mentally ill. Mary did not want to go to a mental hospital

or take medication because she believed by doing so, she would alienate the self, which she

saw as a sin. Although this proved to be very trying for her, Mary was able to find an

alternative to the hospital that gave her the opportunity to go through madness with

support, as well as write a book to share her experiences and tell her story.

       Elyn came in contact with the mental health system in both the United States of

America and England. When she first began experiencing hallucinations and delusions, she

was in England where the physicians were surprisingly helpful and did not force her to do

anything she did not want. For example, Elyn was given the option of checking into the

hospital in England or just going strictly as a day patient. At first, Elyn was reluctant to go

as a day patient, but she realized her need for help and went to the hospital to receive it.

Her physicians were understanding and gave her advice on staying in the hospital and

taking medication. For a long time, Elyn did not want to take any medication because she had not come to terms with her illness. She viewed medication as a weakness, which is one of the reasons she fought against medication for so long. "People ought to get better because they work at it, not because they take some pill" (Saks, 2007, p.68). One factor that contributed to this thought pattern was a short stint in a rehabilitation facility which she attended in high school when her parents found out she had smoked marijuana. The rehabilitation centre made her believe her illness was mind over matter and drilled into her mind that weakness must be fought. Specifically, Elyn believed "to be weak is to fail; to let down your guard is to surrender; and to give up is to dismiss the power of your own will" (Saks, 2007, p.32). Furthermore, Elyn's experience with the hospital in the United States was much less helpful. Although she was not locked and held in a traditional insane asylum, she felt she was treated poorly, held down by restraints for long periods of time and given medication against her will. This affected her in such a way that she felt inclined to share her story in the form of a book in hopes of helping others struggling with schizophrenia.

Another factor contributing to these books becoming a discourse is the experiences both women had with the mental health system where they felt the need to resist traditional psychiatric practices. Social interactions that contributed to this resistance included the education both women received. Elyn attended prestigious schools where she received undergraduate and graduate degrees. Mary completed training to become a nurse and worked throughout World War II. As such, some of their interactions during schooling gave them resources to look into other available treatments besides the institution and medication. Keeping this in mind, both women had the money to pay for alternative

treatments such as talk therapy, which is not available to everyone as it is an expensive

form of treatment. Without their negative experiences with medication and the mental

health system in general, both women may have ended up institutionalized and drugged

against their will. Mary, although struggling immensely, was able to get herself through

hard times dealing with auditory hallucinations and inner demons, to wait for a spot to

open in Kingsley Hall under Laing's supervision. Elyn was in and out of hospitals during her

stay in England, but found a talk therapist with whom she connected and helped her

through her stay without using medication. After this until today, Elyn continues to use talk

therapy, which she believes has allowed her to continue her education at ivy league

schools, receive her degrees, and obtain a job at a prestigious law school. Overall, without

the deinstitutionalization movement, we would not have had the opportunity to see what a

person considered mad was capable of.

Determine What Institutions and Social Processes Influence the Narratives

Mary and Elyn were both influenced immensely by their schools and therapists.

Mary learned the fundamentals of nursing at school and later went on to become a

practicing nurse. She wanted to pursue further education; however, her American visa was

denied due to her mental state. Elyn always had a drive to do well in school. She

consistently kept up with schoolwork and saw her success at school as very important. She

graduated from Vanderbilt University, received her MA from Oxford, graduated from Yale

Law School and also holds a PhD in psychoanalytic science from the New Center for

Psychoanalysis. Although she graduated with high standing, each time was not easy for

Elyn. She had to push hard to keep on track, resorting to medication and therapists when

needed. Elyn especially had problems when she felt she did not do well on assignments or

if the assignment involved any sort of oral presentation. Most of Elyn's professors were very accommodating and supportive during her psychotic episodes. One of her professors knew she was having a psychotic break and contacted her therapist to ensure she got the help she needed. This could have resulted in a hospitalization; however, Elyn had a good relationship with her professor who was understanding and non-judgmental and knew Elyn's wished to avoid the hospital.

The Catholic Church influenced Mary immensely while she was growing up. She spent many hours praying and admitted to being extremely demanding of God. She prayed constantly asking for help for her brother Peter who was also diagnosed with schizophrenia and for herself. Specifically, the church's views on marriage, premarital sex and masturbation affected Mary. She felt ashamed for acting on her instinctual desires and this even swayed her choice of therapist, as she was too embarrassed to speak with a Catholic psychiatrist. Mary's psychiatrists, Dr. Berke and Dr. Laing, supported her throughout her journey through madness. Mary viewed the hospital's compulsory admissions, use of drugs and physical treatments as controlling; thus, she sought alternative treatments. Berke and Laing helped Mary find a place where she could live without the restraint from the hospital, while still providing the support she needed. Kingsley Hall provided a supportive environment for Mary and other patients, many of whom had experienced poor treatment in mental hospitals previously.

Elyn's therapists and physicians in both England and the United States influenced her positively and negatively. In England especially, she found the support she needed with a talk therapist, Mrs. Jones who ended up being a huge part of Elyn's life during her time at Oxford. Although her transition to the United States was difficult, she eventually made

another solid relationship with her new talk therapist with whom she stayed for many

years. Elyn describes one of her first talk therapists in the United States called White:

"unlike medical doctors, White did not recoil from me. Never put me in hospital (under the

guise of protecting me while actually protecting himself), but stood his ground when I was

most frightening and vowed to protect me" (Saks, 2007, p. 213). For Elyn, her talk

therapists, Mrs. Jones and White, supported her even during her most frightening times. All

of her talk therapists helped her to deal with many of her problems when psychotic,

sometimes without medication as Elyn wished, and at other times with medication she

clearly needed.

Elyn's peers were another supportive force that influenced her life. One of the

diagnostic criteria for schizophrenia is poor peer relationships. Despite this, Elyn always

found a small group of close friends at each school with whom she continues to maintain

contact. Having these friendships helped Elyn during her down times as those who became

close with Elyn made her feel comfortable and supported when she was in need. Her friend,

Steve, would speak with her on the phone every day, sometimes for hours at a time when

Elyn had gone off her medication and needed to talk to someone. Finally, Elyn's schooling,

which led to her getting different jobs at a few schools, had a major impact on her life.

Specifically, Elyn's training allowed her to develop writing skills. She was required to write

a specified number of articles per year to maintain employment. This led her to write and

publish this book telling her story.

Although Mary was in Kingsley Hall during the 1960s when the anti-psychiatry

movement was in full swing, her book was not published until the early 1990s. The anti-

psychiatry movement challenged traditional psychiatric practices, and this sparked further

interest in society. This can be seen in popular culture where films began to be made as early as 1961, including *Through a Glass Darkly* and followed by *One Flew Over the Cuckoo's Nest*, released in 1975. These films depicted the poor treatment patients were receiving within the institution. As time progressed, more films about mental illness began to be produced including *Rain Main* in 1988, *Girl*, *Interrupted* in 1999 and *A Beautiful Mind* in 2001. *One Flew Over the Cuckoo's Nest* and *Girl, Interrupted* were books that were later adapted for the big screen. These fictional accounts about mental illness helped to raise awareness within society, paving the way for individuals like Mary, who have suffered first-hand with a mental illness and faced poor treatment within institutions to share their strife and successes.

While considering Elyn's account of her mental illness, we must consider Foucault's (1972) subjugated knowledges which are defined as "those blocs of historical knowledge which were present but disguised within the body of functionalist and systematizing theory and which criticism — which obviously draws upon scholarship—has been able to reveal" (p. 82). Furthermore, these knowledges are those that have been disqualified and deemed inadequate, including all knowledges not considered dominant. This thesis seeks to illustrate through the use of subjugated knowledges, like Elyn's self-account, that these so-called inadequate and disqualified knowledges challenge and criticize knowledges such as medicine, that Foucault calls popular knowledge. Again, this can be linked to Foucault's concept of genealogy which seeks to demonstrate and "establish a historical knowledge of struggles and to make use of this knowledge tactically today" (p. 83). One of Elyn's reasons for writing and publishing her book: she wanted to share her story and struggles with

others like her, so that despite what mental health professionals say, there are always other

treatment options available and possible positive outcomes.

Determine Who Gets to Speak and with What Authority

Throughout these books, both women share their experiences of being treated

poorly due to their diagnosis. Again, what can be seen is that physicians had considerable

control in Mary and Elyn's treatment at first. Eventually, both women were able to make a

stand and seek alternative treatment despite physician recommendations. For Mary,

although she was able to speak her mind regarding the hospital and treatment she

received, she was unable to pursue higher education due to her mental status. Elyn also had

similar experiences where she was forced to drop out of law school due to her mental

status, but was eventually re-admitted.

We are slowly starting to see more books like these emerging and becoming

available to read. This illustrates that those who are part of a minority do not get to freely

share their experiences. What has been reviewed in the two previous steps and these books

show that some people diagnosed with schizophrenia are capable of being successful. Elyn,

however, makes an interesting point: many individuals with a mood disorder make a list of

famous and successful individuals who also share their problem. People with thought

disorders on the other hand do not as no such list exists. "Few schizophrenics lead happy

and productive lives and those who do don't tell the world about it" (Saks, 2007, p. 329). It

is obvious there is a negative stigma surrounding thought disorders. Saks suggests this has

a great impact on whether individuals like herself would choose to reveal and share their

experiences. Elyn goes on to discuss her intentions for publishing her story as a way to give

others hope and dispel many myths held by mental health professionals. When Elyn was

diagnosed with schizophrenia, she felt as though she had received a death sentence and

found many professionals believed "people with significant thought disorder can't live

independently, can't work at challenging jobs, can't have true friendships, can't be in

meaningful, sexually satisfying love relationships, can't lead lives of intellectual, spiritual,

or emotional richness" (Saks, 2007, p. 331). Elyn is an example of someone who was

diagnosed with schizophrenia and found all of these things. When she began prepping to

write her book, a friend suggested she use a *nom de plume* to save face and privacy;

however, Elyn felt doing so would send the wrong message.

Living with Voices

Unlike the self-accounts above, this book includes 50 voice hearers' stories of

recovery. For the purpose of this analysis, only four stories will be reviewed. These include

stories from Antje Muller, Audrey Reid, John Exell and Jo, all who have been diagnosed with

schizophrenia or have experienced auditory hallucinations and received unsuccessful

treatment from traditional medicine.

Determine the Conditions Needed for the Object to Become a Discourse

Similar to the self-accounts above, the deinstitutionalization movement allowed for

the writing and publication of a book such as *Living With Voices*. Mental health patients are

no longer kept in asylums and hospitals, and are thus seeking treatment outside of the

institution. This book is different from the books used above, however, as it was written by

a team of researchers interested in exploring the lives and recovery of individuals who

have experienced hearing voices in their lifetime. Two previous books have been written as

part of this project: *Accepting Voices,* which had the purpose of analyzing the experiences of

voice hearers away from the medical model and *Making Sense of Voices,* which outlines a

different approach for professionals to follow while working with a voice hearer. What is

evident here is how the traditional medical model approach towards mental illness,

specifically for dealing with schizophrenia and voice hearers, has been significantly lacking;

as a result, new treatment approaches are being explored.

Another contributing factor allowing this book to become a discourse is the voice

hearers involved in this research process, on the one hand, did not receive the help they

needed from traditional medicine or, on the other, had a negative experience while

hospitalized and joined voice hearer groups as an alternative. In particular, the researchers

recruited participants from *Intervoice*, an international *Hearing Voices Network* that holds

support meetings for voice hearers. During one of Antje's hospitalizations, she was locked

in a psychiatric ward where she was given medication and within three days, she was

hardly able to speak (Romme, et al., 2009). She discusses that she has been hospitalized

upward of twelve times and with each hospitalization, she felt there were fewer

possibilities available in her life. Audrey had similar experiences with medication as she

was put on Prozac, which made her feel detached and unable to concentrate on schoolwork

resulting in her dropping out of school. Like Antje, Audrey was also hospitalized numerous

times. For her, hospitalization "seemed so pointless. Nothing changed, nothing got better. It

was just a place to go when things got out of control" (p. 119). Audrey found the hospital

staff unsupportive, they did not give her a positive prognosis and, during her stay in

hospital, she was constantly medicated, which made her drowsy. In fact, Audrey states "I've

felt angry ever since; that such a big chunk of my life was stolen by the drugs. I got better

despite them, not because of them" (p. 123). Although it is unfortunate that both women

had such negative experiences with the mental health system, without these experiences,

stories like theirs would not be available for others to read. As well, individuals who felt as though they were unable to speak freely with mental health professionals about their voices created groups such as *Intervoice* and the *Hearing Voices Network*.

Determine What Institutions and Social Processes Influence the Narratives

The hospital affected the voice hearers in a negative way. Of their stories, all four voice hearers had bad experiences within the hospital where they were forced to take medication without results. This made them each more aware of their situations. If they continued to stay on medication as recommended, their prognosis was not positive. Additionally, each of these individuals shared a similar experience when telling professionals, family members and friends about the voices they heard. Antje viewed hearing voices as a deficit and did not tell anyone about them until she let it slip to one of her physicians. His response was to institutionalize her. At the age of five, Jo asked one of her friends if she heard voices as well. In turn, she was called "a nutter". This was Jo's first realization that she was different and knew she needed to keep her voices to herself.

Despite the negative stigma surrounding mental illness, some of the voice hearers also had positive experiences in the hospital and with mental health professionals. During one of Audrey's hospital stays, a community psychiatric nurse realized the effect the medication was having on her. Audrey was not finding the medication helpful; it did not stop her from hearing voices and made her very drowsy. The nurse pointed Audrey in the direction of a voice hearers group for support. John's first few hospitalizations resulted in negative experiences as well as a bout of depression after being released where he mentions "I had been a lot happier, though a bit crazy, before I went in" (Romme et al., 2009, p.213). John also went to a *Hearing Voices Network* and finally felt as though he was

able to speak freely about his voices without being judged. Thus, the different hearing

voices groups each individual attended are another social institution that influenced these

voice hearers. For Jo, she did not have a negative experience in the hospital and found

mental health professionals to be positive and helpful. As a young girl, she had traumatic

life events that triggered her voice hearing and professionals realized this, giving her

coping strategies to deal with her issue. Often, physicians do not speak to patients about

their delusions and hallucinations, but the physician who eventually helped Jo did just that.

In fact, Jo mentions that her psychiatrist was the first person to directly deal with the

voices and her "reaction was 'God somebody is actually bothering to talk to me about my

voices'" (p. 211). As well, John really began to feel happier once he began talking with

others about his voices and eventually realized he creates them within his head. John

discusses how this realization changed his life dramatically. He has not been sick with

schizophrenia since as he has learned to control the voices.

Finally, it is important to consider the underlying factors that motivated Romme et

al. (2009) to conduct various studies examining the experiences of voice hearers. Hopton

(2006) discusses the impact anti-psychiatry has had on mental health perspectives in the

1960s where newer critiques began to emerge in the 1980s and 1990s. Romme et al.

(2009) first published a book in 1993 entitled *Accepting Voices* with the purpose of

showing a voice hearers experience outside of the medical model. These ideas claimed a

voice hearer may not necessarily have schizophrenia and may in fact manage voices

without the use of psychopharmacology and anti-psychotic medication (Hopton, 2006).

Furthermore, Hopton (2006) discusses that cognitive-behavioural therapy and talk

therapies have started to gain acceptance where physicians once viewed these techniques

as ineffective. Thus, Romme et al.'s (2009) work has been influenced by the anti-psychiatry

movement and has sought to dismantle traditional Western scientific beliefs that voice

hearers should be viewed through the disease model lens and move towards a recovery

approach.

Determine Who Gets to Speak and with What Authority

As in the other self-accounts, mental health professionals and pharmaceutical

companies have played and continue to play a major role in the treatment of schizophrenia.

In the four stories being analyzed, at one time or another a physician had control over the

voice hearer's treatment. Although the stories do not go into great detail, each individual

was in hospital, some more times than others, and eventually released. Each voice hearer

describes how during his or her stay in hospital, medication was used many times against

the voice hearer's will. Additionally, a common frustration shared amongst the voice

hearers was their lack of input into treatment. For example, Antje recalls "no one had ever

asked me anything about voices. As far as I recalled no one had ever asked me anything

about the voices even though it was the voices that made life impossible for me" (Romme,

et al., 2009, p. 115). While being treated by mental health professionals, Antje points out

that no one discussed her voices with her; instead, she was heavily medicated which did

not relieve her of her auditory hallucinations. Once released, the individuals all found their

way to voice hearer groups, which allowed them to become comfortable in speaking about

their voice hearing experiences, which they were unable to do in the past.

Intervoice and *The Hearing Voices Network* allowed for the voice hearers the

freedom to discuss their voice hearing experiences without being judged and hospitalized.

In turn, these groups have allowed for these self-accounts to exist as the researchers

recruited these individuals from such places. Again, this research project has allowed these

voice hearers to share their accounts of schizophrenia and auditory hallucinations that may

not have been available to us otherwise. Antje discusses that the most important way to

have the voices vanish was to change her attitude towards them. Instead of responding

with fear or obliging to the voices requests, she simply asked them to return where they

came from and now she no longer hears voices. As well, she is now the coordinator of the

German *Hearing Voices Network* where she receives support, as well as helps others speak

about their voices. One of Audrey's coping strategies was to give her voices time slots when

they could speak. This helped her manage them much better and as she began to take

control of her life and voices, the positive voices got stronger and she felt much better. For

John, his breakthrough came when he realized he was responsible for the voices as they

were coming from within. He mentions that the voice hearing group gave him the support

he needed to speak freely about his voices. Additionally, he was able to listen to others'

stories and relate. One man gave John the advice that voices are unreliable and the best

way to deal with them is to ignore them. Finally, Jo developed various strategies to help her

when she was having an off day by doing things like listening to music, being with animals

and talking with supportive people. These four stories demonstrate that although each of

these individuals shares the voice hearing experience, they found relief from their voices.

As such, each case is in fact unique and each individual has a different relationship with his

or her voices.

Interestingly, John's relationship with his 'good' voices proved to be helpful for him.

He recalls that when the voices disappeared, he missed them. Additionally, John mentions

that he sometimes asked his voices for advice when he had an important decision to make.

Furthermore, he recounts that some voices even had important things to say to him. In some situations the voice hearer may have a positive relationship with his or her voices, as John did with his 'good' voices. However, not all voice hearers may be so lucky and John states, "the individual voice hearer must weigh up all the evidence for themselves and act accordingly with their voices: ignore them, relate to them, even enjoy them" (Romme, et al., 2009, p. 216).

In summary, the self-accounts reviewed although different share commonalities. *The Best of Youth* illustrates the deinstitutionalization movement that occurred in Italy, with scenes showing the poor environment patients faced in the asylum. *A Beautiful Mind* depicts the experiences of John Nash and his success in overcoming mental illness with the use of medication. Although as illustrated by Whitaker (2002) and PBS (2002), the film strayed from real life events and Nash was able to stop using antipsychotic medications without continued problems, due to hallucinations and delusions. Although fictional, these films are accurate portrayals of schizophrenia, which can be seen by the similarities found between them and the three books analyzed.

Mary and Elyn's books are self-accounts that describe these women's experiences with schizophrenia. Additionally, four other accounts were reviewed from a larger research project looking at the experiences of voice hearers. What can be seen here is the six accounts of schizophrenia, along with the films, were impacted by the deinstitutionalization movement, which allowed for all of these individuals to write and share their stories with us. Furthermore, these individuals were all impacted by similar institutions and social processes. These include mental hospitals and schools, as well as interactions with mental health professionals, family, friends, therapists and academic

peers. From these interactions, each individual has been able to share their story about living with mental illness. Their positive and negative experiences inspired each to get their stories out there to bring awareness to others.

Over time, there has been a shift in power regarding who is given the authority to speak. In the past, patients had no say in their treatment plans, which were based solely on physicians' orders. As we have seen, with the deinstitutionalization movement, patients have been given more say in their treatment and recovery process. Although complete control has not been given to mental health patients, it is through self-accounts of mental illness that we can move toward this. Sharing their experiences will allow physicians and others to see the importance of listening to patients and involving them in the treatment process. As well, each situation is unique which again shows why patients' input is so important. Grouping everyone into one category of "schizophrenic" and treating them with the same techniques and medications does not work. In the coming section, self-accounts and alternative treatment options are explored.

CHAPTER FOUR: DISCUSSION

In the coming section, I will look more closely at the self-accounts analyzed above and consider the findings both in the context of dominant literature surrounding schizophrenia and in relation to the central themes addressed in the literature review. Through a further examination of anti-psychiatry, this discussion will also illustrate the role language has played in constructing knowledge and binary categories and how these constructions have affected modern views toward psychiatry. New ideas and alternative treatments for schizophrenia and hearing voices will also be discussed.

Anti-Psychiatry

As discussed previously, the anti-psychiatry movement has had a major impact on how psychiatry was viewed and also how psychiatry is viewed today. The main goal of the movement was to change the field of psychiatry into a more positive practice where patients are treated with dignity and respect. Again, Cooper's (1978) definition of anti-psychiatry points out three key factors of the movement: trying to change the negative fundamental backings of psychiatry which include reversing the rules of psychiatry; abolishing the power hierarchies found within psychiatry and giving the patient authority in their treatment, which may include alternative options that allow them to open up to new experiences. Furthermore, Romme et al. (2009) similarly suggest that we need to move away from a deficit model of mental illness and towards a recovery approach focusing on promoting health and resilience in patients. For Cooper (1978), anti-psychiatry "means that profoundly disturbing, incomprehensible, 'mad' behaviour is to be continued, incorporated in and diffused through the whole society as a subversive source of creativity, spontaneity, not 'disease'"(p.117). This can be linked to the fundamental beliefs of Laing

and Berke who ran Kingsley Hall. Both believed that allowing oneself to experience

madness was a form of rebirth where one could emerge from the journey with new insights

about the self; as we saw in Mary's story (Barnes & Berke, 1991). Cooper (1967) agreed,

stating "psychotic experience may, with correct guidance, lead to a more advanced human

state but only too often is converted by psychiatric interference into a state of arrest and

stultification of the person" (p.79). This appears in each case addressed in the analysis: the

individuals diagnosed with schizophrenia all had negative encounters with mental health

institutions that resulted in a diminished quality of life.

        For Cooper (1967), a factor that contributed to the power imbalance found in

psychiatric practices is that when a person is diagnosed, they take the role of a passive

patient. The passive patient is expected to accept the pathological approach taken by

physicians, is rarely encouraged to help themselves, and is often subject to unwanted drug

therapy (Romme et al., 2009). This model was shown in *The Best of Youth* (2003) where

Giorgia accepted her diagnosis and was subject to electroshock treatment in the institution.

As well, Elyn discussed her feelings of hopelessness and despair when she was originally

diagnosed. These types of feelings were also found in the other voice hearers' self-accounts.

Furthermore, Romme et al. (2009) mention that in psychiatry, voice hearers are

approached only in relation to the symptoms they present to find a cure. The voice hearers

did not find psychiatry helpful as it takes the disease model approach, rather than seeing

the problems in one's life as a cause of mental illness. Rather, Romme et al. believe

individuals who hear voices should be viewed as people who have problems, but also

possibilities. For example, when Elyn was first diagnosed, her prognosis was grim;

however, she was able to graduate from university and maintain meaningful relationships

despite this. Cooper (1967) states that once a patient is diagnosed and labeled, he or she is expected to take on a sick role, which links to the kind of passivity mentioned above. This can also be connected to the social expectations present today. As Cooper (1978) states,

> One is punished for madness. If you go mad, by normal social definition, in psychoanalysis your likely fate is the usual psychiatry incarceration with all the violent trimmings-at least until your language-words and acts-becomes normally 'grammatical'- and normally banal once again. (p. 22)

This quote illustrates the role social norms play in dictating behaviour and society's reaction to those deemed abnormal. Davis (2006) discusses how the person does not have an illness or disability, but rather how society has constructed normalcy which creates the illness and disability as a problem within an individual. This coincides with Parker, Foucault, and Basaglia's beliefs, where society constructs madness; madness does not stem from within the individual. As Barnes and Berke (1991) showed, psychiatry proved oppressive with the mental institution and functioned as the agent of social repression. One factor that contributes to the creation of these norms and expectations in society is language.

Language and Knowledge

Dominant thoughts and language impact society substantially, especially in relation to discourse and norms. Parker et al. (1995) state that "psychiatric knowledge ha[s] been concerned with what goes on inside an individual's mind and body and tried to brush away the role of language and society in the experience and treatment of distress" (p.3). The language used to describe such mental illness negatively constructs those who differ from them as a deviant margin. This creates fear as a dominant discourse. This fear of difference

amongst individuals in society, especially in terms of madness, is due to its being viewed as unpredictable.

As well, Brown (1995) discusses the role language and knowledge play in diagnosis. Although the language surrounding mental illness can be oppressive, in some instances a diagnosis can bring relief personally and emotionally. Cooper (1967) showed this by explaining that individuals seek out professional help because they are searching for someone who can assist them in learning techniques to enable them to conform to social norms and expectations. Similar to disability, being diagnosed with a mental illness excludes certain individuals from certain activities in society based on their different appearances, behaviours and economic ability (Tregaskis, 2002). For Elyn, finally being given a diagnosis did not bring relief, but rather left her feeling despair as she discusses her prognosis:

> I would largely lose the capacity to care for myself. I wasn't expected to have a career, or even a job that might bring in a paycheck. I wouldn't be able to form attachments, or keep friendships, or find someone to love me, or have a family of my own - in short, I'd never have a life. (Saks, 2007, p. 168)

Along with diagnosis comes prognosis and treatment. What we have seen thus far from the self-accounts analyzed is individuals diagnosed with schizophrenia were given poor prognoses and limited treatment options. As Brown (1995) observes, diagnosis can be used as social control by the dominant and powerful groups, both socially and institutionally. Furthermore "diagnosis locates the parameters of normality and abnormality, demarcates the professional and institutional boundaries of the social control and treatment system and authorizes medicine to label and deal with people on behalf of the society at large"

(Brown, 1995, p. 39). Through the use of language, norms and diagnostic categories are constructed and individuals are grouped and labeled according to the behaviours they perform (Parker et al., 1995). With the creation of categories also comes binary discourses, such as normal and abnormal.

Historical Views of Madness

Discourse is deeply embedded in society making it difficult to move away from old definitions and historical constructs of madness. However, these definitions are continuing to restrict not only those labeled as mad, but many other oppressed groups as well. This is evident in discussion within disability studies where theorists like Oliver (2009) have been moving away from a medical or individual model, both of which have dominated the field of disability, towards a social model. This allows views to move away from placing the problem within an individual where all medical interventions intend to return the abnormal body back to "normal" (Lewis, 2006); instead, disability can become a social problem where society creates social restriction and oppression. This is similar to the purpose of the anti-psychiatry movement as discussed previously, which aimed to show the impact society plays on constructing madness. Foucault's (1959) account in *Madness and Civilization* illustrates the power dominant discourse played historically in creating the social norms that led to the creation of asylums. Again, this archaeology can be linked to the idea of normalcy given scientific backing in the 1800s (Davis, 2006). Furthermore, as scientific knowledge surrounding madness began to emerge, society's views were swayed accordingly resulting in the negative stigma and stereotyping surrounding mental illness still present today. To illustrate the hold scientific knowledge has on society, Lewis (2006) discusses the story of Prozac between 1987 when it was first released and 2002. In that

period, 27 million prescriptions were written for the drug. As well, Prozac led to the release

of other anti-depressant drugs. Statistics show that one in every four Americans had been

prescribed one of the drugs (Lewis, 2006). This clearly shows the power scientific

knowledge can play in a biomedical model of illness, an issue discussed further below.

Additionally, as illustrated by Whittaker (2002), although different from the film's

portrayal, Nash discontinuing antipsychotic medication "may have been fortunate because

their deleterious effects would have made his gentle re-entry into the world of

mathematics a near impossibility". Nash, like Mary and Elyn, refused to take or continue

taking medication against their physicians' recommendations.

> Medicalization, or psychiatrization, legitimizes the medical community's expert
>
> authority over the domain of mental difference. And the binary between normal and
>
> abnormal shores up this psychiatrization by providing tremendous social and
>
> psychological pressure to stay on the side of normality, or sanity. (Lewis, 2006, p.
>
> 340)

Foucault's (1959) term 'resistance' is helpful here, as he saw that wherever there is

domination, there is also resistance. The self-accounts of madness demonstrate this as each

individual had experiences with mental health institutions ending with involuntary

restraint, both physical and chemical. Although medications were used in some cases, most

of these individuals were eventually able to resist this dominant form of treatment and

found alternative and effective options. Dating as far back as the 1880s, Lewis (2006) gives

an example of quite possibly the first self-narrative surrounding mental illness and the

asylum practices that would eventually evolve into psychiatry, published in 1886 by a

former asylum patient. This is one of the first published forms of resistance towards the

inhumane treatment of those committed to asylums because individuals felt as though they were "being treated with disrespect, disregard, and discrimination at the hands of psychiatry" (Lewis, 2006, p. 341). Many other resistant texts have been released since this example and, today, despite constantly being subject to dominant discourse, individuals who are labeled as different are able to resist power and change these notions by pursuing, what Deleuze and Guattari (1987) call, lines of flight or challenges to dominant notions that reterritorialize oneself outside these rigid definitions. Churly (2011) quotes a person diagnosed with schizophrenia as saying, "people like me can have jobs, they can have relationships, they can live independently and live a life worth living. You just have to claim it" (p.25). For many, 'claiming it' means making a stand about their treatment and recovery processes.

Another point to consider is how all individuals are expected then to fit into one of these categories created through discourse and binary oppositions. When one does not fit into the dominant category, normal rather than abnormal or mad rather than sane, there is a problem as was illustrated earlier during the discussion of language, ideals and norms. Additionally, it is problematic when an individual who is labeled abnormal does not fit neatly into one of the categories set to define them. Those who voluntarily stayed at Kingsley Hall had a say in the treatment of their mental illness. Again, the purpose was to disregard all traditional roles of physician and patient and create a space where all were equal and no one had the right to give or receive orders (Guattari, 1996). Mary Barnes was one member of the community who was fully immersed in her journey through madness and did not necessarily fit neatly into what was expected of one labeled as mad. This was problematic for her parents, especially as her father did not believe Kingsley Hall was a

sufficient treatment option for his daughter. He questioned Dr. Laing about Mary's specific

diagnosis as either manic-depressive or schizophrenic. Dr Laing's response was that "those

terms relate to how a person behaves. In certain circumstances, Mary might behave in a

manner you could call schizophrenic. Here at Kingsley Hall, Mary is a member of a

community. She is being helped to simply be herself" (Barnes, 1991, p.115). Dr. Laing was

trying to avoid placing Mary into a subordinate category; however, it is obvious how

language is used by society in an oppressive way to define those labeled as mad. One of the

leading reasons is the fear caused in society by difference. This fear is instilled in the

categories of mental illness used to define these individuals.

Language has been used in many situations as a constraint because certain

definitions place individuals in subordinate positions in society. A newspaper article

written by Rogers (2011), who has been diagnosed with Bipolar Disorder Type II,

illustrates just how language and labeling can create the categories where a person with a

mental illness feels ashamed and guilty. Individuals who do not meet these normal

expectations are made to believe the problem lies within them, rather than the issue being

a result of society and the language used to define them. Elyn discusses her feelings about

feeling as though she was broken inside and crazy because she was unable to control her

thoughts (Saks, 2007).

Parker et al. (1995), however, point out that language can also be a resourceful tool

used to reconstruct these dominant notions. How is this possible? One way to set change in

motion is to deconstruct the dominant discourses and binary categories found in society.

Jacques Derrida initially developed the concept of deconstruction. Deconstruction is useful

in these situations where hierarchies and binaries exist and need to be dismantled within

institutions (Caputo, 1997). Parker et al. (1995) states that "deconstruction in [its] original and purist sense, identifies conceptual oppositions, recovers notions that have been excluded and shows how the ideas that have been privileged are dependent on those they dominate" (p.3). In order to move away from these dominant ideals, Basaglia (1987) discussed the roles of technicians and intellectuals. The technicians are working and surrounded by the ideologies constructed by the intellectuals, who have the best interest of the dominant class in mind. In other words, the intellectuals represent physicians and the technicians represent those working under the physicians. The general public then truly believes a crazy person is crazy and must be locked up because this is an ideology that has been justified by the dominant class through science and reason (Basaglia, 1987). Additionally, the general belief behind the institution is individuals enter to be 'cured' or rehabilitated back to a normal state of being. Again, this was illustrated in *The Best of Youth* (2003) where Giorgia was placed in an asylum by her family, who assumed she would be cured and released, although this was not the case. Physicians are considered experts with patients and their families relying on these physicians to make the best choices in treatment. The binary of physician/patient is problematic. The purpose behind mental institutions is hidden behind the false belief physicians are there to serve patients. In fact, an institution made to serve a specific population should consider that population's input when making decisions regarding treatment, which institutions like asylums do not. To ensure those labeled mad have a say in their treatment, dominant notions of madness and the treatment of madness need to be challenged and changed. Deleuze and Guattari's (1987) concepts of molar and molecular lines as well as lines of flight require exploration to see how this can occur.

For Deleuze and Guattari (1987), molar lines can be viewed as the dominant

discourses in society and lines of flight are those which redefine these notions. Specifically,

molar lines are rigid lines created to fix boundaries and social roles. We use these

boundaries to create our identities in relation to expectations to fit into society. Molar lines

can be envisioned as a square box. An example of a molar line would be the traditional

nuclear family. The molecular lines are those that allow for some flexibility in the rigid

definitions set by the molar lines, those which put pressure on the boundaries of the box.

Finally, lines of flight violate and go beyond the restraints created by the molar and

molecular lines. In order to break free of these rigidly set definitions, one must show it is

possible for people to be different and exert different capacities. Again, these terms are

important to consider when investigating the role language plays in the social construction

of madness, as society is used to being kept within the confine of this box created by the

molar lines; we accept being told what is normal and what is not. The deconstruction of

dominant notions allows people to redefine themselves as lines of flight. For Derrida

(1988) deconstruction is the process of dismantling binary oppositions, which creates the

opportunity to open these categories to the possibility of change. However, the goal of

deconstruction is not to create new categories or definitions because this would not solve

the problem, but only create new discourses and binary opposites. Instead, the purpose of

deconstruction is to allow these categories to open to new possibilities and allow for being

without order (Derrida, 1988). Again, deconstruction does not look to redefine terms and

revalue or replace one knowledge or category higher than the other, but looks to challenge

and dismantle hierarchal knowledges and open them to new possibilities. Through self-

narratives, this can be linked to anti-psychiatry and the movement away from the

medicalized, individual model found in psychiatry today.

Medicalization of Schizophrenia

In North America, the DSM-IV-TR is the diagnostic tool used to determine which

disorder is present in a patient and the required treatment. Brown (1995) states, "in

constructing their definition of an illness, people also construct what they consider

appropriate ways to treat it" (p.47) which, in many cases, are influenced by the dominant

scientific knowledge at the time. Farber (1993) discusses the two most common models

used to view mental illness: the psychoanalytic model and the biochemical imbalance

model. Both models suggest an inherent problem coming from within an individual.

However, Farber (1993) stresses how the reaction to disease and illness is culturally

determined and causes some to question the underlying notions of the medicalized models.

In relation to schizophrenia, the main form of treatment includes psychotropic medications

that have many negative side effects. Crawshaw (2011) points out some of these side

effects, including weight gain, type II diabetes, high cholesterol, cataracts, and tardive

dyskinesia. Elyn, as well as those individuals accounts collected by Romme et al. (2009)

also note the negative side effects they experiences while taking antipsychotic medication.

Additionally, new research has shown the risk of deep vein thrombosis and pulmonary

embolism from repeated use of antipsychotic medication (Crawshaw, 2011). These side

effects alone are reason to look to alternative forms of treatment. Romme et al. (2009)

discuss the disease model that stems from diagnostic tools such as the DSM-IV-TR where

mental health problems are reduced to symptoms, rather as systemic problems present

within a patient's life. Furthermore, traditional psychiatry views a disease as creating

symptoms. In this case, the symptom of voice hearing leads to a diagnosis of schizophrenia.

Romme et al. (2009) go on to state the "scientific criticism of the diagnosis 'schizophrenia'

has been growing and argues that scientifically speaking, the disease of schizophrenia does

not really exist; rather it is just a group of very different people labeled as such" (p. 25).

Oliver's (2009) discussion of the social model of disability connects with this idea when he

states,

> The problem arises when doctors try to use their knowledge and skills to treat
>
> disability rather than illness. Disability as a long-term social state is not treatable
>
> medically and is certainly not curable. Hence many disabled people experience
>
> much medical intervention as, at best, inappropriate, and, at worst, oppressive. (p.
>
> 23)

In terms of madness and schizophrenia, the self-accounts discussed illustrate the

physicians' power over treatments, such as psychopharmacology, which also suggest a

biologically based brain disease. *Mad Pride* is an organization that began in the 1970s as a

result of various individuals coming together who had first-hand experience with

psychiatry. These individuals had negative experiences with psychiatric treatments and

wanted to challenge its fundamental practices or, at the very least, bring awareness about

psychiatry to others (Lewis, 2006). Lewis asserts, "rather than pathologizing mental

difference, *Mad Pride* signifies a stance of respect, appreciation, and affirmation" (p. 339).

For example, Frank, a member of *Mad Pride*, was hospitalized for bizarre behaviour,

including growing a beard, not working, and becoming a vegetarian. He received shock

treatment as therapy and states, "these so-called [shock] treatments literally wiped out all

my memory for the [previous] two year period...I realized that my high-school and college

were all but gone; educationally, I was at about the eighth-grade level" (Frank, 1993, as

cited in Lewis, 2006, p. 342). Frank began receiving this treatment when he was first

committed in 1959 with the side effects immensely impacting his life. Around this time

Mary Barnes and John Nash had run-ins with psychiatric institutions, medication and

involuntary commitment, which also impacted these individuals' lives. These experiences

caused these individuals to come forward and share their stories in order to bring

awareness to others like them, as well as to make a stand against traditional psychiatry.

        Lewis (2006) connects *Mad Pride*'s fundamental principles with Oliver's social

model of disability where he discusses the problems caused by medicalizing not only

disability, but mental health as well. That is because medicalization means

individualization, whereas for Oliver (2009), as well as Lewis (2006) and *Mad Pride*

members, disability and mental health should be reframed in such a way that society can

see the social restrictions and oppression created by medicalization that creates social

exclusion, isolation, lack of opportunity and negative side effects (Lewis, 2006). After all, it

is not the individual's fault they are being excluded socially and oppressed; rather, as

Foucault (1975) stated, "responsibility for their exclusion has been rightly placed at the

door of a normalizing society which has rigidly developed and maintained structures

designed to create a docile workforce" (p. 193). As Tregaskis (2002) points out, those who

conform to the ideal norms of appearance and behaviour are rewarded and those who do

not are punished. Again, linking this to disability, Tregaskis (2002) explains Oliver's point

that capitalism defines individuals with disabilities so they are viewed as 'dependent',

having non-disabled professionals making decisions for them. In terms of mental illness,

we have seen this occur with the self-accounts analyzed where Giorgia's family had her

institutionalized, Mary's family expected her to be 'cured' by the hospital, Elyn and Nash

were pressured by physicians to take medication that had many negative side effects. Being

committed and put on medication, as we have seen, restricts an individual's capacity for

being.

Blocking the Rhizome

Theorists like Farber (1993) believe mental illness and the medical model have zero

human or scientific justification. Farber's (1993) beliefs are similar to Thomas Szasz who

proposed that mental illness was all a myth or metaphor as there was no objective

observable truth. I do not agree fully with Szasz and Farber and do not intend to

illegitimatize mental illness; rather, I want to show how the medical model has overtaken

most thought surrounding mental illness, and thus support the need to move towards a

social model as Oliver (2009), Lewis (2006), and Romme et al. (2009) suggest. As well, my

intent is to illustrate Deleuze and Guattari's notion of the rhizome, which has been blocked

by the medical model of mental illness, by disallowing those labeled mad to fully exert their

creative capacities and potential, which, as Romme et al. (2009) suggest, also impedes

recovery. We have seen in the above sections the consequences of psychiatry and the social

control and repression it creates. In order to dismantle these notions, we must move

towards a depsychiatrization of madness, which has been an ongoing battle illustrated by

the anti-psychiatry movement and the *Mad Pride* movement. The disability movement

named the social stigma and oppression created by society as 'ableism' where the *Mad*

Pride movement uses 'mentalism' or 'sanism' to describe similar phenomena (Lewis, 2006).

There are many similarities among the disability movement and anti-psychiatry

movement, although Lewis (2006) points out the *Mad Pride* activists are also faced with

involuntary commitment and forced medication laws. Furthermore, all social movements

have struggles with truths created by biomedical science, which has been used to

subordinate many groups such as women and homosexuals (Lewis, 2006). By coming

together, the disability movement and anti-psychiatry/*Mad Pride* movement can form a

coalition together to fight political and epistemological struggles, thus releasing the blocks

put in place by the oppression and social stigma that is created through labeling.

Releasing the Blocks

Groups such as *Mad Pride* as well as other oppressed groups including disability

movements and *Gay Pride* have been challenging dominant notions surrounding their

oppression for years. This can be viewed as a form of resistance in that these individuals

have come together to try to break dominant thought and show society they deserve

equality. One issue these groups work to combat is "the linguistic conventions that

structure the meanings assigned to disability and the pattern of response to disability that

emanate from, or are attendant upon, those meanings" (Linton, 2006, p. 161). In relation to

mental illness, Farber (1993) states it "is a concept used to characterize behaviour that is

unwanted. It exists in the mind of the person who uses the concept to categorize others" (p.

137). Therefore, these groups work to restructure the language used to describe them and

with that break the stereotypes surrounding disability and madness. Again, these

movements can be linked to Deleuze and Guattari (1987) who defined the norms and

stereotypes found in society as molar lines. These molar lines rigidly define all aspects of

society and are restricting to those who do not fit the definitions they create. Once more,

we can see how lines of flight can be produced to break free of these restricting and

oppressive definitions found in society. *Mad Pride* is just one group that has pushed the

boundaries of the molar lines, challenging them and causing others to question their

validity. The self-accounts discussed throughout this work are all examples of lines of flight.

Each individual account challenges the notions of mental illness in society where they

illustrate what individuals are capable of when they are not restricted. Specifically, Mary

lived unrestricted at Kingsley Hall where she was able to enjoy art, Elyn found success at

university where she became a professor. As well, in her personal life she found love and

got married. The four self-accounts discussed by Romme et al. (2009) mention how much

happier each individual became once finding the recovery approach and moving away from

medication and the biomedical approach. Finally, John Nash found great success in the

mathematics field, which as Whitaker (2010) mentions, may not have been possible if Nash

had continued his medication regime. Thus, these accounts challenge dominant discourses

surrounding schizophrenia and illustrate that despite having such a diagnosis, individuals

live fulfilling lives. Again, this does not fit into the molar line definitions of what one with

schizophrenia can do. As lines of flight, these self-accounts challenge dominant discourse

and redefine notions surrounding mental illness.

Furthermore, the definitions that structure society are beginning to be questioned

by others, allowing for those labeled as different or with a mental illness to deterritorialize

away from the molar lines by creating lines of flight and reterritorializing themselves

outside these definitions. Again, self-accounts of disability and mental illness can also be

viewed as lines of flight. Lewis (2006) discusses the 1977 publication of Judi Camberlin's

novel *On My Own*, which was considered a milestone in the development of peer run

alternatives. Throughout her book Camberlin discusses the challenges she faced while in

psychiatric care including abuse. She, like many others who have had experiences with

psychiatry, believed there must be other ways to help people like her, so she created *Mad Pride*, which is considered a psychiatric survivors' movement. As *Mad Pride* progressed and grew, some individuals who joined considered themselves 'consumers' of psychiatry and were not completely against it (Lewis, 2006). These members were still welcomed into the group as their main goals were in "developing alternative perspectives on psychiatry that emphasizes the importance of social models and democratic research and treatment" (Lewis, 2006, p. 344). Romme et al. (2009) discuss how the medical model does not account for the voices one with schizophrenia hears. The voices are ignored and the individual is medicated to alleviate their hallucinations. What Romme et al. found was those voice hearers who were medicated were not relieved of their voices, but instead became more socially isolated, dulled by the medications and inhibited by the voices. Therefore, by viewing voice hearing from a recovery approach, one must accept the voices and appreciate that their meaning can be beneficial in relation to the patient's life. Romme et al. found those who had help accepting their voices either from professionals or self-help groups, such as *Hearing Voices Network*s, were able to change their relationship with their voices and reach a level of recovery that allowed them to live more unrestrictedly. "The more the process of recovery develops, the more the relationship with voices becomes functional instead of pathological. They become the mirrors of the soul and well-being; a reflection of one's mental health and well-being" (p. 22). Furthermore, Romme et al. state that some voice hearers do benefit from neuroleptic medications; however these doses must be low. Elyn Saks found a dose she was comfortable and able to function with in the workplace. Those who are given high doses rarely find positive results and do not find the medications helpful as "it diminishes the possibility of using one's own capacities" (p. 95).

In some cases, medication can be viewed as a force blocking one's rhizome; however, in

other situations, one needs the medication to function.

Gibson's (2006) notion of dependency or connectivity explored while discussing

disability and the relationship between a person with a disability and the tools, machines,

animals and people who assist them, points out how these can be viewed as a dependency

or as tools to achieve independence. This promotes the medical model, or the idea of

conforming to the norm in that individuals are expected to use these tools to become more

independent and function more normally. Furthermore, the things that assist people thus

become a part of them or as Gibson (2006) states "an extension of the body that resists and

exceeds its closure" (p.187). Relating this to mental illness, one who relies on medication or

a talk therapist can be viewed as an extension of the individual. Gibson (2006) asserts:

> The goal of independence limits desire and the appreciation of connectivity. It
>
> reinforces disability as limitation rather than possibility and thus may contribute to
>
> legitimizing the repressive systems that exclude disabled people. It assumes that
>
> inclusion in these systems is worth pursuing. Perhaps it is not. Perhaps, there are
>
> possibilities in experimenting with various forms of dependency, giving and
>
> receiving, expecting nothing and everything. (p. 190)

Although this quote is directly related to individuals with disabilities, it can also be linked

to those with mental illness. Mary Barnes was one individual who did not see inclusion as

something worth pursuing. She agreed with Laing and Berke that experiencing madness is

therapy in itself. As Cooper (1978) stated: "madness is the destructuring of the alienated

structures of an existence and the restructuring of a less alienated way of being" (p. 40). As

Elyn Saks fought against medication for many years and relied on talk therapists to help

her deal with her schizophrenia, she eventually realized she needed the medication to

continue doing the work she loved at the university where she was employed. In this sense

she does not resort to medication to maintain independence; rather, the medication for her

is a release, a release in the sense that her rhizome was blocked prior to taking medication

because her voices were inhibiting her functioning. Now that she has found a balance

between therapy and medication, Elyn has not been 'cured' or overcome her schizophrenia;

however, she is no longer restricted by the blocks in her mind.

Linton (2006) notes many people use the term 'overcoming disability' to describe a

person who has been successful *despite* having a disability or mental illness. We saw this in

the movie *A Beautiful Mind* (2001) with John Nash, as well in articles written about Nash's

success, where Nash is someone who 'overcame his schizophrenia'. The implications of a

phrase like this suggests as Linton (2006) points out that the individual is no longer limited

by their disability or has risen above society's expectations of what someone with this label

is capable of. Instead however, "it seems that what is overcome is the social stigma of

having a disability" (p. 165). Again, one way to continue moving away from these dominant

notions is through self-narratives.

Self-narratives can be useful not only in that individuals are able to voice their

experiences, but they can also help during treatment for both the patient and the physician.

When a patient's story is incorporated into the treatment process there is a less chance the

therapy will be dehumanizing as we have seen with so many treatments in the past

(Roberts, 2000). In other words, the person stops being a 'case'. Additionally, with the

impersonality of the medical model and psychiatry, patients are sometimes overlooked as

persons. Furthermore, Romme et al. (2009) found having patients share their experiences

with their voices allows them to come to terms with and accept them. This is an essential part of the recovery process as an individual is able to relate the voices to their own life as well as learn to cope with the entire voice hearing experience. Roberts (2000) discusses the fact that "stories give cognitive and emotional significance to experience, they are a means of constructing and negotiating a social identity and give moral weight and existential significance to actions and events" (p. 434). When a voice hearer becomes 'ill', it is because they are unable to cope with their voices and the problems that have caused the voices in the first place. Roberts (2000) continues to discuss the value in using narratives to allow one to begin to understand the delusions and hallucinations, rather than explaining them. Allowing the individual to re-contextualize their experiences can aid them in the recovery process (Roberts, 2000). By doing so, as Romme et al. (2009) point out, voice hearers need a good balance of support and the structured help they need. Romme et al. also point out for the voice hearers they interviewed, voice hearing support groups did not give these individuals enough support to complete the recovery process. Each individual must find a balance of treatment and support that works for them. In some cases, this may include medication.

Summary

To summarize, a shift in thinking is needed. Less emphasis needs to be placed on the biomedical model of mental illness and more focus placed on recovery approaches and peer run alternatives. Groups such as *Intervoice* and the *Hearing Voices Network* have provided support for voice hearers for years now, and, as Romme et al. (2009) showed, these groups play a substantial role in the recovery process, although they are not enough on their own. Medical support is often needed in conjunction with these groups; however, a

combination that fits the patient should be used. Romme et al. also showed those individuals forced to use high doses of medication did not have a good outcome as medication inhibited their recovery process. Instead, a lower dose combined with self-help groups was found most successful. Where the medical model seeks to cure mental illness, a recovery approach does not mean recovering from mental illness entirely. Rather, it entails finding a level of treatment allowing one to maintain a level of functionality and live in a more unrestricted manner, or, in other words, finding a level of recovery that suits the individual's life.

Furthermore, self-narratives of mental illness can also be an important aspect of a voice hearer's recovery, as Roberts (2000) has illustrated. Romme et al. (2009) also discussed the importance of voice hearers sharing their experiences as part of the recovery process. By sharing their stories, they are able to come to terms with and accept their voices. Once the voice hearer has done so, the recovery process is possible. This was illustrated not only in the accounts Romme et al. collected for *Living With Voices,* but also in Elyn's story. Once Elyn began to share her voice hearing experiences and writing her book, she found it easier to come to terms with her situation because she no longer had to pretend and hide from the truth. As one of her co-workers suggested Elyn use a nom-du-plume to hide her identity, Elyn believed this would defeat the purpose of sharing her experiences at all.

Here it is important to consider the implications of this research. The main purpose of this thesis was to illustrate the usefulness in using self-narratives in research surrounding oppressed groups. One implication to consider is that I, as the researcher, do not personally have schizophrenia, nor do I have any first-hand experience with anyone

diagnosed with schizophrenia. Thus, it may appear I am speaking on behalf of these

individuals. However, I in no way intend to speak on behalf of anyone, rather I merely want

to illustrate the importance of self-narratives in research and their usefulness. Another

factor to consider is that I did not personally interview the individuals but viewed films

about schizophrenia and read books written by people with schizophrenia. Although these

pieces have been considered self-accounts, the films have been altered for the big screen.

This was evident especially in *A Beautiful Mind* where the film strayed from the original

story quite substantially. As well, the books were edited before publication, which means

some information may have been cut. Thus it would be more beneficial to interview these

individuals directly. That being said, self-narratives are interesting and full of important

information, however future research studies should consider interviewing individuals

diagnosed with schizophrenia directly. This would allow for a dialogue to develop through

open-ended questions where there would be no restrictions and the conversation would be

free flowing.

As illustrated throughout this thesis, these self-accounts are an important force in

challenging and shifting dominant notions of mental illness in society. With more and more

self-narratives of mental illness coming available, others are able to see the importance in

considering the patient's views and feelings when creating treatment processes.

Additionally, although these individuals do not fit into the molar definitions of normal, they

are still able to obtain jobs, have friends, get married and live a fulfilling life. These

accounts are proof each individual case is unique which should also be taken into

consideration. Self-narratives are a force to deconstruct the dominant molar line

definitions structuring society as they can be considered lines of flight, that which violates

and goes beyond dominant definitions. Lewis (2006) discussed *Mad Pride*, a social and political movement that has contributed to the *American Psychiatric Association* being forced to release evidence that specific mental illnesses are brain-based disorders. Unable to do so, the APA released a statement saying, "brain science has not advanced to the point where scientists or clinicians can point to readily discernible pathological lesions or genetic abnormalities that in and of themselves serve as a reliable or predictive biomarkers of a given mental disorder" (p. 346). It is statements such as these that will lead to a shift in thinking; however, there are still many forces standing in the way. As Lewis (2006) points out, and as we saw in John Nash's case, the pharmaceutical companies are huge forces and ones that groups such as *Mad Pride* are continuing to fight today. Furthermore, Lewis (2006) states, "the movement has worked impressively to expose psychiatry as a limited field of inquiry, to open up its clinical services to more peer-run alternatives, and to reduce coercive connections between psychiatry and the state" (p. 350).

A shift in thinking requires, as Linton (2006) discusses, changing the language we use to describe mental illness and disability. This can be useful not only in phrasing the language in a less oppressive way, but also in re-defining the definitions found in society. Language is a powerful tool to deconstruct dominant notions of mental illness and move away from the tree-root structures that organize society towards a rhizomatic way of thinking. Again, this will allow individuals to live more unrestrictedly, outside the box, outside the rigid molar lines, and the traditional discursive practices in society today. Continuous deterritorialization is required to break free of prevailing discourses and reterritorialize outside of these encompassing definitions. This was illustrated by each self-account analyzed throughout this work, as well as by groups such as *Mad Pride* who have

fought to change the notions surrounding mental illness. As well, each self-account is a line

of flight, which has allowed each individual to exert their creative force despite being part

of an oppressed group. If these individuals had been institutionalized, they would not have

had the resources to account for their experiences and would have been limited to the life

within the asylum. Through discursive practices, society instills in everyone the idea that

difference causes trouble and needs to be destroyed or changed to a more 'normal' state.

Difference leads the medical approach to mental illness to medicate individuals to return

them to a normal state, or at least to rid them of their abnormal behaviours regardless of

the ramifications of the medication. Therefore, as illustrated throughout this work, it is

important to shed the notion of binaries such as sane/insane, normal/abnormal,

independent/dependent and embrace difference rather than trying to force change upon

others and make everyone conform to what society deems normal. I will finish by using the

quote with which Elyn Saks (2007) sums up *The Center Cannot Hold*:

> If you are a person with a mental illness, the challenge is to find the life that's right
>
> for you. But in truth, isn't that challenge for all of us, mentally ill or not? My good
>
> fortune is not that I've recovered from mental illness. I have not, nor will I ever. My
>
> good fortune lies in having found my life. (p. 336)

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