

MADNESS AS MENTAL ILLNESS OR MENTAL ILLNESS AS  
MADNESS: MENTAL ILLNESS AS CONSTRUCTED BY YOUNG  
PROFESSIONALS

by

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*Dedicated to my husband, Henrico Morkel.*

*Your wisdom has been an inspiration.*

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## Abstract

The aim of the study was to explore the constructions and meanings around madness/mental illness among a group of young professionals in order to broaden the dialogue around mental illness to include the voices of a certain section of the community. The current dialogue around mental illness is dominated by the view that madness/mental illness is the domain of scientifically trained professionals. The aim of the study was to explore the constructions of those not part of a mental health profession and those not suffering from mental illness and how these constructions may influence their behaviour towards those suffering from mental illness.

The epistemological framework of the study falls into a social constructionist perspective. This epistemological approach allows for the exploration of previously taken for granted truths. When adhering to this approach the function of research is to explore a particular version of reality in an embedded context and language seen as the structuring aspect of social reality. From this approach a discourse analysis was done using the transcripts of audiotaped interviews with the participants. The four participants chosen for the study fell into the 23-26 years age group brackets, had finished tertiary education and have started working on a professional career. None of the participants have had any formal contact with mental health services or professionals or those suffering from mental illness.

In the process of analysing the texts five discourses were identified and discussed. The first of these discourses was the scientific discourse around mental illness in which madness is constructed mostly as an illness with genetic, chemical or emotional causes. The knowledge and expertise of mental health professionals is seen as important to the general public as they seem to have little knowledge on the meaning of mental illness themselves. The second discourse that was identified was mental illness as the domain of professionals

and mental institutions. Most of the respondents seemed comfortable with this idea and used distancing strategies in order to explain their non-involvement in the care of the mentally ill. Mental illness as individual experience was discussed next and in this discourse mental illness was seen as an exclusive experience to which few except the sufferer has access. The fourth discourse discussed was the mental illness as unknown discourse. In this discourse madness/mental illness, those suffering from it and the treatment thereof, is a mystery to those who are not part of these experiences. The final discourse discussed was the mental illness as bad discourse where those suffering from mental illness were constructed as dangerous, possibly violent, unpredictable and damaging.

During the analysis of the data it was found that the majority of the respondents used techniques to distance themselves from involvement of the mentally ill and ascribed to the discourse that madness/mental illness is the domain of mental health professionals only.

### **Key terms**

Madness; mental illness; modernism; social constructionism; qualitative research discourse;

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## Chapter One

# Introduction

*A tree that can fill the span*

*Of a man's arms*

*Grows from a downy tip;*

*A terrace nine stories high*

*Rises from hodfuls of earth;*

*A journey of a thousand miles*

*Starts from beneath one's feet.*

*LAO-TZU*

## 1.1 Introduction

Madness has intrigued mankind for centuries. One can argue that the question of what madness is has accompanied man since the beginning of time.

Over the course of the centuries the meanings around mental illness have shifted many times according to the societal beliefs and political atmosphere of the day (Foucault, 1974). The way madness is defined has far-reaching effects on those who have a mental disorder, and determines how they are treated by professionals responsible for their care and the society of which they are a part. Part of the present discourse around mental illness in society today is that it is the domain of mental health practitioners such as psychologists and psychiatrists (Mills, 2003). This is the context in which I find myself.

In the course of my tertiary education I have come to be part of the discourse around madness/mental illness from the perspective of clinical psychology. Some of the ways in which this discourse shapes my perception begins, for example, in my use of certain words to describe behaviour outside of the social norm. As I work in a psychiatric institution I describe my charges as patients suffering from a mental illness. The rehabilitation of these patients is the responsibility of a multidisciplinary team of which I am a part, and includes a social worker, psychiatrist and occupational therapist.

I do not view my patients as dangerous or scary or inherently defective. In general, I believe that mental illness can 'happen' to anyone; most importantly, this helps me maintain my view of my patients as human beings that, for some reason or another, have difficulty in living within the society of which they are a part. My view of what it is to be mentally ill has been shaped by people such as C.G. Jung, Sigmund Freud, existential phenomenological psychology, systems theories and postmodern, social constructionist ideas. But this does not mean that those who are not part of this context do not have constructed meanings around what it entails to be mentally ill. What are these meanings and what are

the processes by which they are constructed? How does this influence these people's attitude toward the mentally ill? What are their constructions around the work that psychologists do? In my various discussions with young adults not in the field of psychology, I have become aware of stigmatising views, indifferent attitudes and curiosity toward what it means to be mentally ill. The question then becomes: what is the view of these young people; and how does it affect their behaviour towards the mentally ill?

## **1.2 Aim of the Research**

The majority of studies on the meanings of madness have focused on the patients' own constructions of their experiences and those of the clinicians who treat them (Corrigan & Watson, 2002; Gingerich, 1998; Holmes & River, 1998; Littlewood, 2001). However, little attention has been given to the constructions of the society to which the patients and clinicians belong.

The aim of the present study was to explore the constructions of madness/mental illness among young professionals. I aimed to gain a deeper understanding of their constructions and meanings of madness/mental illness through their own words. This study formed part of a larger ongoing dialogue around mental illness, and aimed to illustrate the complexity of experience and meaning related to mental illness. It aimed to amplify the current view of mental illness as being the terrain of mental health practitioners only. This was done by broadening the field of enquiry to include a diversity of voices on this topic in order to explore the understandings of the community of what it means to be mentally ill. The study took the form of a discourse analysis of transcribed interviews with young professionals between the ages of 23 to 26.

### 1.3 Motivation for the Research

The identity of the researcher becomes relevant in discourse analytic research in a number of ways. Most importantly it influences the choice of the research topic or research area (Wetherell, Taylor & Yates, 2001). The researcher is likely to choose a topic which ties in with personal interests, sympathies and political beliefs. The researcher's special interests and personal links to the topic are not in themselves a sufficient basis for research, but they are a probable starting point for the project.

I am currently completing my internship at a psychiatric hospital in Pretoria. In many ways it has been a difficult experience for me. I have become aware of the profound suffering of the patients with whom I work. Many struggle with accepting a psychiatric diagnosis and with finding meaning in their lives. For me it was interesting to see how large a part their being diagnosed with a mental illness played in their difficulties. The patients often experienced the diagnosis as a derogatory label, and felt that it describes them as being inherently defective even though they experience themselves mostly as being the same as everyone else, or as having special attributes. Many of my patients ascribe different meanings to their condition: for example, they might see themselves as being the chosen prophet of God, being more sensitive than others, or as having a greater capacity to feel and understand life and its complexities. I began to explore what my personal views were on being mentally ill and realised that I have many ambivalent feelings about describing people as mentally ill. In most of the lives of my patients there has been some very real neglect and difficult circumstances, and I feel it is no wonder that they experience psychological distress. Defining these people as ill feels to me to be a very narrow description of their experiences. I also began to wonder how people outside the mental illness discourse see madness. How do they understand it for themselves if I, who am part of the discourse, already have conflicting ideas around it? This sparked my interest in researching the meanings surrounding mental illness.

A second important factor in considering this research topic was the reaction to patients of society outside the hospital. In conversations with various individuals I have become aware that the meanings they attach to mental illness differ considerably from my own. Often, these meanings do not engender empathy and compassion; rather it may provoke fear and avoidance.

In her budget speech on 17 June 2004, the deputy Minister of Health, Nozizwe Madlala-Routledge, spoke about the movement introduced by the passing of the Mental Health Care Act to integrate the care of mentally ill patients into the community setting (Madlala-Routledge, 2004). Addressing parliament, she stated that:

There will be an increasing demand on our clinics and hospitals to provide treatment and on NGO's to expand services. There has been progress in developing community capacity to care for mentally ill people... (Madlala-Routledge, 2004, para. 5).

If the integration of the mentally ill into the community is an objective for the South African Department of Health, then surely the community's view on what it means to be mentally ill, and how this view influences their behaviour towards the mentally ill, is of great importance.

#### **1.4 Theoretical Framework**

The guiding epistemology of this study falls within the postmodern, social constructionist framework. The assumptions adhered to in this type of study are very different from the assumptions of modernist research (Wetherell, Taylor & Yates, 2001), in that the goal is not to formulate objective descriptions of static and measurable reality; instead, it is a subjective, qualitative description of constantly changing realities and truths (Hanson, 1995). Thus the focal point is the myriad of possible meanings of madness/mental illness.

## 1.5 Process of Enquiry

A qualitative research design was selected because qualitative research tends to be concerned with meaning (Willig, 2001), and thus lends itself particularly well to the study of the meanings on mental illness.

Because in-depth, semi-structured, open-ended interviews offer greater freedom and fewer restrictions for the participants, this method was selected as the means for gathering data (Meese, 2005). Although the questions in the interviews are similar, the interviews were driven by the responses and information that the participants presented.

Using Parker's (1992) seven stage guidelines as a basis, a discourse analysis was conducted to give a textured view of the different meanings on mental illness. According to Burr (1995, p.48),

a discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events. It refers to a particular picture of an event (or person or class of persons), a particular way of presenting it or them in a certain light.

In order to understand the current dialogue on mental illness, it is important to look at some of the meanings around it.

## 1.6 Discourse Analysis

The findings of the discourse analysis were discussed according to five central discourses. These discourses were: the scientific discourse of mental illness, mental illness as the domain of professionals and mental institutions, mental illness as individual experience, mental illness as unknown and mental illness as bad. The findings were integrated with the relevant literature as discussed in the literature review. Throughout the process I reflected on my part in shaping certain

conversations, my influence in the analysis of data and my reflections on the literature on the meanings of madness/mental illness.

## 1.7 Terminology

A variety of terms were used to denote mental health problems in this study, including *mental illness*, *mental disorder* and *madness*. This reflects the diversity of interpretation of this phenomenon. No single term is privileged over another because all are equally meaningful (or meaningless), depending on the experience and perceptions of the individuals (Casey & Long, 2003). However, in discussing the results, the power of the term 'mental illness' to categorise and refer to a wide range of abnormal behaviours made it convenient to lean heavily on the term. As such, this term may occur more frequently throughout the text. It may also reflect my position within the "madness as mental illness" discourse and the way that my understandings of madness are shaped by it.

## 1.8 Conclusion

In summary, this study aimed to explore the diversity of the meanings surrounding mental illness in young professionals between the ages of 23 and 26. The social constructionist epistemology acknowledges that social realities are constructed through the language we use, and therefore a discourse analysis on the family of words used by the participants to describe mental illness was considered appropriate to highlight the lived reality of the society of which those with mental health problems are a part.

## Chapter two

# Literature Review: The differing meanings of mental health problems

*What's madness but nobility of soul  
At odds with circumstances*

*Roethke*



## 2.1 Introduction

Questions of how to define and treat what is now called mental illness have troubled civilizations throughout history. Public fascination with madness has shaped a broad spectrum of historical and contemporary popular culture, from Shakespeare's plays to television talk shows and supermarket tabloids (Connor-Greene, 2006). One can argue that these questions are as old as humanity itself, but the meanings surrounding what it entails to be 'mad' have changed over time. What were those meanings then, and what are they now? What do they mean for those then that do not behave according to the social norm?

A recent pamphlet published by the National Alliance for the Mentally Ill (NAMI) (cited in Fee, 2000, p.1) asserts on its first page that "mental illnesses are disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. Just as diabetes is a disorder of the pancreas, mental illnesses are brain disorders... [They] are not the result of personal weakness, lack of character, or poor upbringing." This pamphlet seems to assume that the only way to view mental illness is that it is a purely medical condition situated in the individual (Fee, 2000). This represents a radical view of the madness as mental illness discourse. According to Fee (2000), "our modern understanding of mental disorder, an Enlightenment product, was created through the understanding that disorders were 'alien' – external and irrational maladies to be fathomed and hopefully rectified by the scientific expert, imbued with mysterious powers of moral adjudication" (p. 3). But madness was not always seen as a mental illness/disorder. There have been many times throughout history that it was understood and treated in different ways.

## 2.2 Historical Definitions of Madness and its Cures

In his work *Madness and Civilization* (1974), Foucault asserted that madness should not be considered a stable condition, but that it should rather be seen as

the result of social contradictions in which humans are historically alienated. According to Mills (2003), Foucault is one of the leading theorists that trace the way that madness has been constructed and judged throughout history. In this seminal work Foucault shows that in the Classical period, rather than being classified as a mental illness as we do now, madness was seen as a manifestation of animality (Foucault, 1974; Mills, 2003). As he states

Madness borrowed its face from the mask of the beast. Those chained to the walls were no longer men whose minds had wandered, but beasts preyed upon by a natural frenzy: as if madness, at its extreme point, freed from that moral unreason in which its most attenuated forms are enclosed, managed to rejoin, by a paroxysm of strength, the immediate violence of animality. (Foucault, 1974, p. 74)

In the age of Enlightenment when logic or reason was seen as man's crowning achievement and the characteristic that differentiates man from beast, madness was seen as the loss of reason, or as Foucault describes it, unreason (Foucault, 1974). Madness eradicated that which was human in man, and those afflicted by madness therefore became bestial. This had a profound impact on how the mad were treated at that time. If madness is seen as a manifestation of animality, then the only way to curb its passion is discipline and brutal methods (Foucault, 1974; Mills, 2003). As such, confinement of the insane became a practice to protect humanity from what is bestial. In describing the practices of that time Foucault states that: "This model of animality prevailed in asylums and gave them their cagelike aspect, their look of a menagerie" (1974, p. 72). People were chained to the walls or kept in cells with bars and straw to cover the floor (Foucault, 1974).

Foucault also explores the strange treatments of madness which developed in the eighteenth century, when the meanings of madness evolved yet again and were seen as caused by an imbalance in the humours. Patients were given blood transfusions, were shocked by sudden immersions in cold water, and were forced to ingest bitters (Foucault, 1974; Mills, 2003).

Many of the treatments that were thought to be innovative and promising seem almost cruel by our modern day standards. Treatments that today seem unfounded, ineffective or even dangerous developed from the dominant definition of madness/mental illness within a particular historical period (Connor-Greene, 2006). In 1916, a time when bacteriological theories of disease gained scientific and popular support, a prominent physician, Dr. Henry Cotton, hypothesised a focal infection theory of schizophrenia (Connor-Greene, 2006). In an attempt to remove the site of the infection he resorted to extracting the teeth of patients. He was so convinced of the validity of his theory that when this did not cure these individuals, he removed various internal organs, including the stomach, liver and uterus.

In *Madness and Civilisation* (1974), Foucault examines the way that institutional change, such as the availability of houses of confinement, contributed to the development of a distinction between madness and sanity, and does not assume that the distinction between madness and sanity is self-evident. Foucault shows how the institutionalisation of the insane developed from the twelfth century practice of confining people with leprosy (Foucault, 1974). Leper houses were built in order to protect the population from the spread of this highly infectious disease. Largely due to the removal of infectious people from general society through confinement and the end of the Crusade that brought people into contact with infectious agents from the East, leprosy had largely disappeared from Europe by the end of the sixteenth century (Foucault, 1974; Mills, 2003). By the end of the seventeenth century houses that were built for the confinement of lepers were largely taken over to be used as asylums for the 'socially useless'. For example, those who could not and would not work were placed in these houses along with the poor and those who had disgraced their families (Foucault, 1974; Mills, 2003). Foucault (1974, p. 62) states:

But in the history of unreason, it marked a decisive event: the moment when madness was perceived on the social horizon of poverty, of

incapacity for work, of inability to integrate with the group; the moment when madness began to rank among the problems of the city.

The confinement of this very diverse group of people was not enacted on grounds of medical incapacity or with the aim of curing the confined. In the nineteenth century these houses began to be used solely for confining those who were considered insane (Foucault, 1974; Mills, 2003).

With the shift towards defining madness as a mental illness, behaviour such as hearing voices, speaking in tongues or hallucinations that would in another period in history have been seen as possessions by spirits or God became something that needed to be treated by confinement and the administration of drugs (Mills, 2003). Foucault (1974) refers to this in his statement that

In the Middle Ages and until the Renaissance, man's dispute with madness was a dramatic debate in which he confronted the secret powers of the world; the experience of madness was clouded by images of the Fall and the Will of God, of the Beast and the Metamorphosis, and of all the marvellous secrets of knowledge. In our era, the experience of madness remains silent in the composure which, knowing too much about madness, forgets it. (p. *xiv*)

In medieval Europe madness was conceptualised around the central concepts of demonic possession and witchcraft (Castillo, 1998). The Christian church defined society's view of nature. Therefore, life in the world was defined as a constant struggle between the forces of God and Satan. The mad were seen as either possessed or the victims of witchcraft, and therefore the 'cure' of the 'mad' was the responsibility of the church through religious rituals and purification (Castillo, 1998). The preferred method of treatment for demonic possession was exorcism (Nevid, Rathus & Greene, 2000). Exorcism was used to try and persuade evil spirits that the bodies of their victims were basically uninhabitable. Methods included prayer, waving a cross at the victim, beating, flogging and even starving the victim. If undesirable behaviour persisted then even more powerful remedies

like the rack (a torture device) was employed (Nevid et al., 2000). During the late fifteenth through the late seventeenth century the dominant explanation of abnormal behaviour was witchcraft in which the person entered into a pact with the devil and hence could perform impressive feats such as flying and having sexual intercourse with the devil (Nevid et al., 2000). It was believed that witches committed terrible acts such as poisoning crops and eating babies; and in 1484, Pope Innocent VIII decreed that all witches be executed. Certain tests were devised to find out if someone was involved in witchcraft. One was the water-float test, which was based on the principle that pure metals settle to the bottom of smelting and impurities bob on the surface. Suspects of witchcraft were thrown into a river bound hand to foot. If they sank and drowned they were cleared of all suspicions. If they managed to keep their heads above water they were executed for witchcraft mostly through burning (Nevid et al., 2000).

### **2.3 Madness as Mental Illness**

During the first half of the eighteenth century, a strong psychosocial approach to madness called *moral therapy* (Taubes, 1998) became influential. Its basic assumptions included treating institutionalised patients as normally as possible in a setting that encouraged and reinforced normal social interaction. Moral therapy as a system originated with Philippe Pinel (1745-1826) (Barlow & Durand, 2002). Asylums had appeared in the sixteenth century, but they were more like prisons than hospitals. It was the rise of moral therapy in Europe and the United States that made institutions more liveable and even therapeutic (Barlow & Durand, 2002).

Although it is difficult to pinpoint the exact development of the biological explanation of madness, the biological tradition developed rapidly in the nineteenth century after the discovery of the nature and cause of syphilis (Barlow & Durand, 2002). Behavioural and cognitive symptoms of advanced syphilis include delusions of persecution, delusions of grandeur and other bizarre

behaviours. Although these behaviours appeared to be the same as psychosis, a subgroup of these patients seemed to deteriorate and become paralysed and die within five years of onset. This contrasted with most psychotic patients who remained fairly stable. Louis Pasteur's 1870 germ theory of disease enabled the identification of the specific bacterial micro-organism that caused syphilis (Barlow & Durand, 2002). Ultimately it was found that penicillin cures syphilis or *general paresis* as it was called. Many mental health professionals then assumed that similar causes might be discovered for all abnormal behaviours and came to believe that physical causes were always the reason for abnormal behaviour. This led to the development of many new treatments. By the end of the 1800s a scientific approach to madness and its classification had begun with the search for biological causes (Barlow & Durand, 2002). According to Tone (2005), after World War II, psychiatrists applied the rhetoric and findings of neuroscience to explain mental illness. The suggestion that mental illness had neurobiological origins destigmatised mental illness to a large extent, for it defined it in the same way as other diseases such as cancer; and as such, mental illness was deserving of dignity and medical attention. However, not everyone has such a positive view of these developments.

In an interview with Miller (1983), Szasz states that the distinction of madness as a mental illness developed after the Enlightenment period, in about the 1850s, with the development of medical microscopy. It was then that the idea of disease as tissue damage or bodily illness developed. It was during this same period, when the concept of disease changed from humoral to cellular, that the idea of insanity changed from madness to mental illness (Miller, 1983). Szasz argues that this change is linked to the operational approach to mental illness: psychiatry. According to him, the patient is a creation of the psychiatrist, much as the heretic is a creation of the theologian; and the two concepts grew together. Szasz (in Miller, 1983) argues that madness is misrepresented as a disease and that the myth of mental illness has given the medical profession dangerously

unlimited license to imprison and manipulate mad people in the name of philanthropy.

The classification of madness as a disease represents, according to Szasz, a tragic error in philosophical judgement. Echoing Foucault, he states that in the eighteenth century the dominant part of society was confronted with a class of people who did not fit in. Those who did not fit into society were alienated. But society at that time could not morally lock up people who did not fit in and were not criminals of sort who deserved to be locked up. The only way to remove them from society was by classifying them as 'sick' and then hospitalising them. He believes that the hospitalisation of the mentally ill is a form of social control with two effects. One is to remove the unpleasant elements from society, and the other is to protect the people themselves, who are often so alienated that they are homeless and unwanted by relatives. According to Foucault (1995), there is not a single culture in the world where everything is permitted. He argues that humanity does not start from freedom but from limitation and the line not to be crossed.

Szasz believes that all psychiatric approaches are fundamentally flawed because they look for solutions along medical-technical lines. But what are the solutions for? According to Szasz (quoted in Miller, 1983, p.30): "For Life! But life is not a problem to be solved. Life is something to be lived, as intelligently, as competently, as well as we can, day in and day out. Life is something we must endure. There is no solution for it."

Psychiatrists such as R.D. Laing (1965) have argued that mental illness represents an eloquent protest on the part of the patient, and that psychosis, for instance, enables the individual to escape from the intolerable psychological pressures exerted by tyrannical families and uncaring societies. Laing insists that the physical treatment of these illnesses is an elaborate way of evading the political issues involved, and that therapeutic regimes in modern hospitals

express the ideals of a society eager to see its members behave in a conveniently decorous and economically productive manner. Laing (1965) also states that the clinical psychiatric approach to mental illness is too narrow as it only looks at certain aspects of the experience of mental illness. Laing (1965) is of the opinion that the vocabulary used by clinical psychiatry is too reductionist in nature:

Technical vocabulary either refers to man in isolation from the other and the world, that is, as an entity not essentially 'in relation to' the other and in a world, or they refer to falsely substantialized aspects of this isolated entity. (Laing, 1965, p. 17)

This critique of the language used by psychiatry to categorise persons with a mental illness is echoed in more recent writings from the social constructionist worldview.

## **2.4 Diagnosing Mental Illness**

In an article by Mirowski and Ross (1989), the authors focus on how the linguistic legacy of the eighteenth century development of biology and epidemiology has influenced the development of psychiatric definitions and explanations of mental illness. According to the authors,

Superimposing a diagnosis on a person's symptoms and situation does not add information; rather, it removes information. Worse still, it entices us to think, talk, and act as if a hidden entity has been revealed. The mythical entity insinuates itself into the role of a named actor, and the symptoms and situation dissolve into mere signs of its presence.

(Mirowski & Ross, 1989, p. 12)

These 'hidden entities' that the authors refer to are the presupposed biological basis for mental illness. Although studies have not conclusively indicated biological causes for mental illness, the model of the language used to conceptualise it presupposes such a basis, and therefore justifies the use of biochemical treatment (Mirowski & Ross, 1989).



These authors also reflect on the socially constructed need for a diagnostic system. Government agencies and insurance companies want to know exactly where the boundaries for reimbursement are drawn. Psychiatrists and other physicians want to sell their services. The pharmaceutical industry wants to sell its drugs. Government and the insurance industry want to know what it is all going to cost. Insurance companies will only pay for specific cases of mental illness. In this way society has constructed the need for a classification system (Mirowski & Ross, 1989).

In terms of diagnosis and the biological approach to mental illness, an observation by Derrol Palmer (2000) represents an intriguing paradox in medical psychiatry. He states that symptoms or 'disorderly conduct' are identified on a social rather than a biological basis. The importance of biological knowledge in diagnosis is undermined by the fact that symptoms could be identified long before the biological origins of the condition were known. Rosen (1968) reports cases of hallucinations and delusions in ancient Greece that were treated as such. Palmer asserts that how a symptom is identified and what causes it are separate issues. The judgment of 'pathology' involves ascribing meaning to a person's actions and how they make sense in a particular social setting. So some actions acquire symptomatic significance not because they contravene the laws of biological functioning but because they infringe on the social order. Palmer further states that the social constructionist worldview reconceptualises delusions as the product of a power relationship where the views of the less powerful patient are pathologised (Palmer, 2000).

Not everyone has this negative view of the use of psychiatric language in order to define madness/mental illness. Gough (1971) states that the goal of diagnosis is not to label or stigmatise those with a mental illness, although it may be an unfortunate byproduct or effect of diagnosis or the abuse thereof. He feels that the goal of diagnosis is rather to identify the problem a patient has presented in such a way that the appropriate treatment for the restoration of the patient can be

carried out. According to Gough, there are three levels of diagnosis. The first level is aimed at identifying and clustering certain symptoms together to be able to identify a disorder. Treatment that results from a diagnosis at level one is aimed at relieving and not curing symptoms. Gough believes that most diagnoses aim toward at least a level two diagnosis, which is concerned with the underlying pathology that causes symptoms. Thus, the treatment at this level is curative and brings about more than only symptomatic relief. However, the ideal is for clinicians to strive towards a level three diagnosis. This is the most basic level of diagnosis, and at this level, aetiological factors are identified. Once the aetiological factors are identified, there is the possibility of designing interventions aimed at prevention. At this level lies the value of careful conceptualisation and understanding of mental disorders.

The psychiatric diagnosis is also often adopted by people who experience mental distress in order to structure and explain their experiences (Casey & Long, 2003). Some people find that having a name for their problems provides them with a sense of order and a way to reconstruct their lives. Concerning her diagnosis of manic depression, McIntosh (cited in Casey & Long, 2003, p. 94) reflects:

On a positive note, at least when I did learn of my diagnosis I was able to begin coming to terms with my illness and dealing with it on a constructive basis...I discovered a common identity and a camaraderie with fellow MD's, which enhanced my life tremendously.

Peters et al. (cited in Casey & Long, 2003, p. 94) talk about the discomfort of not having a name for disconcerting experiences: "Not having a label, I think that's the real problem so I can put it in a box and go 'yeah' it's that. I've got that now I can get on with me life. I can't deal with the unknown." A diagnosis along medical technical lines also relieves some people of a sense of guilt and self-blame (Casey & Long, 2003).

## 2.5 The Role of the Psychiatric Patient

Mills (2003) reflects that the understanding of madness as a mental illness has resulted in the alleviation of suffering for many people, but according to her, this has also resulted in a greater stigmatisation of mental illness, and has placed responsibility for the 'cure' of madness in the hands of professional psychiatrists and psychologists (Mills, 2003).

Research shows that persons with severe mental illness must cope not only with the symptoms of their disease but also with social and self-stigma. Societal attitudes toward severe mental illness lead to lost opportunities for education, employment and housing (Holmes & River, 1998). Self-stigma occurs when individuals assimilate social stereotypes about themselves as persons with severe mental illness. In an article by Corrigan (2007), he discusses the ways in which diagnosis can increase the stigma of mental illness. He shows that many people who are in need of mental health services avoid using them so as not to be labelled a "mental patient" or suffer the prejudice and discrimination the label brings. People with mental illness who live in a society that widely accepts stigmatising ideas may internalise these ideas and believe that they are less valued than others because of their mental illness. According to Corrigan (2007), the process of diagnosis both accentuates the "groupness" of those with a mental illness and simultaneously emphasises their "differentness" from the general public.

The hospitalisation of persons with mental illness also has another and important effect. A study by Corrigan, Green, Lundin, Kubiak and Penn (2001) has shown that unfamiliarity with mental illness heightens stigmatising attitudes. The segregation of the mentally ill into mental institutions to which the general public have no access heightens stigma towards those with a mental illness and classifies them as dangerous and incompetent.

## 2.6 Diagnosis as a Reflection of Power and Powerlessness

In a powerful example of how the diagnosis of mental illness reflects the political and societal influences of the time, Connor-Greene (2006) describes how a New Orleans physician published seven articles in 1851 in which he described two mental disorders ‘observed’ in African slaves. “Draepotomania” was a disease that prompted slaves to run away and “dysaesthesia aethiopica” referred to lethargy and a partial loss of sensation in the skin, supposedly found in slaves whose owners allowed them too much freedom. These people were classified as ‘sick’ if they did not behave according to the dominant political view of this age, which justified enslavement. In this way madness and the meanings surrounding it become inextricably bound to power and politics.

Women have also historically experienced this phenomenon. In the same article, Connor-Greene (2006) cites how women in the 1800s who were too outspoken or independent for the norms of their time were diagnosed as mentally ill.

## 2.7 Cultural Factors in the Definition of Madness

Although madness as mental illness seems to be the dominant Western view of madness, it is by no means the only view of what it means to be ‘mad’. The symptoms of madness or mental illness occur in all cultures of the world but have different meanings in different cultural contexts. Evidence suggests that meanings of mental illness have a significant impact on the subjective experience thereof, the idioms used in the expression thereof, the indigenous treatment, and the outcome (Castillo, 1998). Thus the societal understandings of madness are central to the problem of mental illness. In the African view of abnormal behaviour the biological, sociocultural and the transpersonal aspects being are integrated, and the interpersonal is united with the intrapersonal domain (Beuster, 1997). Traditional Africans define abnormal behaviour in terms of fractured and disharmonious relationships. Behaviours that threaten the social

well-being and stability of the community are seen as pathological, and include animosity, aggressiveness, arrogance, selfishness and envy (Beuster, 1997). Abnormal behaviour may also be the result of disharmony with the ancestors.

The African model of madness/mental illness is more holistic than the Western viewpoint. For example, this approach makes no distinction between mental and physical illness. Traditional Africans believe that physical and psychosocial systems are interconnected and change in the one inevitable affects the others.

In traditional African cosmology the causes of abnormal behaviour are mostly assigned to external and personalised forces (Beuster, 1997). Beuster (1997) adds that, in South Africa, many people believe that malevolent persons such as witches and sorcerers can cause mental disorder and illness, or that God may afflict individuals with mental illness. The African approach to diagnosis and treatment is more intuitive, experiential and symbolic. The healer, who is called the *sangoma*, is expected to make a diagnosis based on divination and treatment is often more nonverbal and occurs through symbolic acts like chanting and dancing (Beuster, 1997).

Blazer (2007) cites a study conducted in Ghana with women who were depressed during their menopause. The study concluded that because the women could no longer bear children, they developed depression. They visited a shrine in order to gain relief. Their depression arose from the fear of sorcery and evil spirits that made them barren. They felt useless as they could no longer bear children and this made them witches. These women were not considered mentally ill by their community, for if they believed that they had caused harm to others, they were taken at their word. If the woman was restless, agitated and unable to sleep, she had been overtaken by a spirit. It is clear from this study and the example discussed above that madness has many different explanations in different cultures, and that these are important in understanding the meaning of the individual's experience.

## 2.8 Mental Illness and Popular Culture

Popular culture reflects and shapes interpretations of both the causes and the consequences of mental illness (Connor-Greene, 2006). Contemporary television and movies often present skewed images of the mentally ill. At one extreme the media sensationalise and distort mental illness by linking it with violence in the familiar psychotic killer (Connor-Greene, 2006); and at the other extreme television talk shows often oversimplify and trivialise complex mental health problems and treatment (Connor-Greene, 2006). Both ends of this dichotomy ignore and misrepresent the experiences of the vast majority of people with mental illness.

In the last 12 years media studies have started to address the problem of stigmatisation of mental illness in the media. One of the most important of such studies is Otto Wahl's 1995 book *Media madness* (cited in Harper, 2005). He enlists a vast range of popular texts and genres to support his argument on the treatment of madness in the media. He argues, for example, that newspaper stories that link mental illness and violence contain the same stock characters as those found in popular fiction such as *American Psycho* (1991) and *Red Dragon* (1993), namely, "insane killers who prey on multiple innocent victims" (Wahl, 1995, cited in Harper, 2005, p.463). He argues that the media over-represents a link between mental illness and violence.

In reaction to Wahl's book, Stephen Harper (2005) examines the mental illness, violence and media discourse. He agrees with Wahl in stating that the media in all their forms often present the mentally ill as violent. In film and television drama, for example, the mentally ill are often presented as unpredictable killers, which create misleading impressions that people with mental illness are to be feared. This is the reason that one of the main contentions of the anti-stigma discourse is that media images of mental illness imply an association or link between mental illness and violence that does not exist. However, he states that

a fundamental problem with such critiques is that a correlation between mental illness and violence has been demonstrated in several studies. According to Harper, the concern here is that while anti-stigma critics rightly point out the ways in which the media contribute to public misconceptions about mental illness, their own arguments can have a similarly distorting effect (Harper, 2005).

## **2.9 Reflections on the Literature Survey**

Most of the literature discussed in this survey forms either an argument for or against the construction of madness as a mental illness. Using such a dichotomous method of reasoning loses some of the complexity and ambivalence of the issue. Working as an intern psychologist, it seems to me that there is no clear-cut way in which to classify the 'madness as mental illness' construction - most of all not either good or bad. Many of the treatments that flowed from different ways of understanding madness were cruel and dangerous for those who did not act according to the social norm. Constructing madness as an illness elicits less cruelty on the part of treating professionals than did many of its historical precedents.

This being said, this construction may also constrict people's experience and meaning-making process of mental illness, and may disqualify any different view of their experiences. Constructing madness as a mental illness narrows the experience of these individuals and could leave them voiceless in the hands of specially trained experts who define and treat their experience.

For me, the value or non-value of the construction of madness as mental illness lie somewhere between these two extremes. The meanings we attach to our lives and experiences differ from individual to individual, and as such we understand and need to understand things in different ways. For some, the construction of madness as mental illness may be beneficial in structuring and understanding their experiences; while for others it may be too narrow and

dominating. I find myself ambivalent in the way I judge the construct, oscillating between the two extremes of good and bad, yet able to see the value in both arguments.

This ambiguous position informed my approach to the study and the analysis of the data, and is evident in my description of the discourses on madness/mental illness. At times, the construct of madness as mental illness is seen as allowing less prejudice against those with it, and in certain discourses this construction seems to invite distance from those who have a mental illness.

## **2.10 Conclusion**

It is clear that the meanings attached to mental illness are varied and have changed many times throughout history. They are shaped by the dominant political, scientific and cultural discourses of the day. They also reflect social inequalities and imbalances of power. Throughout history the meanings attached to madness have had far-reaching effects on the experience of mental illness and the reaction of society towards those defined as having a mental illness. This leads to the question asked in this study: “What are those meanings in the South African community today, and how do they influence the way the public behaves towards the mentally ill?”



## Chapter Three

# Epistemological Framework

*I know I'm not seeing things as they are,  
I'm seeing things as I am.*

*Laurel Lee*

## **3.1 Introduction**

In philosophy, epistemology by definition pertains to “how we know what we know, or how we can make valid knowledge claims based on a particular theoretical framework” (Becvar & Becvar, 2000, p. xiv). My epistemological approach towards this research is influenced by my personal belief system and the lens through which I see the world, thus bias is inevitable and I recognise that the way I see things and analyse information is one way (and not the only way) to think about these discourses. My choice of approach is also influenced by the nature of the research question. In order to explore the different discourses around madness/mental illness I have adopted a social constructionist epistemology. This allowed me to explore the meanings of these different language systems in more detail.

In this chapter the different assumptions of the social constructionist worldview are described. It is important, however, to take a brief detour into the modernist approach to research to fully understand the assumption of the social constructionist worldview.

## **3.2 Modernism**

At its core, modernity attempts to describe the world and to view knowledge in rational, empirical and objective terms. It is characterised by a positivistic search for a truth and an accumulation of knowledge (Kvale, 1992a) that could be uncovered in variously prescribed ways, especially through the scientific method.

### **3.2.1 The Assumptions of Modernism**

Modernism is associated with the physical sciences and embraces positivism and postpositivism. The epistemological approaches to research that fall in this

category are in themselves broad and varied but they share certain assumptions (Wetherell, Taylor & Yates, 2001).

One such an assumption is that through the use of appropriate methods, which have become well established, the researcher can obtain knowledge of the world and its workings, particularly of the causal relationships which operate within it. From this standpoint, relationships can be seen as dichotomous interactions between distinct entities, which can be broken down into their component parts, and must necessarily be studied in isolation in order to be understood (Becvar & Becvar, 1996). Identifying such relationships enables a researcher to apply the research to real-world problems by making accurate predictions and possibly interventions. The knowledge obtained through the research is generalisable to other contexts because it is universal (Wetherell et al., 2001). Students of modernist thought believe that laws exist which govern human behaviour, and that these laws are absolute and external to us (Becvar & Becvar, 1996).

Another claim made in this tradition is that research produces knowledge that is value-free and objective, unaffected by any personal bias or worldview of the researcher (Wetherell et al., 2001). The modernist understanding of the mind and body as being essentially separate is inherent in the assumption that the mind and reality can exist independently from each other; thus individual A (subject/mind) can objectively view B (object/reality) (Becvar & Becvar, 1996). This premise leads to the belief that objective measurement and value-free science are possible, and contributes to the widespread mistrust of the subjective dimension (Meese, 2005). Good research is considered to produce neutral information and to contribute to a cumulative process that aspires to universal truths. The whole or final truth about the world may not be attainable; however, successive researchers attempt to approach this goal by testing hypotheses and taking a fallibilistic approach in which previous findings are treated as provisional and open to further testing (Wetherell et al., 2001).

The view of madness as a mental illness has at its base the epistemological claims of the modernist tradition. The medical view of madness as operationalised by psychiatry assumes that mental illness is a static objective truth for which the correct definition, cause and cure can be obtained through careful and systematic inquiry. Mental illness is a problem that exists “out there” in a “real knowable reality” (Becvar & Becvar, 2000, p. 89).

So here is one set of related claims: that research produces knowledge which is universal, in that it holds across different situations and different times, and is value free. In ordinary terms, this is knowledge with the status of truth: it is enduring and it is separate from the opinions and values of the researcher.

A contrasting tradition is more strongly associated with the social than the physical sciences, and underlying it are quite different epistemological claims. It is to a discussion of these claims that we turn next.

### **3.3 Social Constructionism**

Social constructionism draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically. That is, what we perceive and experience is never a direct reflection of environmental conditions but must be understood as a specific reading of these conditions (Willig, 2001). The use of a social constructionist metaphor opens the possibility for one to consider the ways in which every human being’s social, interpersonal reality is constructed through interaction with other human beings and social institutions; and focuses on the influence of social realities on the meaning of people's lives (Burr, 1995; Freedman & Combs, 1996; Gergen, 1999). The metaphors by which we structure our lives have a profound impact on what we perceive and what we do.

Adopting a postmodern, social constructionist worldview offers useful ideas about how the ‘truth’ around mental illness/madness is negotiated in families and larger cultural groups; and rather than being a stable objective entity to be ‘found’ or ‘explained’ by scientific enquiry, it is a fluid evolving concept embedded in culture. Some of the epistemological claims that relate to this worldview (Freedman & Combs, 1996) and that are important to the present study are discussed below.

### **3.3.1 Realities are Socially Constructed**

A central tenet of social constructionism is that beliefs, laws, social customs (and therefore meanings around madness/mental illness) – all the things that make up the psychological fabric of ‘reality’ – are the products of social interaction over time (Freedman & Combs, 1996). Our shared versions of reality are shaped by the goings-on between people in the course of their everyday lives. Burr (1995) states that the implication of this is that realities and therefore narratives are historically and culturally relative.

Kenneth Gergen (1999, p.50) reflects on the tradition of modernism and the future of psychology:

If we are to build together toward a more viable future then we must be prepared to doubt everything we have accepted as real, true, right, necessary or essential. This kind of critical reflection is not necessarily a prelude to rejecting our major traditions. It is simply to recognize them as traditions - historically and culturally situated; it is to recognize the legitimacy of other traditions within their own terms. And it is to invite the kind of dialogue that might lead to common ground.

Gergen believes that this view still allows modernist psychological perspectives their place in psychology, but as one of the many narratives by which we explain and structure our world.

Social constructionists place great emphasis on the intersubjective influence of language, family, and culture on the construction of the meanings and metaphors by which we live. From this standpoint, our traditions are sustained by a continuous process of generating meaning together (Burr, 1995). This has important ramifications for how we view the nature of madness/mental illness. If realities are socially constructed, then the meaning of mental illness/madness is to be found or generated in the social practices of our time, and cannot be divorced from these practices.

### **3.3.2 Realities are Constituted Through Language**

Perhaps the most pervasive impact that the postmodern social constructionist worldview has on the social sciences derives from its use of interpretive methodologies based on the model of language and discourse (Sey, 1999). The so-called 'linguistic turn' of French philosophy, especially in the 1960s, brought theories of reference and meaning sharply into focus again in a Western intellectual world that had been dominated for over a century by positivism and materialism in the social sciences, and by empirical theories of reference in the human sciences. Under the impact of a rediscovery of the theories of 'structural linguistics' of Ferdinand de Saussure, many intellectuals undertook a revision of theories of reference and meaning, based on the central insight that objective reality, individual consciousness and thought itself were all mediated by linguistic structure (Sey, 1999). Saussure's theory held that there is no natural or necessary connection between objects in the world (referents) and the language which refers to them and gives them meaning.

The idea that the connection between linguistic signs and meanings was a conventional one rather than a natural or necessary one, had the profound epistemological consequence for the social sciences of inverting the hierarchical relationship between interpretation and its objects, thus prioritising interpretation. As a consequence, interpretive strategies began to develop which operated from

the premise that cultures and their objects, products and practices were all equally interpretable according to the model of the interpretation of texts, or, more generally, narratives. It is from this movement that social constructionism takes one of its underlying assumptions.

Social constructionism asserts that the language we use constitutes our world and our beliefs. It is in language that humanity creates their views of reality. The only worlds that we can know are the worlds we share in language. Furthermore, language is not only a passive receiving of pre-existing truths but an active, interactive process (Freedman & Combs, 1996). Language organised into discourses has an immense power to shape the way that people experience and behave in the world. Language contains the basic categories that we use to understand ourselves, and affects the way we act as women or as men, and reproduces the way we define our cultural identity (Burman & Parker, 1993). When we talk about any phenomenon (our personality, attitudes, emotions, for example), we draw on shared meanings. Burman and Parker (1993) state that language produces and constrains meaning. Meaning does not, or does not only, reside within the individual's heads. Finally, social conditions give rise to the forms of talk available. The exchange of language is a symbolic interaction where we exchange and learn social conventions and rules (Babbie & Mouton, 2002).

In agreeing on the meaning of a word or gesture, we agree on a description, and that description shapes subsequent descriptions, which direct our perceptions toward making some descriptions and away from making others (Freedman & Combs, 1996). As Vivien Burr (1995, p. 7) puts it: "When people talk to each other, the world gets constructed."

This is in contrast with the modernist view that reality exists 'out there' and that we can come to understand it through systematic enquiry. For example, in order to understand the 'reality' of madness/mental illness, we would have to critically explore the language used to describe or define it. Gergen (1999) states that

language tells one how to see the world and what to see in it. According to Gergen speaking isn't neutral or passive and every time we speak we bring forth a reality. Each time words are shared legitimacy is given to those distinctions that the words bring forth.

This brings into sharp focus the argument against the diagnosis of mental illness. If our language shapes reality, then surely the language of diagnosis makes it so. This approach to research makes it possible to critically explore the language around madness/mental illness and how this influences practices of caring for the mad/mentally ill.

### **3.3.3 Realities are Organised and Maintained Through Narratives**

If the realities we inhabit are brought forth in the language that we use, they are then kept alive and passed along in the narratives we live and tell (Freedman & Combs, 1996). In effect, we identify ourselves through narration (Gergen, 1999). Narratives help people make sense of their experiences such as joy and sadness. People live according to these narratives (Morgan, 2000).

Modernism requires that narrative knowledge be subjected to the abstract knowledge of positivism (Lyotard, 1984). In traditional African societies, for instance, there is a rich tradition of narrative knowledge. During colonisation the narrative knowledge of Africa was subjugated to the positivist scientific knowledge. Where traditionally knowledge was transmitted in an oral, narrative form and validated through social processes in African societies, modernism requires a scientific validation of knowledge (Bakker, 1999). There lurks a paradox in this, however.

The modern narratives that legitimise scientific knowledge are cultural products. Science, including modernist psychology, is legitimised through appeal to grand narratives (Kvale, 1992b). The dominant view of humanity in Western narratives



of legitimisation was constructed out of a rational self-image by philosophers such as Plato, Aristotle, Descartes, Kant and others. Their philosophies have become the grand narratives informing psychology. Their view of "man" as a rational, self-determining individual has dominated psychology (Bakker, 1999).

A social constructionist worldview rejects such appeals to *grand narratives* (Lyotard, 1984) or *meta-narratives* (Sey, 1999). This position implies that a unifying social theory about people in the world is problematic, and proposes rather that the diversity, multiplicity and different subjectivities be recounted from the transparent perspectives of the researcher in culture and time.

### **3.3.4 There are No Essential Truths**

In the social constructionist worldview, since one cannot objectively know reality, all we can do is interpret and explore experience. There are many possible experiential realities (Freedman & Combs, 1996; Gergen, 1999). As Freedman and Combs (1996, p.34) very eloquently put it: "Within the multiple stories and multiple possibilities of the narrative "multiverse" there are no essential truths."

Knowledge is seen as value laden and subjective and hence objective neutrality is impossible. Social constructionism is critical of knowledge that is taken for granted, as knowledge is sustained through social processes which are constantly shifting (Doan, 1997). The world within which we exist is governed by institutions that are socially constructed by its members over many generations (Henning, 2005). These institutions are our society or culture, and they establish the beliefs, practices, customs, and words that direct our behaviour and give expression to our experiences (Henning, 2005). Reality is subjective as we view it through the lenses bestowed on us by culture (Henning, 2005).

Social constructionism believes that there are certain dominating discourses in society that are embedded in our language, which influence our perceptions of

the world (Doan, 1997). A social constructionist perspective is therefore especially interested in the normative or grand narratives that are formed by and in turn influence people, and against which people measure themselves. It is partly through identifying the dominant discourses prevailing in our society and challenging them that new meaning can emerge (Rapmund, 1996). This worldview then leads us to explore the stories around mental illness/madness, how they influence people to act toward the mentally ill, and how they are measured by the society in which they live.

### **3.4 The Subject in Social Constructionism**

The self is viewed as relational rather than individual. The self is a manifestation of relationships, thus placing relationships in the central position rather than the individual self of modernist worldviews (Gergen, cited in Becvar & Becvar, 2006). The self, being predominantly relational, is therefore multiple, in that it is comprised of the connections we create and sustain with the people, experiences, and places that give our lives meaning (Harre, cited in Henning, 2005). An individual is therefore defined in terms of an ongoing flux of social activity. His or her self and thoughts are actually social processes (Babbie & Mouton, 2002).

### **3.5 The Role of the Researcher**

In the social constructionist epistemology the perspective of the researcher takes on a different significance. The stance of the researcher moves away from a scientifically objective and detached observation of the positivistic position (Wetherell et al., 2001) towards a more interpretive and reflexive orientation (Lyotard, 1984). The argument here is that a basic feature of social research is its reflexivity, namely, the researcher acts on the world and the world acts on the researcher in a loop (Wetherell et al., 2001). If this is accepted, the researcher

moves to a central and visible position. Detachment is impossible so the researcher's influence must be taken into account and even utilised.

### **3.6 Conclusion**

In this chapter the difference between the assumption of modernism, which look to science to produce value-free, generalisable truths, and the assumptions of a postmodern, social constructionist epistemology were explored. When adhering to this approach, the function of research is to explore a particular version of reality in an embedded context. Language is seen as the structuring aspect of social reality; and as such, the only access researchers have to the social world is through the language we use to describe it.

## Chapter four

# Methodology

*Not everything that can be counted counts, and  
Not everything that counts can be counted.*

*Albert Einstein 1879 - 1955*

## **4.1 Introduction**

This chapter entails a detailed description of the research process used to acquire information for this study. It presents information regarding the motivation for selecting a qualitative research method and the implications thereof. It further elaborates on the process of selecting participants and the process of data collection. Finally, I discuss the phases of data analysis in terms of Parker's (1992) seven stage guidelines for discourse analysis.

## **4.2 Qualitative Research Design**

The choice of a qualitative research design was motivated and informed by the selection of the research topic. Qualitative research tends to be concerned with meaning (Willig, 2001) and is therefore the method of choice in this study where subjective meaning around madness/mental illness is explored. Qualitative researchers tend to be concerned with the quality and the texture of experience, rather than with the identification of cause-effect relationships (Willig, 2001). The motivation for this approach was also stated succinctly by Kvale (1996, p. 44): "knowledge is neither inside a person nor outside the world, but exists in the relationship between person and world". This is in keeping with the social constructionist principle that knowledge is created between people through interaction and language. Thus the theoretical framework for this study incorporates the subjective nature of reality and views of our worlds as multiverses that we co-create and reconstruct through observation (Durrheim, 1999).

## **4.3 Sampling and Participants**

Holstein and Gubrium (1995) see participants, in postmodern research, as capable of the production of "representative horizons of meaning" (p. 74) as opposed to being selected as a valid and reliable representation of a sector of the population.

Four participants were selected through purposive sampling, although the final number depended on the saturation of themes. The requirements for participation in this study were defined as follows:

Participants must be between the ages of 23-30. This age group was selected based on the assumption that participants would likely have finished tertiary education and would be in the early stages of building a professional career. In developmental terms, young people in this age group have a relatively well-formed idea of what it is that they believe. Having had time during adolescence and tertiary education to shape worldviews, in this stage they start living according to those beliefs while starting a new career, entering into relationships with others with more or less the same views, and so on. The moratorium society allows its youth to grapple with the many different meanings of society, and to carve their own unique belief system is over by the time young adults enter the work force (Hughes, 2002). Meanings around madness/mental illness should be relatively fixed and start influencing how young adults act towards the mentally ill. As such, these views are a “representative horizon of meaning” (Holstein & Gubrium, 1995, p.74) of the views of the economically active population.

Participants must have finished at least a tertiary degree. The assumption informing this decision is that the education received at tertiary level may broaden the meaning field of individuals and provides more extensive knowledge on social issues. Another assumption is that the critical thinking that is a secondary focus of tertiary education should provide people with a tool for evaluating social information.

Participants must not have had formal contact with the mental illness discourse as their meaning world would inevitably be partly shaped by this discourse. One of the aims of this study is to explore the constructions of those not involved in the ‘madness as mental illness’ model in order to explore broader influences and positions around this discourse. This lack of contact includes no personal or any

close family contact with mental patients or the institutions responsible for their care. This then excludes, for example, any persons that have studied psychology or medicine as part of their tertiary degree.

The participants of this study can be described as follows. Annabelle is a 25 year-old Afrikaans-speaking primary school teacher who lives with her fiancé. Nadia is a 26 year-old Afrikaans-speaking auditor who is engaged but lives with a friend. Ryno is a 25 year-old Afrikaans-speaking senior developer for an IT company, and Kegan is a 26 year-old Afrikaans-speaking business unit manager. They requested to read the discussion of the results and I agreed to send all the participants copies of the final text.

## **4.4 Data Collection**

### **4.4.1 Participant Interviews**

The semi-structured interview gives the researcher the opportunity to hear the participants talk about a particular aspect of their life or experience (Willig, 2001). This style of interviewing is sometimes described as non-directive although it is important to remember that the research question drives the interview. A carefully constructed research agenda can help the researcher to stay close to and not lose sight of the original research question (Willig, 2001). The main advantage of a semi-structured interview is that it gives in-depth data on the question being investigated (Struwig & Stead, 2001).

According to Kvale (1996), interview schedules should not focus on specific standardised questions but rather on themes, as this allows for openness and the unexpected. The themes for the interviews were:

- What does it mean to be in a psychiatric institution?
- What are the possible causes for this?
- How should these people be treated”

- What are the participants' personal views on contact with patients from psychiatric institutions?
- Who can become mad/mentally ill?
- What has shaped the participants' views on madness/mental illness?

The introduction of words describing mental suffering was guided by the words used by the participants, as was the introduction of themes. The interviewer met the participants in locations of their choice so that the participants could feel comfortable. Interviews lasted 45 minutes to one hour.

#### **4.4.2 Recording and Transcribing Interviews**

According to Edwards (1998, p.42), "careful and unbiased description is essential when investigating a new or little researched phenomenon". Mahrer (1988) recommends that to study a phenomenon, researchers should obtain instances of the phenomenon in the form of video or audio tapes of therapy sessions. For this reason the interviews were carefully recorded using audio tapes after informed consent from participants was attained.

In Kvale's (1996) discussion of transcripts, he points out that transcripts are an artificial creation of a different medium of communication. Certain complications in the transcription of interviews arise. Conversations have a different rule system than written language and this being the case, information can be lost when translating from oral to written form. Kvale (1996) thus sees transcripts as interpretive constructions of reality and not copies or representations thereof. As transcripts are a representation of the original interviews, they are no longer the original data and information is lost in the process of translation from oral to written. Despite this, it is important to keep in mind that the transcripts are not the focal point or topic of the study but rather a means by which the interviews are interpreted. An awareness of the interpretive constructions of the transcripts may



play a role in preventing the possible reification of analysis of the text (Kvale, 1996).

While carefully transcribing the interviews, I reflected on my part in the creation of the text by adding these reflections to the text in the margin. The aim of this was to maintain reflexivity on my part in accordance with the social constructionist underpinning of the study.

## **4.5 Data Analysis**

### **4.5.1 Discourse**

One of the key concepts in social constructionism is discourse. A discourse is a regulated set of statements which combine with others in predictable ways (Mills, 2003). Discourse refers to a new way of understanding language (Wetherell & Potter, 1988). It involves an understanding of “language as the basis of thought and selfhood, about the multiplicity of meanings inherent in any piece of text or speech, and about how this leads us to consider personal identity as temporary, fragmented and open to question” (Burr, 1995, p.46).

One of the most important implications for research is the view of a discourse as constructive in nature. A discourse does not merely represent reality, but actively produces the social entities and relationships we conceive of as being part of that reality (Fairclough, 2003). Discourse analysis conceptualises the relationships between the individual and the social, the cultural, and experience in general, as being largely *discursively* patterned (Painter & Theron, 2001). According to Painter and Theron (2001, p. 4), “both the hold that a form of life attains over people’s self-understandings and behaviours, and the powers they have to challenge those discourses or representations that help sustain their forms of life – especially when these are oppressive – are theorised on the level of discursive processes.”. This implies that discourses position people in certain social

positions. As such, all discourses actively construct their objects in certain ways (Gergen, 2001).

The aim of this study is to explore and identify the discourses around madness/mental illness. In the work of Foucault, the term 'discourse' refers to alternative ways of arranging areas of knowledge and social practice. (Fairclough, 2003). According to Burman et al. (cited in Painter & Theron, 2001, p. 2), the object of discourse analytic research is to tease out the "structuring effect of language, and of connecting institutional power relations with talk".

Based on the Foucauldian view of discourses (cited in McHoul & Grace, 1998), there are several clearly observable components thereof. These are *objects*, *operations*, *concepts* and *theoretical options*. That which is being studied is the object. In the case of this study the object is the mental departure from the social norm and is variously described as madness, mental illness and so on.

Operations refer to the various ways of treating these objects (McHoul & Grace, 1998). The theoretical options are the different theoretical underpinnings available to the study, which in this case refer to the social constructionist epistemology underpinning this study; and the concepts are the regularly used terms that form the unique language of a particular discipline (McHoul & Grace, 1998). Foucault further identifies certain characteristics of a discourse: the rules that make the formation of objects and concepts possible (*formation*), the relationship a discourse has with other discourses (*correlation*) and the ways in which the discourse can modify itself and the limits to such a modification (*transformation*). These concepts provided the basis for my understanding of discourse.

The approach to discourse analysis used in this study focuses on the set or family of terms which are related to the specific topic of madness/mental illness. This approach draws attention to how new terms enable people to talk about different things; but this is not simply a matter of attaching different labels to

already existing objects. It also addresses the sense that language is constitutive, it creates what it refers to. Meanings are created and eroded as part of ongoing social change. This approach understands language as situated within a particular social and cultural context rather than only within a particular interaction (Wetherell et al., 2001). This approach is in keeping with the social constructionist epistemology that forms the underpinning of this study.

Another important characteristic of a discourse is that discourses are not neutral, but are embedded in power relations (Burr, 1995). Even though discourse analysis gives primacy to language as structuring psychological phenomenon and subjectivity itself, it never pretends that this takes place in an environment where relations of power are not materially institutionalised and imposed (Painter & Theron, 2001). The type of knowledge available in society is intimately bound up with the powerful discourses in that society. Importantly, this power resides not in individuals or groups, but in discourse which individuals and groups tap into (Burr, 1995). The goal of discourse analysis is to deconstruct dominant discourses and representations that sustain certain oppressive power relations (Painter & Theron, 2001). Marginalised and repressed voices within these discourses are important ways of challenging dominant discourses (Foucault, 1972).

The discourse on madness now falls within a predominantly medical arena. It is seen as an 'illness' and something that can only be 'cured' by relevantly trained practitioners. This immediately constructs the mad in a position of powerlessness. As I am situated in a powerful position within this discourse, namely, I am an intern clinical psychologist who is charged with 'curing' the 'mad' of their 'illness', I have become profoundly aware that there are many different voices involved in the discourse on madness that have specific implications for how subjects (people the discourse relate to) are positioned around the object of the discourse, and that imply certain power relations; however, I am also

profoundly aware that these have not received the attention of psychological inquiry.

#### **4.5.2 Procedure**

In order to explore the meanings of madness/mental illness in a group of young professionals, I conducted a discourse analysis. No single method exists for conducting a discourse analysis. Keeping in mind the characteristics of a discourse discussed above, I made use of the method which is outlined by Ian Parker (Parker, 1992). Parker describes a discourse as “a system of statements which construct an object” (Parker, 1992, pg. 5). Parker’s method refers to seven criteria necessary for distinguishing discourses, as well as three additional criteria relating to power, institutions and ideology. Each criterion has two components. During the data analysis I did not follow Parker’s method as it is indicated. Instead I used the concepts of Parker’s method to inform the way I read the text and to inform how I structure and understand it. In the analysis, particular attention was given to how mental patients are constructed in the various discourses identified. Parker’s criteria are expounded below.

##### **1) A discourse is realised in text**

During research we never find whole discourses (Parker, 1992); instead, we find pieces of discourse which are embedded in texts. Texts are any thing which can be interpreted (Parker, 1992). Included in this category are transcripts on interviews and conversations. To begin with, we need to specify the text we are studying. Therefore, the first two components are:

- 1) Treating our objects of study as texts which are described, put into words
- 2) Exploring connotations through some sort of free association, which is best done with other people

## **2) A discourse is about objects**

Parker (1992) differentiates two layers of objectification. Firstly, there is the 'reality' to which the discourse refers. By referring to something, a discourse brings it into reality (Parker, 1992). The object, therefore, comes to be constituted in and by the discourse (Parker, 1992). The second layer of objectification or 'reality' to which the discourse refers is itself (Parker, 1992). Therefore, the discourse takes itself as an object (Parker, 1992).

As such, the next two components are:

- 3) Asking what objects are referred to, and describing them
- 4) Talking about the talk as if it were an object, a discourse

## **3) A discourse contains subjects**

Even if objects do have another reality outside of the discourse, they are given a new reality by the discourse (Parker, 1992). Discourses as such make available spaces for a particular type of person – a particular self (Parker, 1992). The components concerning this criterion are:

- 5) Specifying what types of person are talked about in this discourse, some of which may already have been identified as objects
- 6) Speculating about what they can say in the discourse, what one could say if one identified with them (what right does one have to speak in that way of speaking)

## **4) A discourse is a coherent system of meanings**

Together, the metaphors, analogies and pictures of a discourse can be drawn together into a coherent set of statements about the reality it is describing (Parker, 1992). The next two components in conducting a discourse analysis are:

- 7) Mapping a picture of the world the discourse presents

- 8) Working out how a text using this discourse would deal with objectifications to the terminology

### **5) A discourse refers to other discourses**

In the simplest sense, in order to speak about discourse we have to employ other discourses (Parker, 1992). Metaphors and so on from other discourses are always available to speak of a discourse (Parker, 1992). Often, these will come about as a result of contradictions within and between discourses (Parker, 1992). Therefore different discourses are always interrelated.

Components nine and ten look at these relationships:

- 9) Setting contrasting ways of speaking, discourses, against each other and looking at different objects they constitute
- 10) Identifying points where they overlap, where they constitute what looks like the 'same' objects on different ways

### **6) A discourse reflects on its own way of speaking**

At some point, most discourses comment on themselves (Parker, 1992). There are various layers of meaning within discourses (Parker, 1992), some of which are rarely voiced but which nevertheless form part of that discourse (Parker, 1992). The two components associated with this criterion are:

- 11) Referring to other texts to elaborate the discourse as it occurs, perhaps implicitly, and to address different audiences
- 12) Reflecting on the terms used to describe the discourse, a matter which involves moral/political choices on the part of the analysts

## **7) A discourse is historically located**

Discourses are not static but constantly change and overlap (Parker, 1992). Therefore we must locate the object in time (Parker, 1992). To do this the analyst must:

- 13) Look at how and where the discourses emerged
- 14) Describe how they have changed, and told a story, usually about how they refer to things which were always there to be discovered

## **8) Discourses support institutions**

Discourses are used to support certain institutions and their practices (Parker, 1992). Therefore the following two components are suggested:

- 15) Identifying institutions that are reinforced when this or that discourse is used
- 16) Identifying institutions that are attacked or subverted when this or that discourse appears

## **9) Discourses reproduce power relations**

Discourse and power are intricately bound (Parker, 1992). The next two components are:

- 17) Looking at which categories of person gain and lose from the employment of the discourse
  - 18) Looking at who would want to promote and who would want to dissolve the discourse
- Within discourses

## **10) Discourses have ideological effects**

The two components associated to this criterion are:

- 19) Showing how a discourse connects with other discourses that sanction oppression
- 20) Showing how discourses allow dominant groups to tell their narratives about the past in order to justify the present, and to prevent those who use subjugated discourse from making history

## 4.6 Ethical Considerations

Wassenaar (1998, p.140) points out that “with the growing national and international diversification of psychology, no single code of ethics will anticipate all of the contexts in which psychologists will work, particularly in a rapidly changing South Africa”. In such a context, researchers are compelled to engage the field of ethics in a dynamic and personalised manner, so that the researcher 'is the ethics' (Snyman & Fasser, 2004). In order to 'be the ethics,' the researcher should self-monitor. This means that researchers should take cognisance of every research encounter and the ethical implications of every research dialogue (Snyman & Fasser, 2004).

Some of the basic ethical considerations towards participants are summarised by Willig (2001). These include:

- Informed consent: The researcher will ensure that participants are fully informed about the research process and give their consent to participate.
- No deception: Deception of participants should be avoided altogether. Participants should be fully aware of the aim and purpose of research.
- Right to withdraw: The researcher will ensure that participants feel free to withdraw from the study should the need arise.
- Debriefing: The researcher will ensure that, after data collection, participants will have access to any publications arising from the study they participated in.



- Confidentiality: The researcher will maintain complete confidentiality regarding any information about participants acquired during the research process.

These ethical considerations have been followed throughout the study. I have also tried throughout my interaction with participants to 'be the ethics' as Snyman and Fasser (2004) have suggested, by keeping track of my own interaction with the participants.

#### **4.7 Conclusion**

This chapter discussed the methodological underpinnings of the study and how it was implemented during the data collection and analysis. The choice of a qualitative research paradigm was discussed along with the implications of such a research design. Parker's (1992) method for conducting a discourse analysis as used in the analysis of the interview data was discussed, and ethical procedures followed in the study were explained.

## Chapter Five

# Results of the study: discourse analysis

*And, if they're said with the right passion and the gods are bored, sometimes the universe will reform itself around words like that. Words have always had the power to change the world.*

*Terry Pratchett  
Soul Music*

## 5.1 Introduction:

According to Parker (1992), we never find whole discourses during research; instead we find pieces of discourses embedded in texts. During the analysis of the interview transcripts used as the texts for this research project, a number of differing discourses were identified.

These discourses were: The scientific discourse of mental illness; mental illness as the domain of professionals and mental institutions; mental illness as individual experience; mental illness as unknown; and mental illness as bad.

In this chapter these discourses are discussed in terms of how they construct those with a mental illness and those without a mental illness. Similarities and differences between the discourses are highlighted.

## 5.2 Scientific Discourse of Mental Illness

In this discourse mental illness is given a scientific explanation and those with a mental illness are constructed as suffering from a medical condition, psychological problems, or a combination of the two.

When we turn to the medical discourse, patients are constructed as having a genetic abnormality that is to be found in their families, as is evident in the following statement:

**“Obviously something went wrong somewhere along the line, I don’t know if it was genetic or if their families maybe somewhere in the bloodline have this sort of thing in their background.”**

This view sees those with a mental disorder as being inherently defective, and mental illness is confined to that individual. This discourse constructs patients as

'other than' the normal population; they are not the same as those without a mental illness:

**“...and obviously people that were born like that. That, um, like with only, born with a defect or something. Like Down’s Syndrome.”**

Those without a mental illness are positioned in this discourse as healthy individuals who do not have the genetic defect that leads to mental illness or madness. They therefore have no genetic predisposition that leads to the experience of mental illness. This position is maintained by describing themselves as different from those who have such a defect and represents a technique to distance themselves from people who have a mental illness as the result of a genetic abnormality and their families:

**“...,but it’s not in my genes, I know or obviously I think. OK because we don’t have it in our family.”**

The medical discourse also constructs mental patients as experiencing a chemical imbalance that causes them to behave differently from those who do not have an imbalance:

**“Well I don’t know, it’s obviously a chemical imbalance.”**

Mental patients as such have very little power to control their lives and experience. If they are constructed as having a medical illness the only treatment for this is medication:

**“...it’s something that affects you and that you can’t fix yourself without medication, I see it as an illness.”**

**“Deeper...medication. He needs science.”**

Furthermore, it is not constructed as a passing affliction but rather as a chronic problem that needs to be managed with medication:

**“...it’s a chronic illness I think. It’s something they have to live with.”**

In this way mental patients will never be healed and will remain ill although medication may keep their condition under control. This idea overlaps with the discourse of mental illness as bad. (This discourse is discussed below.) If mental illness is a chronic affliction that can only be managed on medication, then the only responsibility of the mental patient is to continue taking this medication on a regular basis. When medication is stopped by the bearer of the condition (as is quite possible from the perspective of those without a mental disorder), then they will relapse into the illness and it will make treatment more difficult for the professionals who are in charge of their cure:

**“...then they are in an even deeper hole than they were, because then they have maybe been without medication for so long and then the medication doesn’t work anymore and then they need other medicine, ten to one.”**

If those who do not act according to the social norm are constructed as suffering from a medical defect, then those who do not have such a defect easily subscribe to the construction of a professional medically trained person or personnel who need to treat these patients by medical means. The above quoted text represents the participant’s firm belief in the medical explanation of mental illness. As such, healthy individuals do not have to take responsibility for treating these individuals, as they do not have the necessary skills. This represents another distancing technique employed by those who do not have a mental

illness. Pleading ignorance of the scientific explanation of mental illness successfully exempts the participants from any responsibility in the care for the mentally ill:

**“...but I don’t know, I don’t have scientific training...”**

This position overlaps with the position of those who do not have a mental illness in ‘the mental illness as unknown’ and the ‘mental illness as the domain of professionals and mental institutions’ discourses. In these discourses, as in the discourse above, the participants adopt an outsider’s position in the discourse as not having the necessary expertise to understand the experience and treatment of mental illness. They are also comfortable with this position, as can be seen from the techniques employed to distance themselves from those with mental illness.

This discourse constructs mental health practitioners such as doctors and psychiatrists as the experts. They have the relevant knowledge about medicine and medical causes of illness and they are charged with the cure of those who are mentally ill. As such, they are not only talked about in this discourse but also have the most power to talk, whereas those with mental illness become the object of treatment and those not without mental illness remain outside observers. As such, they are therefore also powerless in this discourse and can only comment on it from the outside.

The family of the mental patient also remains on the outside of this discourse. Although they are constructed as wanting to care for their relative and wanting to help, they are powerless to do so:

**“...know love, love doesn’t fix everything in my view. If you think you care for the person and he will come right, no shit**

**man, there's deeper, a deeper illness that Med Lemon can't fix."**

Some of the metaphors used to speak about this discourse come from the medical model of illness with doctors as treating professionals and medical intervention such as medication and operations:

**"I just go back to what is familiar to me. If you go to a doctor and you are ill they normally treat the symptoms..."**

**"...if you ask me about the treatment then I think of normal doctor treatments that you can link back."**

The second scientific explanation of mental illness is that such individuals also have psychological problems. In this discourse mental patients are constructed as the victims of very difficult life circumstances such as physical and sexual abuse, and the intense emotion that go with these experiences:

**"It depends what emotion it is. Is it pain, what emotion and the strength that abuse came to the fore with."**

Appealing to this discourse, those who have mental illness are constructed as deserving of sympathy as they have suffered much in their lives. This discourse allows for more identification with people who have experienced emotional and physical abuse by those who have not experienced it. Those who did not experience this abuse are construed as having a moral responsibility towards the former, if they are to be good people. This is because the possibility of experiencing terrible events that can disturb one to the point of madness can happen to anyone:

**“I think it can happen to anyone. Um...yes, it only depends on the intensity of what happens...”**

**“And I think if something happens in your life you stand a chance that it will happen to you. So that is how I feel about it. So I think anybody can uh, stands a chance.”**

Even though the participants could understand and identify with escaping from difficult life circumstances into madness, the idea persists that non-sufferers are not the same as those who have a mental illness. They are the lucky ones who have not suffered these horrid life circumstances; they are the survivors of the onslaught of life; and this safeguards them from the possibility of developing a mental illness. As such, even though they appear to identify with these people they also distance themselves from them:

**“I think my circumstances are different. If I had different circumstances then I could also have ended up there.”**

After a traumatic event, some people deal with ensuing emotions by withdrawing into mental illness. Mental illness is thus seen as the way some people deal with life events, which implies some sort of intentionality: they are not only passive receptors or sufferers of medical conditions:

**“If you as normal person, you get taken out of your comfort zone and then you develop something mentally, and then you create your own little world one can basically say.”**

Treatment for mental illness does not lie in medication but in the help of psychologists who can assist mental patients to work through these emotional difficulties in various ways. In this discourse, as in the medical discourse discussed above, mental patients remain powerless and cannot really speak



about their experience, unlike psychologists, who have the necessary expertise to help them. Some of the ways in which professionals can treat people with psychological problems is by building a relationship of trust:

**“So some or other relationship of trust if it is possible to help them with enough confidence that it can help with their healing process.”**

Psychologists can also teach afflicted individuals how to behave differently. This idea draws on learning theory that explains all human behaviour in terms of learned impulses and reaction to life events:

**“...but like any other problem, like bad habits or switching a light switch on and off twenty times, and you learn not to. It’s like quitting smoking.”**

In the same way these behaviours can be learned by mental patients as they interact with other mental patients:

**“And maybe you will get worse and you will...I think if that person is worse than you, then you will definitely learn it...”**

Within this discourse, medication and the intervention of psychiatrists is seen as misguided; and fails to treat the cause of the problem:

**“I also think medication is just something to suppress the person’s instability or to suppress the person’s condition.”**

A reflection on the medical model of mental illness, where illness is caused by a genetic defect or a chemical imbalance, and the view of the mental illness as being due to psychological problems, reveals various contradictions between the

two discourses. In the first, those with mental illness are constructed as having an inherent defect that positions them in a definite place of being 'other than' those who do not have these defects. In the 'mental illness due to psychological problems' discourse, those with a mental illness have experienced something that it is possible for anyone to experience. In the discussion it appears as if these two discourses stand apart from each other, but in the text there is considerable confusion about which of the two discourses and which of the two constructions surrounding mental illness is dominant. Respondents move from one to the other in an unstructured, erratic way; and this reflects some confusion around the understanding of mental illness and its causes by those who have no contact with these discourses:

**“I think the genetic one. It doesn't mean that because your mother had it that you are going to get it also, not definitely, but if the circumstances are of such a nature, say you have had a traumatic experience or something, then you are more prone to lead to depression than the person next to you that maybe does not have it, that maybe does not have the genes.”**

These two discourses are subsequently combined in the construction of mental illness and those who have a mental illness. People without a mental illness seem to distinguish between genetic, medical causes of mental illness and psychological causes, but also acknowledge an interaction between the two:

**“So I think, I think it is inherent, I think it is genetic, but I think the people around you and the support network certainly has an influence on it.”**

**“It I think can be genetic...I think it can be like a genetic defect. Then I think it can be abuse, I think it can be external factors.”**

Exactly how these different explanations or causes interact is not so clearly defined by those outside the medical or psychological discourse; and there is some confusion about these causes. In this way this discourse supports the role of mental health practitioners as experts, and constructs them as the most powerful players in this discourse both as those who have the most potential to speak and as those with the most knowledge about and power to heal those with mental illness. As such, this discourse also supports institutions of learning that educate these professionals in the art of curing those afflicted by mental illness, and support the scientific biopsychosocial model of madness as a mental illness that can either develop due to medical causes, emotional causes or an interaction of the two. This discourse also constellates a multidisciplinary treatment team, with psychiatrists who treat with medication, psychologists who provide psychotherapy, and so on.

This discourse also draws on the modernist tradition that assumes that mental illness is a static objective truth; and assumes that the correct cause can be identified and treated through careful examination. This discourse assumes that mental illness is inherent within the individual, and as such, correlates with the Western view of madness as mental illness.

Absent from this discourse are spiritual explanations for mental illness such as those provided by the church in earlier centuries. There was no mention of possible possession or witchcraft, as explained in African culture. As such, the church, spirituality and culture have no significant place in this discourse. It places on the periphery and strips of power those explanations that do not fit within the scientific worldview. In this way, people with mental illness who do employ these explanations will be marginalised by this discourse. This has the implication that some of the cultures in our South African society will feel even more powerless when they find themselves in this environment. Not only are they already suffering from subjectively difficult

experiences but the explanations they employ in order to understand these experiences will be marginalised by those who they seek help from.

This discourse overlaps with the discourse of mental illness as the domain of professionals and professional institutions that will be discussed in the following section.

### **5.3 Mental Illness as the Domain of Professionals and Mental Institutions**

In this discourse mental illness is seen as the domain of mental health professional and the institutions in which they work. People who have a mental illness are constructed as needing help from others because they cannot function normally and are in need of containment by those from whom they seek professional help. Mental health workers are charged with the responsibility of the care of these patients; and psychiatric institutions are the place where they go to be cured and housed while they are under the supervision and treatment of professionals.

In this discourse people with a mental illness are only talked about but have no power to talk for themselves. This is the role of the trained professional who can understand what it is the individual is experiencing:

**“...you know, qualified decision made about, about which treatment...”**

**“... but if someone that obviously has the competence to make that decision...”**

Decisions about whether people need treatment, the kind of treatment they need, and whether they need to be institutionalised, all lie in the hands of the mental

health professional. As such, patients have no power to make decisions regarding their own treatment and confinement:

**“I don’t think necessarily they are fit to decide which treatment they get.”**

The participants acknowledge that institutionalisation must be an anxiety-provoking event for people with a mental illness. They perceive it as a negative experience:

**“You know ten to one it is precisely how those people feel when they go to the hospital. The patients. You know and I think that is how we would feel, I would feel if I walk in there. Definitely you don’t know what’s gonna happen with you.”**

**“...because I think an institution is already emotionally difficult for you...”**

The participants constructed people with a mental illness as being incapable of looking after themselves and not being able to live in normal society. This gives the mental health practitioners the moral right to institutionalise them.

**“I think because they cannot function on their own and they need help.”**

**“...the best for Pietie is actually to have a place where qualified people can look after him and where he can make little friends.”**

In the above text mental patients are construed as child-like in their needs and abilities. The mental patient must go to the institution to make friends and be

cared for. Nothing like adult expectations are expected from these patients. Among the participants chosen for this study none have any experience in caring for dependants and feel ill-equipped to make the relevant decision if such a situation arises:

**“I have not been in a situation to say: Listen I am not going to look after Pietie anymore,” or “I have to look after Pietie”. So I cannot say it’s right or it’s wrong...**

Within this frame, it is easy to abdicate the responsibility of looking after the child-like and the dependant to professionals who know what they are doing. Again, the idea of difference arises between those who do not have a mental illness and those who do. If the latter are seen as child-like and unable to make decisions about their lives, the participants are the opposite. They all have the ability to make good decisions about their lives, do not need others to look after them and can function in an adult capacity in society.

Mental patients in an institution are seen as passive, as is evident in the following statement where they are compared to people in an old age home:

**“People in pajamas, that are normally locked up for a large part of the day and that are in group discussions, group sessions and suchlike. I actually don’t think...almost like people in old age homes. Just people that sit around.”**

Even though mental patients have no say in what treatment they receive they are constructed as having to ‘buy into’ the treatment in order for it to work. It seems that the responsibility for the choice of the treatment lies with the professional, but if treatment fails the fault lies with the patient. In this way the treating professional is exempt from all responsibility and only carries the honour of being the one with the sought-after knowledge to manage the problem:

**“But um the people must definitely buy into it.”**

**“You must make the decision yourself, you know, I am gonna change my being...”**

Those who do not have a mental illness are also marginalised by this discourse and excluded from it by the construction that it is professionals with specialised training who are, firstly, able to identify and secondly, able to treat mental patients. The participants as laypersons are constructed as non-experts, powerless to intervene and help those with a mental illness:

**“You know, I don’t know what treatment they get and what medication they get and that type of thing...”**

**“...but I don’t think any man on the street will be able to walk into a hospital and then give assistance.”**

**“You don’t understand it, even if you want to, you can’t help them. Physically your hands are tied...”**

Even though the community may have an interest in helping and understanding people with a mental illness, they are unable to and they remain powerless in the face of professional knowledge. By saying that they would not be able to help, the participants also create distance between themselves, the treating professionals and mental patients. If they then do not want to help, they are employing a logical argument that supports their non-involvement in the treatment and support of the mentally ill. This allows them to remain distant while also exonerating them from blame for not caring.

The family of the patient is constructed in a supportive role only. They need to retain contact with the patient in order to provide support for the treatment the patient receives:

**“...I think if the person still has people or ten to one family that he is accustomed to, then it will be good to have contact with those people”**

**“...so that if they are released from the hospital in the end that they can go into society and still have someone that supports them emotionally”**

Very prominent in this discourse is how the different objects are constructed in a less than favourable light. The institution as seen by those on the outside – the man on the street – is invariably described as a clinical place where the patients are locked up by the staff in white buildings in small rooms, almost like a prison:

**“You see these white buildings with, again, white suits, and the people in their small rooms just sitting.”**

**“You think it’s a clinical place and then you think the people are locked up...”**

**“...a lot like a boarding house setup, certain sleeping times, lights out um...people were one-one in a room and some of their doors were locked...”**

The treating staff is constructed as uncaring and unfeeling in their methods to subdue and manage patients. They also use ruthless means to discipline patients:



**“...and they put him in this small confined space, cage-thing, with his straitjacket or with his white suit and um...it looks as if they just leave the people there.”**

**“...and then they give shock treatment...”**

This constructs mental health practitioners not only as the lofty experts but also as those who abuse power and do not really cure those suffering from mental illness:

**“...but I am still under the impression, you know, are people really cured there?”**

There is a strong overlap with the discourse of ‘mental illness as bad’ in these constructions; and this is discussed more fully later on in this chapter. Both the patient and the mental health expert are constructed as ‘bad’ in this discourse. Mental patients are seen as child-like, unable to care for themselves, and somewhat of a burden; and mental health professionals are seen as the uncaring, ruthless wards of their child-like charges. Discursively the participants, as people without a mental illness, feel obliged to justify this construction of mental health professionals and as such plead ignorance of the discourse:

**“So I think you don’t really understand why people go there. But you know that’s my perception.”**

They also blame the media for creating unsatisfactory images as their only contact with the discourse:

**“Again, you know, you, and ten to one the TV is the wrong thing to use, but it is the only...It’s the only exposure that you,**

**if you didn't have it in your family and you have not read or studied about it, then it is the only exposure you get.”**

In this way people without a mental illness can abdicate responsibility of the care and treatment of mental patients to professionals, and can also rationalise any bad constructions of those professionals as the result of skewed media portrayal. They therefore do not have to assume any responsibility even though they have some idea of mental health professionals as 'bad' and inefficient.

Importantly, the discourse on mental illness as the domain of mental health practitioners and institutions overlaps strongly with the scientific explanations of mental illness. It seems that when mental illness is constructed as having a scientific explanation it gives mental health professionals the responsibility and the power to treat individuals without their consent or even input, no matter how controversial and shocking the means of treatment. As such, the community, family and the individuals themselves have very little voice or power in these discourses.

#### **5.4 Mental Illness as Individual Experience**

This discourse speaks about mental illness as an experience that only those people with a mental illness can fully understand. Mental patients are constructed as living in their own world that differs from normal reality, and that they seem to experience as the proper reality. Those who do not have a mental illness have no access to them and also cannot understand their differing reality.

The most important construction in this discourse is mental patients live in their own world:

**“...you know they are in their own little world, by themselves.”**

**“...but you know their perception of life and you that sit next to them, across from them is not the same as yours. Their windows look a bit different than yours.”**

There is a sense that mental patients do not understand or experience that their reality is different from the norm at all; and that they experience their own world as normal and society as abnormal:

**“...because they are normal and we are the weirdoes. I think that is how they also see us.”**

This throws into sharp relief the social constructionist argument that reality is created through interaction and language; and the participant above reflects on the possibility that a different reality is created by people with a mental illness. Despite the fact that people with a mental illness create their own world and seem to feel comfortable in this new world, there is also a sense that they are isolated. If they create a world of their own, they lose contact with loved ones and also greatly minimise the possible contact they can have with others, as very few people share their reality. According to this discourse, they seem to isolate themselves totally from others:

**“...on the wall that that guy built around his life.”**

**“Dark and alone.”**

Not even the love of family members can really penetrate their isolation and, in some cases, despair:

**“...there are people around them, but they don't think so...”**

**“...love can only penetrate the outside. You know the person feels love, but inside he still has that pain. You know. It doesn’t go away.”**

This constructs the subjects in this discourse – those without a mental illness – as being in a powerless position when confronted with people who have a mental illness. They cannot understand and they cannot help. It also leaves them with very limited speaking power as they cannot gain access to the private world of the mental patient:

**“Because if they can’t help themselves then I won’t be able to help them. Me and the common people on the street.”**

In some instances the mental patient becomes the object of envy because they have the capability to create their own world. They do not have to face the negative aspects of society at large. There is an attempt to identify with those with a mental illness. This becomes prominent in South Africa where a large number of our society is very preoccupied with their own safety due to the crime rate:

**“They are so bloody happy and in a certain way I will actually think they are lucky, because they are totally out of these worldly circumstances. They are totally away from the norm and we worry about murder and lock our gates and go wild. They don’t worry about it. They live carefree.”**

As discussed in the literature survey, psychiatrists such as R.D. Laing (1965) have argued that psychosis enables the sufferer to escape intolerable psychological pressures exerted by uncaring societies. The construction of mental patients as creating their own little world to escape the horrors of this one

falls into this discourse. They do not have to worry about their safety and can live a carefree life.

Even though the different reality is envied by those on the outside it also opens mental patients to ridicule as they are seen as acting in a way that is different from others:

**“I think you giggle about it but don’t really realise it’s a problem and you don’t really do something else about it other than it is only weird for you and you giggle about it, probably.”**

In this discourse the role of the family and those who do not have a mental illness is to maintain contact with mental patients to bring them back to the normal reality. This is then also the function of mental health professionals:

**“...you know and I also think the people in hospital should have contact with other normal people that they also have.”**

**“...people must... one, the person, one must first feel comfortable with his surroundings and I think slowly and systematically the person must be exposed to reality again.”**

Although this discourse constructs mental patients as the experts of their experience, it nonetheless also places them in a position of powerlessness in society as a whole. If they do not access the same reality as normal society they cannot contribute to societal life. This justifies institutionalisation and the intervention of medical professionals who can help them regain their grip on ‘normal’ reality.

People without a mental illness are constructed as definitely different from those with a mental illness as they are firmly in touch with the accepted social reality.

This discourse does not allow for any identification and ‘same-ness’ between these two groups.

## **5.5 Mental Illness as Unknown**

The most important characteristic of this discourse is that the construct of mental illness/madness and those diagnosed with it remains unknown to the general public if they are not directly involved in it. This has many important implications for how these objects are then constructed by the community.

The participants in the study shared an overwhelming feeling that they had no knowledge about mental illness, mental patients, or even its treatment:

**“No, I don’t know! No, I don’t understand it. It’s hectic because I don’t understand it.”**

**“No, no, it is not something that I know...”**

**“...I must tell you it’s difficult for me to tell you precisely what I think it is. It is, one has these half confusing images of what now actually happens.”**

As such the community really has no power to speak in this discourse:

**“My physical perception thereof is that if you don’t actually have physical background of what it means or what it entails or were already physically there yourself or have any knowledge of what happens there, then it is actually very difficult to have an opinion.”**

The participants are left with only their own interpretations to understand mental illness:

**“So I think you take things that are known to you and you tweak it according to how you think it must be in a hospital. Because I have no other framework, so I have to take things that I have already seen and is familiar to be able to link back.”**

The major texts used to inform and shape the participants’ constructs of mental illness are media texts such as books and films, even though these are not perceived as an accurate description:

**“...I think mostly movies. What you have learned in the movies. Movies and books, I think form a large perception.”**

**“People watch those movies like “28 Days” where those people are in rehab with Sandra Bullock and all those other movies. Except it, it isn’t precisely the true picture, but it is a bit of an idea of how it can be there.”**

Since the community is left to their own devices and the depictions of the media to construct an understanding of mental illness, the participants suspect that this creates misunderstandings and misperceptions of what it means to be mentally ill, and what the treatment for it is:

**“...but I think people have a misperception of people that uh...people like this who are mentally disturbed.”**

**“...and again you have the perception that the media create and of you do not know what goes on there, what treatment the people get, then, then you will most probably be a little**

**scared of it. I think it is important that people know what it happening there, because if you don't, then you will, you know it's, you are going to create bad perceptions."**

The fact that the larger community has no knowledge of mental illness, those who experience it and the institutions and professionals who treat it leads to mental patients being constructed in various ways. Mental patients are perceived as interesting and exotic, like a mystery or secret that needs to be explored or discovered:

**"...I think you see lots of different characters and the reason I say it, again each guy is maybe in his own little world and I know it will be interesting..."**

**"But I think it will be interesting to see the unknown."**

This view is in contrast with the previous discourses as it constructs mental patients as almost enticing, and inviting contact from those who have not experienced a mental illness. It is quite different from the other discourses where contact is not invited and not desired by the participants. However, some distance is still maintained by the above participant in that he does not really crave a relationship, he only wants to "see the unknown", almost like going to a circus or zoo. Therefore, even though this discourse constructs those suffering from mental illness in an interesting light, participants still seem to distance themselves from any real contact with people with a mental illness and experience themselves as being different from them. They themselves are not unknown but predictable and straightforward. In addition, the unknown has a scary element to it because the general public do not have easy access to mental patients, and the situation needs to be investigated before they would take any responsibility towards the mentally ill:



**“Um I think you need to see and experience it first before you, before I will just say: “Yes I am going to do my social responsibility and I’m going to work in the hospital every weekend.”**

Constructing mental illness in this way leaves the participants free to plead sensitivity and fear as reasons to not have contact with mental patients. This discursive argument allows the participants to keep an interested but aloof distance from those with mental illness.

As discussed above, this discourse also constructs those who experience mental illness/madness as scary and frightening, which makes the general public wary of interacting with them:

**“If I see a hole in the wall I am not going to put my hand through it. You don’t know what is on the other side.”**

**“...it’s bad and it is actually shocking...”**

The concept of ‘mental illness as unknown’ overlaps with the discourse of ‘mental illness as bad’ in that mental patients are constructed as potentially violent and unpredictable:

**“I don’t know. I don’t know. It’s a good question. I don’t know. I will be afraid he snaps.”**

The general public may become the victims of these unpredictable and possibly violent people and this allows people who do not have a mental illness to protect themselves through distance.

People with a mental illness remain voiceless in this discourse as they have no means to communicate their experiences to the community or any other people who are not part of the scientific or professional discourse of mental illness. The community also remains powerless to understand and contribute to this discourse, even though they seem to find it important to have contact with this discourse. When people are admitted to an institution they become isolated from the outside world; and the only voice they have in that discourse is the voice and interpretations of the media.

**“No, I think it is very important that we know what is going on there or just have a better perception and idea of what is going on there.”**

**“...if they understood what those people, the patient go through if they are there, then maybe people will take off their hats and one; have respect, one for the people who work there and for the patients who are there.”**

The unknown nature and definition of mental illness renders mental patients vulnerable to discrimination. Although the participant here uses a discursive technique to distance himself from this position by referring to the perception of ‘other people’, a discriminatory position or view held of people with a mental illness is discernible. The distancing allows the participant to voice his opinion without actually appearing to be prejudiced and discriminatory:

**“...I think people think you are going to a cuckoo’s nest or something and they are um... you know, they’re not normal...”**

In this discourse professionals who treat those with a mental illness are constructed in positions of power as they are the ones who have the knowledge and understanding of mental illness, its treatment and mental patients. The most

powerless in this discourse are ordinary people who have nothing but indirect means by which to make sense of that reality. As such, the institutions where the mentally ill are treated and the professionals who treat them benefit from this discourse; even though the general feeling of the participants is that it should be dissolved, and more transparency and involvement with the object of the discourse initiated.

## **5.6 Mental Illness as Bad**

The 'mental illness as bad' discourse constructs all its objects and subjects in a dangerous or harmful way. Those suffering from mental illness are constructed as dangerous to themselves and others, devious, incurable, mad, insane and bad for their family. This discourse overlaps with many of the previously discussed discourses. It constructs mental health professionals as the ones with the knowledge to cure, although they are also constructed as uncaring and institutions as punitive, where people are locked up like in a jail to protect others from them. There are a variety of terms used in this discourse to describe those suffering from mental illness:

**“...that guy was a serial killer or something, he is insane.”**

**“...then they go off their rockers...”**

**“...they are actually cuckoos...”**

**“Shit I will be scared of people like that, because they can just do something any time...”**

**“...and then the guy can go commit bloody murder, because he thinks it is the right thing to do.”**

**“...a guy with maybe any psychopathic tendencies or something that is very violence...violent or something.”**

One of the ways in which these patients are constructed is as having lost their reasoning ability. If they think murder is the right thing to do then surely they are not reasoning properly, according to social norms. This resonates with the Enlightenment construction of madness as the loss of reason (Foucault, 1974).

As can be seen by the cited texts, this discourse is very robust in the way it shapes mental patients as unpredictable and violent and as a

**“...threat to society...”**

This becomes particularly worrying in the light that this condition is considered incurable; it is something that will be present in an underlying form for the rest of the individual's life, and can possibly be triggered by life events that might make the person violent again:

**I think underlying it will always, it will always be there.”**

**“All it does is suppress it and it will build up and build up and build up.”**

The construction of mental patients as potentially dangerous and violent provides a moral justification for their confinement in psychiatric hospitals. If someone then has the potential to harm himself and others, then the act of society in confining them to psychiatric institutions rather than prison is empathic and caring. However, the ideal (to confine and remove unwanted elements from society) remains the same:

**“But you don’t want him in society. It is not the best for him or for those around him...”**

In this discourse mental patients are very powerful in the way that others talk about them. They have the potential to do powerful damage to others, such as committing murder and rape. Mental illness is so powerful that it can drive otherwise caring individuals to wipe out their families:

**“...um because one day they can just snap and then you hear about a dad that killed his whole family and shot himself, or whatever.”**

Those who do not have a mental illness are constructed as the potential victims of irrational violence and harm to their person. As such, they feel that mental patients are scary:

**“I’ll be a bit afraid;”**

and possibly disturbing to have contact with. Even if the mentally ill person is not violent, the participants fear that contact with them may be damaging:

**“I’m too sensitive for these things.”**

**“...you know it can be very disturbing for me, ten to one, to see people...”**

These constructions of madness/mental illness seem to echo the ideas discussed by Foucault (1974) in *Madness and Civilisation* where he discusses the view of madness in the Classical period. Madness was seen as a manifestation of animality and therefore violence. The ideal way to deal with this is through confining the individual to protect humanity from what is bestial.

Of all the discourses discussed, this discourse most justifies the distancing of people without a mental illness from mental patients. The sentiment conveyed is: “If they are potentially dangerous and we do not know how to handle them or even understand what they are going through then we cannot possibly be expected to have contact, can we?” As such, mental institutions are charged with the protection of society from these possibly harmful individuals. Even the family becomes exonerated from the care of mentally ill members as it can become too expensive and too tedious to care for them:

**“...then it is a schlep. It becomes tedious I think.”**

**“...and the medication maybe costs a fortune...”**

What is interesting in this discourse is the reluctance of participants to frame mental patients in a bad light. They do not openly describe mental patients as bad but use a morally and politically correct manner of speaking when alluding to mental illness as bad:

**“Ok, I’ll be scared of myself, not because I think he’s now going to take out a knife and stab me... I don’t want them to see I’m scared of them or they should think I don’t want to talk to them or something. So I don’t want to make them unhappy.”**

**“No it’s jail cases. And it is actually bad to say it because obviously they have psychological problems...”**

Through distancing themselves from a negative view of mental patients by using politically correct ways of speaking, or by saying that these are the views held by others and not by them, the participants are able to communicate their views of the mental patient as unpredictable, possibly violent and ‘bad’ without admitting to their own prejudice:

**“...and ten to one that is why people in society say: “O jees, you know that guy was in a mental hospital, we don’t want anything to do with him...”**

In South African society there is currently great sensitivity to prejudice due to our turbulent history of apartheid, among other things. Although people likely have a less than favourable picture of people who have a mental illness, they do not wish to appear judgmental in our highly sensitive society, and may therefore appeal to morality in supporting their opinions. It seems that although stigma and prejudice does exist towards mentally ill people, society must guard against uttering this lest it should appear prejudiced and uncaring.

This discourse overlaps with the ‘mental illness as unknown’ discourse in various ways. One of the prominent ways is that the general public, having no knowledge of mental illness, may exacerbate the possibly violent tendencies of mental patients:

**“I’ll be afraid I say the wrong thing and he snaps.”**

The same texts used to elaborate and inform both discourses. The general public (as represented by the participants) have access to the experience of mental illness and those suffering from it only through the media. Although this is the only contact they have with the discourse, the media is not always perceived as giving an accurate depiction of mental illness; moreover, it is perceived as adding to the construction of mental illness as bad, and to those who have a mental illness as violent:

**“Mostly TV and stuff. Like over the radio, like yesterday, a boy he is twelve and he was bloody-well stabbed how many times with a knife.”**

**“You mostly see the negative; you don’t see the positive side of it actually, or the better side. Otherwise it wouldn’t be on the news.”**

This throws into sharp relief the role that the media has in the construction of mental illness and the mentally ill. As discussed in the literature survey, the anti-stigma discourse on the portrayal of mentally ill in the media is that media images of the mentally ill imply an association or link between mental illness and violence. This creates the impression that people who are mentally ill are to be feared. According to the findings of this study, the media is fulfilling just such a role. However, it seems that this construction provides people without a mental illness with a good explanation for not initiating contact with the mentally ill, or in this case, severe ‘badness’. If the general public believes that people with a mental illness are potentially violent and harmful, then it provides a good moral argument for the institutionalisation of these individuals and their removal from society.

This discourse may prove a stumbling block for the reintegration of the mentally ill into the community, and may open these individuals to possible attack. In this discourse the construct of mental illness is synonymous with the construct of violence, and thus it may be difficult for some community members to accept that these individuals are not confined to an institution. What is also important is that even though the participants were reluctant to own these views, and distanced themselves by stating that these views were held by others, the discourse is very robust and prominent.

## **5.7 Discussion**

What is important in the discussion of the data is the absence of certain discourses and voices in the description and experience of mental illness. Absent from the discourses described above is the spiritual discourse of mental illness.



As Foucault (1974) reflected in *Madness and Civilisation*, the church seems to have lost its power to define the world. Mental illness is no longer given a divine explanation and the 'cure' therefore can no longer lie in the hands of the church. No god was called upon to intervene in treatment and no religious doctrine was enforced to make sense of the experience of mental illness. This reinforces the power ascribed to mental health professionals and the institutions where they are trained, as well as the institutions where the mentally ill are treated, as the sole keepers of knowledge and cure for the mentally ill.

Also absent in all the discourses are cultural explanations of mental illness. As discussed in the literature survey, many traditional South Africans believe that mental illness is due to bewitchment from malevolent individuals and the only cure for this can be sought from a traditional healer or *sangoma*. The absence of this discourse may be due to the homogeneity of the participant population, although it does shed light on the silence of certain voices within the debate on mental illness. As an intern psychologist working at Weskoppies Hospital it has become increasingly clear to me that there is very limited space for cultural descriptions in the experience of mental illness. If a family believes that their loved one has been bewitched, the multidisciplinary team feels that they need psycho-education to clear up the family's misunderstanding of their family member's condition, and to assist the family to comply with treatment. It seems likely that mental health professionals would not encourage a rich description of mental illness if the use of other discourses put the power and responsibility of cure into other hands. One of the criticisms often raised against the medical model of madness as mental illness is that it is culturally one-sided, and shows a singular lack of responsiveness to different cultures (Louw, 2002). These critiques are often phrased in terms of a "Eurocentric", "Westocentric" and "individuocentric" focus (Holdstock, 2000). In a society where many of the existing cultures are not based on a Western worldview, it is possible that the construction of madness as mental illness could marginalise and fragment

certain elements. However, a greater exploration of the various South African cultures is needed to fill this gap in the debate on madness/mental illness.

What is also noticeable in these discourses is that the phenomenon of mental illness is invariably constructed as situated within the individual. This correlates with the modernist view of the person as a self-contained, rational individual (Bakker, 1999). In African thought, for instance, rather than dwelling on the relationship that one has with one's own thoughts and feelings, one ideally projects oneself "outwards" to establish relationships with the sky, the land and one's community and kinship group. It seems, therefore, that all the participants in this study subscribe to the Western discourse of people as self-contained entities, and discourage the involvement of the community and the family of the individual. This attitude therefore supports the construction of institutions that are able to look after these individuals as their family cannot. This view seems to discourage the reintegration of the mentally ill into the community as the latter will not be able to understand the phenomenon of mental illness. The consequence of this is that individuals with a mental illness may be further stigmatised, as responsibility and fault is situated within the individual.

All five of the discourses exclude the general public and therefore the community from actual understanding the discourses on mental illness. They do not have the necessary training and knowledge and so cannot help people with a mental illness. This is especially prominent in the 'mental illness as the domain of professionals and mental institutions' discourse, as well as the 'mental illness as individual experience' discourse. According to the construction of mental illness as unknown, the general public cannot obtain access to the discourse, which creates fear of those with a mental illness because it is unknown territory. How can the reintegration and care of the mentally ill move to a community level if the community has no access to the discourse and also no understanding of mental illness? This is especially worrying in the light of the public's robust construction

of mental patients as unpredictable and possibly violent that is encouraged by the media.

The most powerful objects and subjects in all the discourses are the mental health professionals. They are constructed throughout as having the necessary expertise and knowledge to cure the mentally ill; and in the 'mental illness as bad' discourse are morally sanctioned by the public to confine and treat mental patients because of their capacity to hurt themselves and others. All the discourses discussed support the institutions that train professionals (psychologists and psychiatrists) and that care for the mentally ill. Mental illness then becomes the sole terrain of mental health professionals who must fathom and hopefully rectify these irrational maladies (Fee, 2000). They become imbued, according to Fee (2000, p.3), "with mysterious powers of moral adjudication."

Even though these professionals are also constructed as uncaring and possibly not effective, the participants use various techniques to distance themselves from people with a mental illness and to justify their non-involvement. For example, they blame the media for creating skewed ideas of the 'badness' of the treating professionals. What is prominent is that none of the discourses place people without a mental illness in a position that encourages real empathy and real identification with mental patients. Those on the outside of the discourse seem for the most part to be comfortable with this distance and even seem to prefer it, although they state that they would like to understand more of the experience of madness/mental illness. This may reflect the effect of using the term 'mental illness' described by Corrigan (2007). According to him, using this construction emphasises the "groupness" of people with a mental illness, but at the same time accentuates their "differentness" from the general public. It seems that all the discourses involving the use of the 'madness as mental illness' construction indeed emphasise the "differentness" of those suffering from it and the participants of the study.

The most powerless objects and subjects in the various discourses are the people who have a mental illness. They do not have the power to speak of their experiences and they also do not have the relevant scientific knowledge and therefore need to consult professionals for their cure and management. They do not have a say in their treatment and confinement, and their opinions on their suffering are not deemed important. The majority of these discourses construct mental patients in a less than favourable light. The 'mental illness as bad' discourse constructs patients as potentially dangerous; the medical discourse constructs patients as suffering from an inherent chronic illness that can only be managed; the 'mental illness as unknown' discourse constructs patients as suffering from something that the general public does not understand and therefore fears. As a result, members of society are generally reluctant to get involved in the care of mental patients. In only a few of the discourses are mental patients constructed in a more positive light. In the discourse of 'mental illness as individual experience' there is a discourse of envy because mental patients do not have to face the harsh reality of current South African society. In the psychological discourse, patients are constructed as the victims of difficult life events, while in the discourse of 'mental illness as unknown' mental patients are constructed as interesting and exotic. This is important when attempting to reduce societal stigma against the mentally ill. If mental illness is framed as being the result of difficult life experiences rather than an underlying illness, community members may be more understanding and willing to become involved, as it seems that this discourse is the most likely to invite more real identification and empathy from those who have not experienced such difficult events.

## **5.8 Role of the Researcher**

This section reflects on my role in gathering and interpreting the data. During the transcription and the analysis of the texts I have become aware that it was very difficult for me to stand outside my own use of the term "mental illness" as a

means to categorise and describe a certain set of experiences and behaviours. I invariably introduced the term into my conversations; and in the analysis of the data I leaned heavily on the term to discuss and describe the different discourses. It seems that even though I am ambivalent about the usefulness of this construction in the description of experience, I also subscribe to the medical discourse to a certain extent. Part of the appeal of this discourse is the efficiency with which the language used categorises and refers to a broad variety of experiences and constructs. I can only reflect on the prominence of this discourse in society today, and state that according to the epistemology that I have chosen as the basis of this study, no one can be objective and stand outside of the discourses that shape our societal understandings.

## **5.9 Conclusion**

In this chapter I have discussed the results of the study in terms of five different discourses identified in the transcripts of the participant interviews that formed the texts of this study. The five identified discourses are: the scientific discourse of mental illness; mental illness as the domain of professionals and mental institutions; mental illness as individual experience; mental illness as unknown; and mental illness as bad.

The different ways in which people with a mental illness are constructed was explored and discussed. The majority of those ways seem to construct the mental patient in an unfavourable light. Some implications for the reintegration of the mentally ill into their various community settings were also discussed. Finally, the section concluded with a reflection of the role of the researcher in the process.

## Chapter six

# Conclusion

*Every end*

*Is a new*

*Beginning*

*Anon*

## 6.1 Introduction

The aim of the study was to explore the constructions of madness/mental illness among young professionals. The research aimed to gain a deeper understanding of their experiences and meanings of madness/mental illness through their own words. This study hopes to form part of a larger ongoing dialogue on mental illness, and to illustrate the complexity of experience and meaning in this area. It aimed to amplify the view of mental illness as being the terrain of mental health practitioners only, by broadening the field to include a diversity of voices on this topic. The study took the form of a discourse analysis of four transcribed interviews with young professionals between the ages of 23 to 26.

This research process was described in the previous chapters. Relevant literature on the construction of madness/mental illness in different historical periods was discussed, as were the implications of this for both people diagnosed with a mental illness and those charged with their care and treatment. The social constructionist underpinning that directed the study was discussed and the methodology used to analyse the text was described. The discourse analysis discussed the discourses that emerged from the analysed texts and these were integrated with the relevant literature.

This chapter represents a final reflection on and evaluation of the research, discusses the limitations of the study, and makes recommendations for future research projects.

## 6.2 Final reflections

In the process of analysing the texts five discourses were identified and discussed. The first of these discourses was the scientific discourse of mental illness. In this discourse madness is constructed as an illness with primarily genetic, chemical or emotional causes. The cure of this illness is seen as the

sole responsibility of those who have the proper scientific training and expertise. The general public seem to have very little knowledge about the meaning of mental illness, and so defer to the responsibility and knowledge of the experts in the treatment of the mentally ill.

The second discourse was mental illness as the domain of professionals and mental institutions. There was a prominent overlap between this discourse and the scientific discourse, in that mental health practitioners are seen as the relevant authorities to deal with those who do not act according to the social norm. For the most part the participants seem comfortable with this idea and use distancing strategies to explain their non-involvement in the care of the mentally ill. What is interesting about this discourse is that both the experts and the patients are constructed as 'bad,' with patients who are child-like and in need of care, and professionals who are uncaring and sometimes even ruthless in their treatment of the patients. Discursively, participants plead ignorance of the discourse and blame the media for creating skewed ideas of the treating professionals in order to abdicate responsibility for acting on these perceptions of mental health professionals.

Mental illness as individual experience was discussed as the next discourse. In this discourse the experience of mental illness is seen as an exclusive experience to which very few except the diagnosed individuals themselves have access. It places the participants in an outsider position where they are powerless to understand and even reach those who have this condition. There was some envy towards those who are able to create their own isolated world and who ostensibly have the ability to escape the harsh reality of current society; although it is acknowledged that this results in their being the victims of ridicule from those who cannot access their world.

The fourth discourse is the mental illness as unknown discourse. In this discourse mental illness/madness, the mentally ill, and the treatment of mental



illness are a mystery to those who are not part of these experiences. The only players who have access to this discourse are mental health practitioners as scientifically trained experts, and the mentally ill themselves.

The final discourse is mental illness as bad. In this discourse those with a mental illness are constructed as dangerous, possibly violent, unpredictable and damaging. This discourse positions those who do not have a mental illness as the possible victims of these individuals and in need of protection. It justifies the institutionalisation of mental patients and imbues these institutions with absolute power and moral responsibility. Unwanted elements need to be removed from society.

One of the aims of the study was to amplify the view of madness/mental illness as being the domain of mental health practitioners alone. The results suggest that those on the outside of the mental health discourse seem to prefer the fact that only specially trained individuals are responsible for the cure and treatment of the mentally ill; and may use many techniques to stay uninvolved.

The study also emphasises how pervasive the construction of madness as a mental illness is among the participants; and how spiritual and cultural explanations in these discourses are marginalised.

### **6.3 Evaluating Discourse Analysis**

In this section some possible ways for evaluating this discourse analysis are discussed. This is necessary to discuss the status of knowledge within discourse analysis. The epistemological claims in discourse analysis differ from that of traditional, modernist research (Wetherell et al., 2001). Traditional research aims to produce knowledge which is value-free, objective and generalisable (Taylor, 2001a). The aim is to gain knowledge of the world as it is and of the workings

thereof, and in particular, to gain insight into the causal relationships between events and objects (Taylor, 2001a).

However, discourse analysis does not aim to discover these objective truths but rather sees knowledge as interpretations or versions of reality (Taylor, 2001a). This is in keeping with the social constructionist approach of the study. The study did not aim to produce generalisable truths about what it means to be mentally ill/mad, but aimed to represent a situated set of meanings. The meanings discussed in this study were derived from a very particular group of people, and as such they do not form a representative segment of the entire South African population; and their views are certainly not held by all South Africans. However, they can be considered to form a “representative horizon of meaning” (Holstein & Gubrium, 1995, p. 74), as discussed in the methodology section, and as such their specific situated meaning is important as representative of a segment of the population.

Taylor (2001b) suggests some further useful methods for evaluating discourse analysis. Discourse analysis can be evaluated through looking at the quality of the interpretation, the relevance and the usefulness of the research (Taylor, 2001b). The relevance of this research lies in the way that relationships are constructed within the differing discourses and the relative power imbalances within it. By identifying and deconstructing certain discourses, new realities can be created and power imbalances can be addressed. The meanings emerging from this discourse analysis give some reference to the perceptions of madness and mental illness that are held by some South Africans. It is evident that the participants in the study have very little knowledge and contact with people who have a mental illness, and also employ a great number of strategies in order to maintain their distance from these people. As such, they rely heavily on specially trained professionals to manage and cure those with a mental illness/madness and the institutions that confine them during their period of illness/madness. Importantly, the constructions of mental patients as dangerous, unpredictable

and scary seem to be fuelled by the fact that the participants have no knowledge of mental illness and find it unsettling, and the fact that the media portrays a mostly negative image of people with a mental illness. If the South African Health Department wishes to reintegrate and care for patients at community level, this study proposes that more transparency is needed regarding the treatment and understanding of mental illness for those who do not have a mental illness and have no contact with discourses on these experiences.

One way to determine the rigour of a discourse analysis is by examining the richness of the detail of the analysis. Inconsistencies within discourses should have been highlighted and investigated (Taylor, 2001b). To obtain a rigorous analysis I discussed findings with my supervisor and colleagues in order to broaden the possible interpretations and analysis of the interviews. The analysis is also placed in relation to previously published works on the research subject highlighted in the literature survey, in order to obtain a more rigorous analysis (Taylor, 2001b).

Another important consideration is the role of the researcher. Within this approach the researcher cannot be separated from the research, and the identity of the researcher will have an impact on the research (Taylor, 2001a). The aim therefore is not for researchers to be as neutral as possible, but to reflect on their part in the research process. This was done throughout the research project.

#### **6.4 Limitations of the Study**

As was discussed above, the participants of this study form only a representation of a segment of the South African population. All of the participants were Afrikaans speaking, white individuals from a very similar cultural and socioeconomic background. As such, there are still many silent voices from the community. The meanings of black, Indian and coloured South African were not explored, and neither were the meanings of the very poor. Consequently, this

study only represents a starting point in the discussion of the views of madness/mental illness of the South African population.

The study was also based on a very small participant sample. Even though the information in this study gives a rich explanation for the situated meanings of these individuals, more information is needed before this information can be used to inform policy making or treatment programmes.

## **6.5 Recommendations**

Based on the findings of the study and its limitations, the following recommendations are made. In order to explore the views of a broader segment of the South African population further studies could examine the meaning of different cultural, socioeconomic and demographic groups in South Africa. As the views of the general public influence how those with a mental illness are treated, and in the light of moves to reintegrate mentally ill people into their community, it is important to explore these meanings in the broader community.

This study also illustrates how little knowledge the participants have of the experience of mental illness/madness. Consequently, they seem to fear contact with the mentally ill. It would be valuable to explore the possibilities of greater transparency in the treatment and understanding of mental illness to reduce this fear in the community.

An exploration of the media's influence in shaping people's ideas of mental illness/madness also seems warranted. As this study illustrates, the participants seem to experience the media images they are exposed to as mostly negative, and find that they paint people with a mental illness in an unfavourable light.

## 6.6 Final Reflections

During this study many of my personal ideas on the experience and perception of mental illness were influenced. I hypothesised that the distance between the general public and those with madness/mental illness was imposed only by mental health professionals in an attempt to protect the rights of their charges. During this study I became aware that people who do not have a mental illness also desire this distance, as they construct mental patients as being dangerous and possibly violent. It was difficult for me to distance myself from this emotionally, as one of my most important interests is the possibility of lessening stigma towards people with a mental illness. Although this was not the focus of the study, this finding has sparked my own interest in possible ways of lessening stigma and prejudice towards people with a mental illness. One of the areas which I would like to investigate further is increasing the contact between the general public and people with a mental illness. Would this have the effect of lessening fear and a need to distance oneself from 'mad' people, or would it reinforce this tendency?

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