

Transforming subjectivities in psychiatric care

Toril B. Terkelsen, Senior Lecturer, Phd

University of Agder, Institute of health- and nursing science

Box 509, 4898, Grimstad, Norway

E-mail: Toril.Terkelsen@uia.no

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Abstract:

This article is based upon ethnographic fieldwork in a Norwegian psychiatric unit practicing a psycho- educational treatment of young adults diagnosed with schizophrenia. An aim of the program is that patients learn to detect and monitor their ‘symptoms’ in order to obtain ‘insight into their own illness’, thus transforming themselves into self-governed and self-responsible subjects who are able to cope with life outside institutions. The program is constituted within a medical framework with strong emphasis on medicine-compliance. I explore the dynamics of power relations inherent in the program, referring to Foucault’s descriptions of discipline and normalisation through pedagogy and examinations. His concepts of governmentality and self-technologies have proved useful as a frame for a critical evaluation of such programs. However, subjectivities cannot be read off directly from educational technology, and my data from everyday, mundane settings in the institution reveal paradoxes and contradictions which are accounted for in this study.

Keywords: Schizophrenia

Psycho-education

Foucault

Power-knowledge

Governmentality

Subjectivity

Introduction

In this article I focus on how subjectivities emerge and transform in relation to a psycho-educational program treating people diagnosed with schizophrenia; in this particular case a Norwegian educational program labelled ‘An Independent Life’ (AIL hereafter). The article is based upon eight months of ethnographic fieldwork in a Norwegian rehabilitation unit. Referring to Michel Foucault, I explore the creation and expression of power relations through AIL and how the programme aims at teaching patients self-observation, self-classification and self-examination in accordance with the psychiatric diagnostic vernacular. The objective of the program is self-governance and independency, and through a specific knowledge-regime designed for regulating psychotic thoughts, feelings and behaviour, patients are supposed to ‘detect and manage symptoms with the help of professionals from the psychiatric field’ (from the introduction of the AIL- program’s workbook, in Gråwe, 1991, my translation). I will discuss how this takes place in everyday practice in the institution and how the program affects the people there.

To say that psychiatric knowledge and technology represent power is hardly controversial today. However, we are not dealing with a ‘one to one’ exploiting/exploited perspective, but a

rather large and ambiguous field of power-knowledge relations, as laid out by Foucault (1972, 2001a). This complex type of power is displayed, not mainly through a centralised state or ‘the law’, but through governmental apparatuses, institutions and procedures (the psycho-educational program is a particular example), aiming at the welfare, security and governance of the population, where the mental health field seems to pose a particular challenge.

Foucault (2001b, p. 220) states that ‘we live in the era of a “governmentality” first discovered in the eighteenth century’. His writings on self-technologies and governmentality are perhaps even more relevant today. Self-governance and self-care are traditional Western liberal ideals. Thus, psycho educational programs may be associated with the increasing neo-liberalism in Western societies. On the one hand, patients are expected to be self-governed and independent, to live a life outside an institution. On the other hand, such ‘freedom’ outside the institution is limited and constricted in several ways. In addition to social and economic limitations of ‘freedom’, people with mental health difficulties are not free to think or speak as they wish. They are expected to accept having a stigmatising chronic psychiatric illness (Estroff, 1993) and taking medicines which have a severe impact on their cognitive functions (Breggin and Cohen, 1999). What is to be done with individuals who do not accept the definition of illness presented to them, who are not able to or willing to govern themselves i.e. to comply with the program set up for them? What about people who do not see their problems as illness and claim their right to refuse medication? These questions are indeed political, ethical and economic. The various rehabilitation programs aiming at helping patients to govern themselves are perhaps not solely expressions of democracy and liberation. As Rose points out, ‘modern individuals are not merely “free” to chose, but *obliged* to be free’ (Rose, 1999, p.87). The change from taking care of ill people to teaching them responsibility for their own health has become a technology of ‘responsibilisation’ (Rose, 1999, p.74). For example,

the introduction of the concept of 'self-care' in nursing literature in the 1970s (Orem, 1971) almost created a revolution in nursing theory and practice. To be able to cope, to be independent and autonomous are highly valued properties described in nursing literature today. The individual has a 'duty to feel well', a moral responsibility to 'stay well' (Greco, 1993, p.357) and an obligation to have self-esteem. Cruikshank (1993 p.330) argues that 'those who have failed to link their personal fulfilment to social reform are lumped together as "social problems", diagnosed as "lacking self-esteem" and charged with "anti-social" behaviour'. Responsible, worthy patients on the other hand, comply with experts' advice in order to obtain self-care and independence. Such 'freedom' is referred to by Rose (1999, p.137-166) as 'advanced liberalism'; in order 'to govern better, the state must govern less' (Rose, 1999,p.139). A different kind of subject emerges, i.e. an individual who does not need to be governed by others but are 'free' to govern him/herself; as expressed in this study by the term 'An Independent Life'.

However, my objective is also to go beyond a power-knowledge perspective. My field data reveal that subjects are not only passively formed or produced by psychiatric discourses or governmental apparatuses. I focus on human agency and lived experience, reflecting on how subjects create and re-create themselves in local interactions (Biehl *et al* 2005, p.14). Not leaving Foucault's and Rose's works aside, I address the issue of experience; how subjectivities emerge, are shaped and reshaped through a flow of multiple, diverse and sometimes paradoxical everyday experiences in a psychiatric institution. Studies of lived human experiences in local, mundane settings in the present have not been issues in Rose's or Foucault's analyses. Blackman *et al* (2008, p.15) state that 'Experience [...] was always an important element for understanding subjectivity' and 'the role of experience [...] has always accompanied the concept of subjectivity '

Kleinman and Fitz-Henry (2007) deal with the issue of subjectivities and experience in a recent anthology. They point out that subjectivities are interactive, multiple, never static, always in-flux (p.55), writing that 'Experience is intersubjective inasmuch it involves practices, negotiations and contestations with others with whom we are connected. It is also the medium within which collective and subjective processes fuse, enter into dialectical relationships, and mutually condition each other' (p 53).

Through examples from my fieldwork, I describe how such practices, negotiations and contestations take place in a psychiatric institution. I also aim at illustrating the ambiguity and bewilderment in psychiatric care today, and how people, both patients and helpers, interact and influence each other in everyday settings

Psycho- educational programs

Psycho- educational programs in psychiatry emerged at the end of 1970. The impetus for the creation of such treatment programs was the explicit aim of many Western countries to reintegrate psychiatric patients into society. This development also took place in Norway. Inspired by the de- institutionalisation reform in Italy, several large psychiatric hospitals and asylums in Norway were closed down during the 1980s, and patients were transferred to open care in their communities. Independence, self-care and ability to cope with life became highly valued properties during this reform. However, many communities did not have the resources, competence or ability to take care of these patients in a proper way. Although Norway has a well developed, public welfare system compared to many other countries, several of these patients became marginalised and were left alone in poor conditions without the ability to care for themselves. The introduction of psycho- educational programs should also be viewed against this background. The programs are for the most developed within a biomedical

framework where acceptance of drug intervention is crucial in coping with illness (Falloon *et al*, 1996, Terkelsen *et al* 2005). Recent research in genetics and pharmaceuticals, and the refinement of psychiatric classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA 1995) and the International Classification of Diseases (ICD-10, WHO1992) have contributed to this development. Within this framework schizophrenia is regarded as a distinct disease, caused by imbalance in chemical neurotransmitters in the brain, characterized by ‘well-defined’ symptoms, such as hallucinations, delusions, ambivalence, thought disorders and social withdrawal. These symptoms are perceived as essential and self-evident. Extensive literature show that schizophrenia is an incoherent, invalid concept, and no consistent evidence for a brain malfunction or disorder has yet been identified (Bentall, 2003, Boyle, 2002, Johnstone, 2001, Thomas, 1997). Nevertheless, patients are expected to adopt the biomedical explanation, accept that they are ill and adjust themselves through education and medicine compliance.

A limited body of research and evaluation of the psycho-educational programs exists, focussing on reduction of symptoms and prevention of relapse. The authors, mostly psychologists and psychiatrists, emphasise what they consider positive effects on symptoms and relapse (e.g., Hogarty *et al* 1991, Goldstein & Miklowitz 1995, Bentsen 2003). A review of 10 studies concludes that psycho education is useful in the treatment of schizophrenia. Usefulness is measured by medicine compliance and decrease in readmission (Pekkala & Merinder, 2006). Ethical aspects associated with this treatment are, however, not discussed, nor questions related to the dynamics of power - knowledge in educational programs. According to my study, usefulness should be measured by how patients define it. Field data reveal that several patients object to the AIL program and do not find it useful at all.

Context and methodological challenges

The rehabilitation unit (Sunhillⁱ hereafter), is nicely situated, surrounded by a large garden, close to a medium-sized Norwegian town. The institution is characterised by a homely, light atmosphere with tasteful furniture and art on the walls. The staff points at surroundings as important in order to make patients feel ‘normal’. Each patient has his/her own room. There are no locked doors except in the staff’s offices, and patients are free to leave the institution in their ‘spare’ time, as long as they tell the staff where they are going and when they will return. The staff is well educated; most of the nurses have had 1-2 years of specialisation in advanced psychiatric nursing. My impression was also that both nurses and therapists were highly motivated and engaged in the welfare of the patients.

The institution has the capacity to treat 10 patients diagnosed with schizophrenia at the one time. 36 (of 40) people gave their informed consent to participate in the field-work: 11 male patients between the age of 19-40, 4 female patients between 20-30, 10 female and 2 male nurses, 4 male and 1 female therapistsⁱⁱ, and 4 female student nurses in their twenties. All participants were white ethnic Norwegians living in the southern part of Norway.

I stayed in the institution several times a week throughout the fieldwork period, carrying out participant observation and having conversations with varying degrees of formality with all participants. I observed and systematically recorded people’s verbal and non-verbal interaction inside and outside the institution. I had access to an office where I could retire to write my field-notes regularly several times a day. I told all participants that I was taking field-notes, and in the beginning they seemed uneasy, but they told me that they got used to it after a while. I participated in all the activities of the unit, such as meetings, individual psychotherapy sessions with therapists and patients, physiotherapy sessions, and informal

social interaction, taking notes either simultaneously or immediately after the sessions. In addition to informal conversations, interviews with 9 patients, 2 ex-patients who visited the institution regularly and 11 professionals were tape-recorded, transcribed verbatim and analysed according to ethnographic methodology (Miles and Huberman 1994, Agar 1980). Some of the patients were interviewed several times. I also had access to and reviewed hospital records and had regular contact with some of the patients after they were discharged.

Having previously been a nurse working in psychiatric hospitals, I easily got access to all rooms in the institution. This was an advantage, but also a challenge, because as a fieldworker aiming at an ethnographic space, I had to distance myself as a nurse. I was treated by the nurses as 'one of them' and balanced between observation and participation. Thus my data were of a different kind than the data collected by the staff. A particularly useful space in the field was the smoking room where staff seldom came. I was impressed by how openly the patients spoke about themselves. An ethical issueⁱⁱⁱ was raised when some patients wanted to make appointments with me as if I were a staff member, although it seemed that they distinguished my role as a researcher from the role of the professional staff.

Psycho-education

The psycho-educational program (AIL) at Sunhill consisted of three courses: the first on managing symptoms, the second on social conversational skills and the third on body awareness. There were three sessions a week, each lasting about one and a half hours. The program was based on ideas of American psychiatrists (Lieberman *et al* 1985) and translated and modified by the Norwegian psychologist Gråwe (1991). The assumption was that people with psychosis have particular problems in these three areas, and that they would manage daily life in a better way if they learned about their illness through theoretical lessons and

practical exercises within these areas. Nurses were in charge of the first two courses, while a physiotherapist ran the final course.

The aim of the first course was to teach patients to detect symptoms of a relapse into psychosis and to manage 'persistent symptoms' of schizophrenia. Gråwe (1991) has compiled a workbook which patients in this unit were expected to use under nurse guidance. In the second course patients were trained to enhance their conversational skills. The body awareness course consisted of simple physical exercises and relaxation techniques.

It seemed that the 'Managing symptoms course' (MSC hereafter) was rather unpopular among several patients, but that they were more willing to attend the 'Social conversation skills course', probably because they felt they had problems in this area. Many patients complained about lack of concentration, that their thoughts just stopped, that they did not know what to talk about in an ordinary conversation. I felt the atmosphere in the Social-conversation course was less tense than in the MSC. Patients appeared to be more engaged, talking and laughing more, seemingly enjoying the funny situations that sometimes appeared during role-plays.

I will particularly focus on the MSC because it involved questions of governance and regulation to a much larger extent than the other two courses. All three courses were compulsory, but staff could decide that a patient should attend one, all, or none of the courses, depending on an assessment of the patient's condition.

In the MSC, patients were to achieve skills related to the following four areas:

- 1) To recognise warning symptoms of relapse
- 2) To manage warning symptoms
- 3) To manage persistent symptoms

4) To avoid alcohol and drugs (Gråwe1991, p.65, my translation).

Patients were thoroughly tested with multiple choice questionnaires, in which they were asked what they would do in the case of symptoms of a relapse. An example of one of the questions was:

I can reduce the danger of relapse by:

- 1) Learning to manage my disease
- 2) Ignoring my symptoms
- 3) Stopping taking medicine
- 4) Taking painkillers every day (Gråwe, 1991:65, my translation).

It is implied that some of the answers are 'right' and some are 'wrong'. The three latter alternatives are obviously 'wrong' answers.

Symptoms were divided into 'warning signs' of relapse and 'persistent symptoms' of schizophrenia. For each sign and symptom, the workbook describes examples, and patients are expected to monitor their own symptoms. 'Warning signs of relapse' were classified as deviations in sleep, appetite, mood, thought, feeling or behaviour. Examples of 'changes in thoughts and feelings' were 'being suspicious' or 'becoming excessively religious'. The 'persistent symptoms' of schizophrenia were described as 'hearing voices', 'suspiciousness towards other people' and 'depressive feelings'(Gråwe1991). Patients were given a registration and classification formula with squares to fill in every day. They were supposed to grade the strength of their signs and symptoms on a scale from strong, moderate, and weak to none. In this way patients were expected to measure and record their own feelings.

The AIL program in action and how it affects people

An extract from a session in MSC gives insight into the concrete workings of the AIL program. It is the eighth session. In the room are two patients, two nurses, and myself, sitting outside the circle as an observer, taking notes. The patients have brought their workbooks. They are going to learn about warning signs of psychosis:

Nurse, (directed to the patients): Today we're going to learn how to recognise and grade warning signs. You have to register the warning signs every day, and you begin here at day one (points at the formula in the workbook). When you've registered for one week, a pattern will emerge. If the curve is completely flat, you've perhaps had a good period. You also have to compare the curve with what you've done. This is also a registration of stressful events. The homework for the next session is to fill out the form.

Following this teaching session, a video is shown about a boy, Anders, who is worried about hearing voices and sleeping poorly. The lesson to be learnt from the video is that Anders should contact a person he knows well or a doctor to get help (which usually means increased medicine dosage). After the video session, the nurses try to establish a conversation with the patients about Anders' problems, but that proved to be difficult. The nurses asked whether the patients had similar problems as Anders', but they hardly said a word. They looked down and replied politely when spoken to. I felt the atmosphere in the room to be tense. For some of the patients, with whom I spoke later, I think the silence was an expression of avoidance, a subtle resistance by retreating.

Some of the patients in the rehabilitation unit did not have the kinds of symptoms that were expected of psychotic individuals. The course however was still compulsory. The following is an extract from a session where this is the case.

Nurse to the patient: Do you record your symptoms daily as requested?

P: No, I haven't come that far.

N: What stops you from doing so?

P: I don't have such symptoms.

N: Does Peter (*the nurse who is in charge of him*) agree?

P: Yes, he does. I don't have symptoms, and it's not my fault.

N: Yes, but it's important anyway to be observant about symptoms [...]What do you benefit most from here?

P: I'm looking for an apartment to rent.

N: It's okay that you use your energy on this. But it's important that you can recognise symptoms when you're going to live alone.

It appears as if the nurse's obligation to follow the program overshadows the patient's actual experience. When the session was over, the patient rushed out in a hurry. He was red in his face and clearly upset. A nurse said after the patients left: 'It's difficult to make the group dynamic now. Nevertheless I think they benefit from it'. Later I spoke with the patient in the smoking-room. He said that he had nothing to learn from this program. He had been living for years in his own apartment and need not learn to live alone, he said. His problem, according to himself, was drug abuse that went out of control when his girlfriend died. He explained his psychotic episodes as a result of using too much amphetamine.

Patients often interpret 'symptoms' differently from the professionals. At Sunhill, professionals and patients often disagreed about having warning signs or not. Professionals more often than patients believed that patients experienced warning signs, therefore disagreeing about the usefulness of AIL. In general the nurses considered the program as more useful and beneficial than the patients did. Below is an excerpt from an interview with one of the nurses (Anna) who was active in introducing the AIL at Sunhill several years ago.

Anna: Many of the patients had developed strange coping strategies... before they came here ...in order to learn to live with themselves. It takes time to make them unlearn and relearn new coping strategies..

[...]

T: There may be some who think they aren't so ill? Is it difficult if you...?

A: Yes, that is difficult. There are many who think they are not ill. But...usually they want to join anyway[...] Even if they don't admit that they're ill, they have a slight suspicion that something is wrong (*laughs a bit*). [...] There are very few who don't want to attend the AIL course. They want it. And it's so good. They learn a lot on that course about coping with symptoms. It's *so* useful, and *such* a good course.

Indeed, some patients thought there was 'something wrong' with them, in spite of the fact that they were sceptical to the AIL program and reluctant to label themselves as schizophrenic.

Like Danny, who told me of his 'strange ideas'

I thought that the the Leonids (*a meteor shower, my comment*) from space should come and take me away. Although it was frightening, it was a thrilling experience too. I looked at a pattern on the wall and was convinced that it was the Leonids formatting on the wall. I asked one of the nurses if she could see it too, and she said yes, she saw it. However, I did not dare to tell most people about my experiences, because they would believe I was mad. So I kept it to myself.

Such 'strange ideas' and 'wrongness' were dealt with differently. Some of the staff did not object to the patients' experiences. They even joined the 'strange ideas', particularly outside the serious atmosphere of the MSC. Moreover, it seemed that some of the nurses were attracted to the 'strangeness' and the 'wrongness'. One nurse said about a patient: 'He is *so* psychotic. It's beautiful. What that guy can see in the stars'. Thus, along with suffering, there was beauty and excitement, but this was not recognised by the AIL program. Patients are simply not supposed to enjoy their illness (Barrett, 1996). When patients did not express their psychotic experiences in an open manner, they were usually perceived as 'better'. Therefore

many patients soon learned how to hide their thoughts. One patient said to one of the therapists: 'When I look down and say nothing, you think I'm well, when I start to speak, you think I'm ill'. In the psychiatric unit and in the AIL program, patients are supposed to speak about themselves, but when speaking freely about 'strange' things, they are perceived as 'very ill'. There is a common expectation that people should reveal their inner thought when they are assigned for psychiatric treatment, but the opposite can be the case. The nurses were expected to limit 'psychotic talk' by making the patient talk about something else, or by secluding the patient in his room. Usually the staff followed this unwritten rule, presumably having been taught that patients may get worse if psychotic experiences are given attention (Leudar & Thomas, 2000). Sometimes, however, the nurses just let 'madness' flourish, joining into the 'craziness', laughing and joking together with patients. Such kind of humour seemed to ease tension for both patients and staff.

On the other side, the nurses were occupied with motivating the patients to attend to the AIL-course, while patients were occupied with different matters, such as getting money or cigarettes, which was a big issue in the smoking-room. Talks about girls was also a common theme there, as most of the clientele were young men. Indeed, I had the impression that lack of a girl-friend was one of the biggest problems. Impotence as a side-effect of psychotropic drugs was also a problem, but these issues were not raised in the AIL sessions, probably because the conversations in the sessions were restricted by the AIL workbook which did not hold such topics.

Sometimes the professionals made deviations from the AIL program. There were many events which were 'merely' social. At times I felt that I was part of a cosy, not very disciplined family, particularly during Christmas preparations when patients and nurses were engaged in

baking and making Christmas sweets. There was no AIL program for several weeks. Even some of the shy patients now voluntarily chose to participate, looking more spontaneous and less tense in these situations. Quite often the nurses and the physiotherapist made trips outside the institution with a group of patients. Such activities included seeing a movie, walking and strolling in the woods, swimming in a nearby pool, going to a cafeteria etc. In such relaxed contexts, the patients laughed, participated and seemed to enjoy themselves. The staff pointed out that patients often changed for the better when they went on trips outside the institution, and staff themselves seemed to enjoy these occasions too. Normal communication in everyday settings seemed to contribute more to patients' well-being than the AIL program. Several patients became friends during their stay at Sunhill, thus strengthening their network resources.

Transforming subjectivities through classification, normalisation and examination

One of the key objectives in the AIL program is to make patients unlearn and relearn new coping strategies, as outlined in the conversation with Anna. Such coping strategies imply that patients learn, accept and integrate the psychiatric definition of illness. Moreover, coping with life is learning about medicines in order to become medicine-compliant. Through these strategies, patients are supposed to obtain a larger degree of self-management.

A relevant question is whether these coping strategies can be associated with the disciplinary techniques described by Foucault in *Discipline and Punish* (1977) and with his later work on self-technologies (1997). The core elements in the AIL program can be understood as technologies of management and self-management, as a way of training and transforming subjects, and as 'a conduct of conduct' (Foucault 2001a, p.341). Foucault (1977, p.170-196) describes 'the means of correct training' through various disciplinary techniques. At Sunhill,

with its strong emphasis on pedagogy, patients' 'conduct is 'conducted' particularly through the techniques of classification, normalisation and examination. I think that the AIL program can be viewed in this perspective, and in the next paragraphs I will elaborate such attempts at transforming subjectivities, however afterwards pointing at the limitations of such an approach.

Classifications/observations: AIL cannot be disentangled from international psychiatric classification systems, such as DSM-IV (APA, 1995) or ICD-10 (WHO, 1994). These systems enable psychiatrists world-wide to define and diagnose symptoms of mental disease. The medical gaze is trained to scrutinize and classify. To examine, diagnose and to monitor the patient's movement from illness to normality or vice versa is part of a medical education. The classifications of symptoms in the AIL program are much the same as outlined in the illness categories described in the DSM-IV and ICD-10, where every disease is perceived as a distinct entity with its own symptoms. A successful outcome of the educational program largely depends on the patient's acceptance of such perceptions of disease.

Diagnoses have several effects. For instance, some patients in the present study said it was a relief to be able to put a name to their problems; others resisted strongly the diagnosis of schizophrenia. Besides, having a diagnosis is needed in order to gain certain advantages in the welfare system, such as sick-leave or disability pension. On the other hand, such classification systems may be understood as a part of a governmentalising enterprise, as powerful tools of configuring and surveying people. Patients are expected to adopt new strategies by learning to 'manage symptoms'. When a patient is diagnosed with schizophrenia, the professionals automatically look for and report pre-defined symptoms. Moreover, anti-psychotic medicines were almost always prescribed for patients in this study without debate. The term

'schizophrenia' triggers some automatic responses in the staff (and in patients too, as long as they accept their illness). This is perhaps an example of what Gordon calls 'techniques of power designed to observe, monitor, shape and control the behaviour of individuals' (Gordon 1991, p.3). I will argue that Foucault's notion of governmentality has even more significance today in the way standard classifications (such as the DSM and ICD) and standard programs (such as the AIL) have been elaborated in detail in order to govern people from a distance. It is to govern 'each and all' (Gordon 1991, p.3) through micro programs which the experts are taught to administer. It is to totalise and individualise, to see and control each individual as well as teaching people to monitor themselves. In such a way the health and welfare of the collective is governed by letting the expert authorities teach the marginalised people to govern themselves.

Normalisation: The idea of normality is pervasive in Norwegian society: e.g. national standards for educational programs, for social aid and for medical practice. The AIL program aims at improving the quality of life of suffering patients. However, viewed from another angle, it can also be conceived of as a normalisation program. Patients have to accept the standard psychiatric definition of mental illness, also termed 'insight into one's own illness'. Paradoxically, patients are told that in order to get well, they have to accept that they are ill. To obtain 'insight into one's own illness' is by most health professionals regarded as an important step on the way to recovery (Flyckt et al, 1999). Estroff's studies of the relation between the self-concept and explanations of suffering are relevant in this context. Her work indicates that psychiatric patients who define themselves as ill lose their sense of themselves as competent individuals and gradually come to see themselves as incompetent. She suggests that learning to be a patient is a way to chronicity (Estroff 1993). Thus the price of 'normality' could be chronicity, paradoxical as it may seem.

Examination and self-examination: Examination is a clue in Foucault's analysis of discipline. The examination, according to Foucault (1977) is a method of control that combines hierarchical observation with normative judgment. It is a prime example of power-knowledge in Foucault's terms, since it combines into a unified whole the deployment of force and the establishment of 'truth'. It both elicits the truth about those who undergo the examination, (tells what they know/should know or what the state of their health is) and controls their behaviour (by directing them to a course of treatment). Control and registration of every detail of individual behaviour was indeed the aim of the new strategies of discipline, as described by Foucault (1977).

The relationship between power-knowledge and examination is significant in the AIL program. Warning signs and persistent symptoms are predefined, and the multiple-choice exam requires the 'right' answer. In this way it is possible to control whether patients have accepted the knowledge presented to them or not. Patients' bodies or souls are minutely registered day by day. The system's efficacy is further developed when patients learn to self-examine and self-report themselves on the registration formula. Patients are supposed to monitor their own 'symptoms' every day by writing down the strength and duration of symptoms in the registration formula. If they have a 'good' period, the curve is flat. If it is not, they are expected to seek help, usually to be persuaded that they need more medicines. Thus, they are governed not only as *objects* of psychiatric disciplines but also as self-scrutinizing and self-forming *subjects*.

Resistance strategies to the AIL program

However, as I suggested, this analysis has its limitations. According to my field experiences, people are not as easily formed as the AIL presupposes. Both patients and helpers proved to be unpredictable and complex, as the many paradoxes in the data reveal.

Foucault in his later work to a larger degree acknowledged the individual's freedom and resistance. He focused on the mobility and instability of power relations, making statements such as 'there is no relationship of power without the means of escape or possible flight' (Foucault, 2001a, p.346). Relations of power and strategies of resistance are intertwined, and the freedom that is a necessary condition for relations of power is therefore the very thing that allows the possibility of resistance.

Several patients developed resistance or avoidance strategies in different ways. Sometimes they did not show up to the AIL-session without any excuse, even though it was obligatory, or they appeared mentally absent during the session, looking down, not really participating. The staff tended to interpret such withdrawal as part of the illness syndrome. However, even some of the nurses were sceptical about the courses, but they said it was part of their job to go through with the program. They pointed out that many of the patients were highly educated people, and thought that the program was a way of patronising them. One nurse said: 'It's a bit like looking down on them from above'. Another stated: 'It's a bit banal, I feel almost embarrassed to present such stuff to the patients. But, on the other hand, it's been developed by highly competent people. They say they've used the program with good results in other countries. They've done research ...but I'm a bit ambivalent'.

Patients seldom voiced their resistance against the AIL program directly in the 'public' areas, but they discussed the program when the staff was not present, for instance in the smoking

room. These patients did not necessarily disagree that mental illness existed, but they did not think the diagnosis was appropriate for them. They did not accept that the problems they had were symptoms of schizophrenia. Reluctance to accept the illness definition was called 'lack of insight' by most of the staff and was interpreted as part of the illness (see also Blackman, 2007, p.8). When I was talking with the patients alone or in the smoking room, they would tell me about all sorts of problems. The smoking room was a 'free area' in the eyes of the patients. They played 'underground' rock music, smoking cigarettes incessantly, sometimes cannabis too, I heard, which was a reason to close down what the doctor called 'an unacceptable subculture within a psychiatric institution', however against fierce protests from several patients. The smoking room was a site through which very different stories started to emerge, circulate and gain currency. Patients told me that they had problems or experiences such as being anxious, hearing voices, having difficulties in sleeping, worrying about their financial situation, being unemployed, having no girl-friend, being lonely, being abducted by UFOs at night (Terkelsen, *et al* 2005) or being controlled by neighbours through satellites in space. Such issues were not discussed during the AIL lessons. One girl spoke about her feelings of depression and despair during three suicide attempts. She had dropped out of school, because the voices inside her head were so loud that she could not hear what the teacher said. However, she did not define herself as schizophrenic. Thus, several patients simply did not integrate the knowledge presented by the psychiatric staff, which in turn tended to see resistance against the diagnosis as a symptom of the illness itself. One patient, who was quite articulate in formulating his dislike for both medication and the AIL program, said that he was being exposed to 'thought control'. 'I am 100% sure that I am not schizophrenic, I need vitamins instead of those brain medicines', he declared several times. When he was confronted with the schizophrenia diagnosis in a therapy session, he opposed the therapist fiercely by saying that 'you try to take away my thoughts, why do you do that? I

feel it's almost a violation'. Claiming his right to believe in UFOs, angels and vampires, he said 'I believe in what I believe in, no matter what you say'. The therapist commented after the session that the patient's prognosis was gloomy, because of 'his complete lack of insight into his illness, his drug abuse and his refusal to take antipsychotic medicines'.

Throwing medicines into the toilet was also a strategy used by patients. Some of the nurses felt they were being manipulated or cheated by patients who tried to spit out the tablets when the nurses were not watching them. This was usually detected by blood-tests which revealed medicine non-compliance. In these cases the therapist tried to persuade the patient to accept depot medication, an injection with effects that last for three months.

However, relations of power and resistance were not necessarily characterised by a 'staff against patients relation' and vice versa. On the contrary, patients often spoke well of both therapists and nurses, and many patients seemed to be particularly attached to 'their' therapist or nurse. I was at first surprised by this paradox: patients who revealed resistance and non-compliance at the same time seemed to have good relations with their nurse or therapist. Moreover, professionals often gave in to patients' will. Sometimes a nurse or a therapist together with a patient would create a powerful dyad against other professionals. The nurse or therapist commonly defended 'his' or 'her' patient's interests at staff meeting. At times this staff member also functioned as 'a lawyer' for a patient, towards other institutions, such as the bank, the social security office, other hospitals etc. The patients were very interested in having such a defence to promote their interests, and they might even take medicines in return. A patient said straight out: 'I don't like the pills, but I will take them for the sake of my nurse'.

Negotiating illness and health

I will argue that subjectivity should not be reduced to a question of disciplinary technologies on one side and resistance, escape or freedom on the other side. As Cohen points out (1994, p. 23) 'the self is not a monolith, it is plastic, variable and complex'. It is 'inconsistent, a chameleon, adapting to specific persons with whom it interacts and to the specific circumstances of each interaction' (p. 98).

Patients are throughout the AIL program urged to accept that they are ill. According to my field notes, they respond to this by rejecting or accepting that they are ill. A third response is ambivalence and uncertainty about being ill or not, trying to judge themselves on a scale from 'normal' to ill. Indeed, the same person may shift between rejection, acceptance and ambivalence. Thus, being a patient can be considered a practice which involves slipping between different, multiple subjectivities, negotiating between 'normality' and illness.

As I pointed out, several patients resisted the diagnosis schizophrenia. At the same time many felt that there was something 'wrong' with them. Patients heard and saw things that nobody else did, and sometimes they became confused of what was in their head, and what was 'real'. Yet, they so much wanted to be 'normal' and do the same things as 'normal' people were able to do, however not wishing to give in to the normalisation-technologies described in the AIL.

Both patients and staff made negotiations about the boundaries of normality; they asked themselves whether certain thoughts, behaviour or feelings would match the criteria of being ill or not. The following is an example of such negotiations. Billy, a 19 year old boy and I, are sitting in Billy's bedroom, talking about his problems hearing male, angry voices mocking him. 'They all the time tell me I'm stupid, gay and worth nothing' he says. His therapist has recently told him that he is suffering from schizophrenia. Billy puts an information-booklet

about schizophrenia in front of me on the table, drawing a line on the sheet, dividing it into two pieces, about $\frac{1}{4}$ and $\frac{3}{4}$, saying: 'I'm perhaps that much ill (pointing at the smallest part), but the rest of me is healthy. So, I'm only one fourth ill'. He tells me that he is relieved to learn what is wrong with him. Finally there is an explanation to his suffering and a label on his condition. Later however, he complains that the diagnosis did not solve anything, he still feels miserable. In the smoking room he said to me: 'I'm afraid that I'm never going to be normal, that I will not be able to work or do other normal things'.

After a while the therapists and nurses become bewildered regarding what kind of illness Billy is suffering from. In a staff meeting the nurse Lisa says 'Billy doesn't have the look of a schizophrenic. I think his voices are more thoughts in his head than real voices' The therapist agrees and says that Billy is not able to be psychotic more than half an hour when he is given no attention. 'That's not schizophrenia', he claims. He writes in the medical record that: 'It seems that Billy is manipulating himself in and out of a psychotic condition'. The antipsychotic medication (Zyprexa) is terminated, and the nurses are told not to focus on his 'symptoms' anymore, because it may worsen his condition. Besides, Billy is not to attend the MSC, because it is assumed that he does not have those symptoms. His condition does not fit into the program anymore. According to the therapist's written record, there were no 'psychotic breakthroughs' reported after this change of treatment strategy. Consequently, the problem 'auditory hallucinations' was deleted from the treatment plan. One month later, however, the problem returned, formulated as 'inexpedient ways of coping with voices'. In the meantime, the therapist tries to find the right diagnosis for Billy. He does not resume the schizophrenia diagnosis, but decides on post-traumatic stress syndrome (PST). Billy tells me that he is relieved to get a diagnosis which he perceives as less serious than schizophrenia. Nevertheless the nurses report in the record that 'he is worried that he might not be a normal

boy'. After a while, the PST diagnosis is abandoned too. The therapist writes that Billy does not match the criteria of PST because 'he lacks an extreme stressful situation'. Instead, he writes that Billy 'satisfies the criteria of adjustment disorders, code F43.2' (in the ICD-10, my comment), due to the fact that 'extended psychological stress and poor coping abilities may have provoked a similar illness'.

This story is an example of the ambiguity of illness categories and the unclear boundaries of normality. Billy's illness was negotiated from 'schizophrenia' to PST, to the less stigmatizing 'adjustment disorder'. It seems that the ICD- classification system find spaces for conditions that do not fit traditional illness categories. Billy was indeed relieved; he could maintain his self-concept as a normal boy, and in his own eyes he was now only a badly adjusted person due to stress, which might be the fate of many 'normal' people. Moreover, the professionals told him that his voices more likely could be unpleasant thoughts than real voices. Billy found this reassuring; he more easily could look at himself as 'normal' ^{iv}. In this way one of the main symptoms of schizophrenia, 'auditory hallucinations' were transformed to 'thoughts'. The story is also an example not only of resistance to diagnostic categories but also of how the validity of the categories themselves is to some extent accomplished through successful attempts by professionals to apply them and by the acceptance of Billy (i.e. of the situated construction of schizophrenia itself). It shows the complexities of power relations and how power can be reproduced at the micro-level of individual diagnoses.

Hearing voices was sometimes a subject in the smoking room. It did not happen very often, because it seemed to be a very private matter. Billy however, spoke openly about his voices in

the smoking room. He was comforted to hear that several of the other patients heard voices too. He thought he was the only one. One of the ‘veterans’, who had heard voices for years, gave Billy advice how to cope with them: ‘Don’t let them bother you, they won’t hurt you. Just yell back and tell them to shut up. Probably they won’t go away, but after a while you don’t care about them anymore.’ Billy told me afterwards that this conversation had been of great help, mostly because he learned that hearing voices was common among the other patients too. Thus, ‘hearing voices’ in the smoking room is different from ‘hearing voices’ in the treatment plan or in the staff’s meeting room.

Lisa Blackman’s research on the Hearing Voices Network (HVN) is interesting in this context (Blackman, 2001, 2007). This network, initiated by the works of Romme and Escher (1993) encourages people to become friends with the voices, to enter into a dialogue with them, and to use the positive voices to deal with the unwanted voices instead of denying the voices. Blackman describes a technology and a workbook developed by and for voice-hearers, i.e. how to cope with voices, how to use them as a resource and how to incorporate them instead of working against them. This is a different frame of reference than the approach described in the case of Billy where professionals interpret voices as symptoms of psychopathology. HVN seems to offer a kind of agency which allows voice-hearers to actively take part in the shaping and reshaping of voices. I assume that such a network may contribute to reframe voice-hearing from a symptom of schizophrenia to a ‘normal’ activity.

According to my field experiences it seemed that at least two kinds of subjectivities co-exist side by side within the same subject. One was the resistant subject, rejecting the pathologisation of the AIL program, refusing to integrate a chronic ill identity. The other subjectivity was aspiring for a ‘normal’ identity, ‘being normal, doing what normal people

do'. Billy was relieved when he could define himself on the 'right' side of normality. Several of the other patients in my study had the same aspirations as Billy. Such a duality is described in Luhrmann's portrait of homeless women in Chicago. They live within two codes, she writes: 'One code is appropriate to the middle-class world to which they aspire, the other one enables them to survive on the street' [...] 'The subjectivity they share is the challenge of negotiating two competing and contradictory sets of display rules' (Luhrmann, 2006, p.347).

The question at hand is how patients suffering from severe mental health difficulties are negotiating competing display rules. They live in two different worlds, in which one is a shared 'normal' world; a world comprised of 'normal talk' display rules, which they try to comply with. The other world is their 'psychotic' world which they often try to keep secret, hiding their experiences of UFOs, Leonids, voice-hearing etc. The suffering, according to my field experiences, lies in the struggle of constantly negotiating between the demands of these two worlds. It is a lonely quest. I therefore do believe that more attention should be given to the struggle of living in two worlds/realities, creating a space for both patients and professionals to explore such experiences in depth. The Hearing Voices Network I believe is an example of the creation of such a space.

Movements of resistance

There are and have been other networks and movements too that challenge mainstream psychiatry. Just to mention a few: The anti-psychiatric movement in the nineteen-sixties (Laing, 1967, Cooper, 1967), the Soteria project (Mosher 1999) and the contemporary Mad Pride (2008) and Mind Freedom International (2009). The latter is an international coalition of more than hundred grassroots groups. According to Wikipedia (2008), Mind Freedom has been recognized by the United Nations Economic and Social Council as a human rights non-

governmental organisation with a consultative status to the UN. Thus, Mind Freedom International has gained considerable formal influence.

Nick Crossley gives an historic account of how such movements have evolved, and how patients, or survivors as they prefer to call themselves, have developed strategies to resist psychiatric domination by making efforts to present themselves as ‘not being mentally ill’ (Crossley, 2004, p. 161). A ‘survivor’ creates other mental images than a ‘victim’. A survivor is not a person who is weak, helpless and dependent, but a strong and potent person who has had the nerve and strength to ‘survive’ the stressors of modern psychiatry. According to these movements (for instance ‘Mad Pride’) one needs courage to survive both chemo-therapy, ECT and the stigma associated by being labelled ‘schizophrenic’. In this way the survivors have transformed their negative experience from weakness to strength, to something they can be proud of, something worthy the admiration of others. Moreover, they reclaimed the stigmatizing word ‘mad’ into their own vocabulary as ‘mad pride’. By this, they reconfigure the very content of ‘madness’ by situating it into another context, for their own benefit, just like for example the gay-movement has done before them (Crossley, 2004, pp.61-180). Some of these movements have transformed themselves from representing an underprivileged class without a voice to become a voice of power (at least to a certain degree) among politicians and health – planners, as well as in the media and in organisations such as the UN.

Conclusion:

Psychiatric knowledge with its predefined concepts of illness has become so powerful that not only professionals but also patients tend to become its defenders. Concepts like ‘thought disorders’ and ‘delusions’ are taken for granted in a biomedical psychiatric power-knowledge

framework. Patients are expected to subdue their perceptions of reality in order to accept and integrate medical knowledge and understanding, where medicine-compliance is a crucial part of the education. The AIL program, the ICD-10 classifications of mental illness (WHO, 1992), and the expert knowledge that such technologies represent, are entangled parts of a large system of governmental technologies, institutions and procedures, not only located at Sunhill or in Norway, but globally spread. Thus, psycho-educational programs can be viewed as a part of a larger social enterprise or governmentality. Foucault's descriptions of discipline and normalisation through training and examinations have proved to be relevant in this context.

One conclusion is therefore that modern psychiatry succeeds in recruiting self-forming subjectivities that master and monitor themselves - but only partly. Many patients who seek help to find out what is wrong with them, do not/will not integrate the explanation offered to them by the psychiatric profession. Even professionals are bewildered about what is wrong, and sometimes they even doubt their own explanations. Often the patients' stories about hearing voices, being abducted by UFO's etc are not listened to in depth and interpreted on the premises of the patient, partly because doctors are trained to concentrate on the 'right' diagnosis and the 'right' medicine, including monitoring the effects of medicines.

Although subjectivity and experience are both regulated by power relations, they have the potential to exceed and subvert them. According to Dean (2007, p.9), 'Power is [...] more like a duel than a total system of subordination.' AIL as a technology of self-production or responsabilisation shows that subjectivities cannot be read off directly from an analysis of the techniques themselves, because people often act in a different manner than what they are expected to do. Thus more research should be done in this area of the mental health field, i.e. to study how people accept or reject biomedical power-knowledge and how power-relations

are enacted in everyday settings. Power creates resistance (and avoidance) on an individual level, as revealed in my empirical material, but also on a larger scale, as shown by the formation of various movements initiated by patients, ex-patients and professionals, who in one way or the other have negative experiences with mainstream psychiatry. Stories about such experiences are for example to be found under 'Personal Stories' on the Mind Freedom web-site (2008).

It seems that some user- groups contribute to another kind of self-conception in patients/ex-patients/survivors, because the very notion of illness is contested. These groups are based on different kinds of self- technologies than the ones described in the AIL-program. Although these movements also have developed programs, they are different, because they are grounded in people's own experiences and conceptions.

In spite of enactments of resistance which I have described in this paper, many patients feel that something is wrong with them, even though they do not accept the illness-definition presented to them by psychiatric professionals. They try to find out what is going on with them, why they see and hear things that others do not perceive. They want to be 'normal' in the eyes of themselves and others. However, the AIL's normalisation-, self-observation- and self-examination- techniques, designed to normalise and 'conduct people's conduct' (Foucault,2001a, p. 341), are of a different kind than the normalisation technologies developed in the context of the consumer/ex-patient/survivor movements. The difference lies in the deconstruction of illness itself. In the survivors' eyes, their experiences are perhaps unusual, but they are not signs of illness, and can be dealt with as normal human expressions of stressful events. Moreover, being 'unusual', can be transformed to something positive, for example being unique and creative (see the Mad Pride 2008 website). In this way, the reshaping of one's self- concept seems to be at the very core of such movements.

I do not claim that joining user movements is a suitable solution for everyone, or that serious mental health problems do not exist. What I ask for however, is less emphasis on psychiatric diagnoses, medicine compliance and 'insight into own illness', less emphasis on standard programs designed by professional health experts, more political and economical support to user-movements, more freedom for patients and professionals to explore the multiplicity of subjectivities in an open manner, and finally, a different epistemology based on categories more in line with how patients/users describe their experiences, which again would imply radical changes in professionals' education and training.

Notes:

i All names are pseudonyms.

ii I did not ask the explicit ages of the professionals, but they were between 30 and 60, with the majority between 35 and 45.

iii The research project has been reviewed and accepted by the Norwegian Committee of Medical Ethics.

iv Shortly afterwards, Billy was discharged. Six months later he phoned me. He was now admitted in an acute unit in another town. He was really sad, he told me, because he had got back his first diagnosis schizophrenia by the new therapists.

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