5. Psychotic Experience and Discourse*

*Interviewer: Ken Stewart***

Ken: In the interview of 1990 I asked about your theory of pathology. You responded to this question with:

> *The word makes me wince! When I hear it, I think about the spectacular success of clinical medicine in the objectification of persons and of their bodies, and the extent to which the pathologising of persons is the most common and taken-for-granted practice in the mental health/welfare disciplines, and the central and most major achievement of the psychologies.*

Would your response be similar today?

Michael: I wouldn't take back what I said in that interview of a few years ago. There now exists a simply fantastic number of opportunities that are available to mental health professionals for the pathologising of people's lives. Due to an extraordinary investment in the development of the dis-

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* This is, in a sense, an interview within an interview. Some of the questions asked here are based on an earlier interview that was conducted in 1990, but was never completed.

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courses of pathology, we now have at our disposal a vast array of ways of speaking with and interacting with people that reproduce the subject/object dualism that is so pervasive in the structuring of relations in our culture.

These ways of speaking and interacting with people puts them on the other side of knowledge, on the outside. These ways of speaking and acting make it possible for mental health professionals to construct people as the objects of psychiatric knowledge, to contribute to a sense of identity which has "otherness" as its central feature. The success of these discourses is beyond question, and I believe that this achievement represents one of the truly great marginalisations of contemporary culture.

Ken: In our field, we are currently seeing a great deal of interest in postmodern thought. Do you think these postmodern influences are having much of an impact on various pathologising discourses?

Michael: As you say, there have been significant developments of this sort. However, I'm not at all sure that these have yet gone very far in challenging the hegemony of the pathologising discourses, which are undergoing constant processes of revision, refinement and elaboration.

Ken: Where does this leave us? Is there a way to address traditional conceptions of the so-called mental illnesses such as schizophrenia, obsessive-compulsive disorder, the histrionic personality disorder, and other personality disorders from the Axis II personality disorders of the DSM-IV, without pathologising people? Do those of us who embrace the social constructionist perspective have to leave this domain to the authors of the psychiatric knowledges, or do we make some kind of counter-claim to this territory? And, if we do, how do we address the phenomena that these classifications refer to? Do you think that family therapy has something to offer here?

Michael: Perhaps I could take your last question first. For some reason, in the critique of the institutions that have played a key role in the maintenance and in the reproduction of these pathologising discourses, family therapy exempts itself. It has so often considered itself on the outside of these discourses of pathology. But I do not believe that family therapy's claim to this exempt status can be sustained.

Historically, family therapy has embraced formal systems of analysis that are informed by the metaphors of "system", "dynamics", "structure", and so on. These metaphors provide for an "expert" interpretation of the events and of the experiences of people's lives, and have been deployed to invoke notions of family or relational "disorder", "dysfunction", and "pathology". And these metaphors have encouraged us to position ourselves in relation to others in a way that also reproduces the subject/object dualism that I have already referred to.

Ken: There have been many critiques of these and other pathologising discourses - both from within and outside the field. Yet, despite this, they continue to dominate all other discourses that have tried to offer alternatives. How do you understand this?

Michael: Yes, there have been many critiques. Perhaps it would be useful here to review one or two of these.

First, there is the issue of the self-presentation of the mental health professional. It has been said that to demonstrate a degree of "mastery" in the ways of speaking about other people's lives that are informed by these pathologising discourses, and to demonstrate a degree of skill in those ways of acting towards others that are informed by these discourses, accords these professionals a small grant of moral worth in their own communities. The achievement of this mastery, and the demonstration of this skill, brings with it the experience of esteem in the eyes of one's colleagues.

Second, it has been argued that to demonstrate this mastery and these skills opens the door to a world of career opportunities, and to economic opportunities. So, the demonstration of "diagnostic acumen" turns out to be highly rewarding - it is lucrative and it provides access to institutional power. But, more than this, here in North America it has become a necessity. It is now becoming virtually impossible for mental health professionals to earn a living if they don't subject their work to the DSM III-R, or whatever the latest version of this is.

Third, it can be argued that, since the pathologising discourses are cloaked in an impressive language that establishes claims to an objective reality, these discourses make it possible for mental health professionals to avoid facing the real effects of, or the consequences of, these ways of speaking about and acting towards those people who consult them. If our work has to do with the idea of subjecting persons to "truth", then this renders invisible to us the consequences of how we speak to people about their lives, and of how we structure our interactions with them; this mantle of "truth" makes it possible for us to avoid reflecting on the implications of our constructions and of our therapeutic interactions in regard to the shaping of people's lives. In this way, pathologising discourses make it possible for mental health professionals to avoid accountability, and to retain and to extend on their monopoly on power.

These are but a few of the many possible critiques. But, aside from these, there are other considerations that may account for the extraordinary development of, and success of, these pathologising discourses. Pathologising discourses have the potential to bring to us a degree of comfort in a world in which it is becoming increasingly difficult to find this. These discourses make it possible to define those problems for which people seek help as aberrations. As such, they assist us to avoid the acknowledgement of the fact that these problems are very significantly of our culture, that these problems are products of our modes of life and of thought. The discourses of pathology make it possible for us to ignore the extent to which the problems for which people seek therapy are the outcome of certain practices of relationship and practices of the self, many of which are actually informed by modern notions of "individualism". And the discourses of pathology make it possible for us to ignore the extent to which the problems for which people seek help are so often mired in the structures of inequality of our culture, including those pertaining to gender, race, ethnicity, class, economics, age, and so on.

If we can see the difficulties for which people seek help as the outcome of some aberration rather than a product of our ways of thought and ways of life, we can avoid facing our complicity in the maintenance of these ways of life and of thought. This assists us to disavow our complicity in the constitution of the worlds we share with others. In obscuring this link between the problems for which people seek help and the modes of life and thought of our culture, we can avoid facing the responsibility that we have to take action to address the context of people's lives, and we can avoid facing the responsibility that we have to dismantle the various structures of inequality that are associated with these.

Ken: Okay. So, let's get down to some of the specifics of your work. I've heard it said that you are opposed to the use of labels and to the use of medications.

Michael: Now that's interesting. I've heard the very same opinion about my position on these matters.

Ken: Well?

Michael: From time to time I hear things about what I have said that I haven't spoken of, and from time to time I read accounts of my thought that do not relate to what I think. And at times I hear accounts of my conduct that are not at all close to my experience of it.

Ken: What's an example of this last point?

Michael: Several years ago, there was a story going around that, during a consultation in Canada, I had externalized a problem with a person who had a diagnosis of paranoid schizophrenia, and that, in response to this, I had been beaten up. What actually did happen was that I had intervened in an assault, in order to prevent the perpetration of grievous bodily harm, and had my face split open in the process. Furthermore, none of this had anything to do with a consultation.

Ken: Sounds simply awful! So tell me, what is your position on labels and medication?

Michael: In regard to drugs, I have not taken a general position on the so-called anti psychotic medications. Instead, I have been far more interested to find what is enabling for people in regard to this question - and here I am using the word "enabling" in its positive sense. This consideration leads to specific questions:

- *How might one go about assisting people to determine whether these drugs are contributing to their quality of life, or whether they are subtracting from this?*
- *How might one go about assisting people to determine in which ways these drugs might be enabling, and in which ways they might be disabling?*
- *How might one go about assisting people to monitor the effects of different medications, and of different levels of these medications?*
- *How might one go about assisting people to evaluate the real effects of these medications on their lives and in their relationships with others?*
- *How might one go about assisting people to establish what might be for them suitable criteria for such an evaluation?*
- *How might one go about assisting people to fully inform themselves about the various negative side-effects of these drugs?*
- *How might one go about assisting people to identify which people are most invested in compliance with regimes of medications, which people are least invested in this, and the particular interests of these parties?*

These are just a sample of the many, many questions that can be appropriately asked about drugs.

I do hope that this discussion goes some way towards challenging the view that I am opposed to the use of drugs. I have witnessed drugs being used in ways that have a profound effect in opening up the horizons of people's lives, in ways that bring a range of new possibilities for action. And I have also witnessed drugs being used in ways that are primarily for the purposes of social control, in ways that subtract very significantly from people's possibilities for action, in ways that dispossess people of choice.

Ken: And what are your thoughts on various labels used in the field of mental health?

Michael: If you are talking about making psychiatric diagnoses, I have no interest whatsoever in trafficking in this trade. In regard to labels in general, and people's use of them, questions similar to those we have just been talking about with regard to drugs seem appropriate.

In responding to questions of this sort, I am mindful of the fact that some people do find such labels enabling. This has been interpreted in a variety of ways. For example, it is said that illness labels undermine the various self-accusations and attributions of personal inadequacy that are experienced by people who are not able to live out their lives in the customary ways. Furthermore, it is said that these labels make it possible for persons to break from the stress of the expectations that they would be subject to if they were "well". And it is frequently argued that psychiatric diagnoses serve to dissolve the guilt that is so often experienced by relatives, and that this has the effect of undermining self-defeating behaviours and of promoting more constructive interactions in familial contexts.

And, while I can appreciate these arguments, and have no difficulty in honouring what people have to say about some of the positive effects of psychiatric diagnoses, I have no doubt that these outcomes provide for some interesting reflection on our culture - that, in order for people to break from these self-accusations and attributions of personal inadequacy, from the stress that is informed by the expectations about what it means to be a real person in our culture, and from the experiences of guilt that we have discussed, they must step into the site of "illness". Illness is a site of culture, one that is structured, one that brings with it particular modes of life and of thought. It is a site of culture that shapes life.

So, diagnosis provides for an exemption that is permissible through illness. But this is a sad reflection on our culture, and I do think that we can do a lot to assist people to find other alternative sites in this culture in which they can succeed in breaking from dominant ways of being and thinking, alternative sites that bring with them other options for how they might lead their lives, options that do not require exemption through illness.

And it is very interesting that, in the work that we do together to identify these other sites, sites that are often defined through the tracing of histories of resistance to dominant culture, the diagnosis itself becomes increasingly irrelevant, and the exemption it brings with it becomes increasingly unnecessary for living.

Ken: So, what happens when you are consulted by people who seem to identify with their psychiatric diagnosis?

Michael: I do not want to be misunderstood on this point. If I am consulting with a person who prefers to use such labels, then I am interested in honouring what they experience this to be doing for them, and I am interested in actively exploring with them what speaking about themselves in this way makes possible.

Ken: But, since these labels co-operate in the colonising of people's lives - treating them as an "other" that is at once "knowable and visible" - I would have assumed that you would be opposed to them altogether.

Michael: Well, it is difficult to be in opposition to labels *per se*. In language, there is always naming, and so we always have labels of one sort or another. What is of critical importance, however, is the nature of the discourses that are associated with this naming. A consideration of discourse takes us to specific questions about any naming. What knowledges are privileged in a particular process of naming, and what knowledges are rendered irrelevant or are disqualified in this process? Who is qualified to speak and to name, and under what circumstances is it acceptable for them to do so? What relational practices and techniques of power are associated with acts of naming, of diagnosing, and what are the real effects, on people's lives, of these practices and techniques? And so on. Here I have been trying to emphasise the extent to which it is discourse that is of vital consideration.

Of course, the labels associated with one discourse can be usurped by taking them up into alternative discourses. This is often achieved by marginalised groups. When these labels are taken up and inserted into an alternative discourse, they often become terms of pride, and ones that represent certain lifestyle choices and knowledges about ways of being and thinking. This has the effect of taking such labels a long way from the mainstream discourse that had been so subjugating of people in marginalised groups.

Ken: So then, in my mind at least, these thoughts take me to considerations of aetiology. What is your position on aetiology?

Michael: In seventeen of the last twenty or so years I have had formal relations with mainstream psychiatric services - I have worked in state psychiatric hospitals and in child and adolescent psychiatric services, and have spent a considerable period of time consulting to a large state psychiatric hospital. And, in addition to this, at Dulwich Centre we have a small independent community mental health project. Now, let me tell you something that you might find surprising. Throughout this entire period, in the totality of my experience of these different psychiatric contexts, the only times that I have witnessed considerations of aetiology having any effect on management whatsoever have been on those relatively few occasions upon which a brain lesion of some sort has been suspected. Even medication is a trial-and-error affair. I say that you might find this surprising, because, despite the general irrelevance of considerations of aetiology, anyone who has worked for mainstream psychiatric services will have witnessed an extraordinary amount of time and energy devoted to these considerations.

So, what are we to conclude about this? Perhaps such considerations of aetiology are a hallmark of the performance of psychiatric knowledge because these considerations provide opportunities for the scientising of this knowledge.

Ken: So, you don't have a position on aetiology?

Michael: To answer your question, I have always resisted taking a position on the aetiology of the so-called psychiatric disorders. In fact, I have consistently refused the incitement that I have experienced to step into a position on this, and to enter into debates and other activities that depend upon such positions. I am willing to consider most notions of aetiology, but, quite frankly, these considerations are as irrelevant to what I do in this work as they are for others.

Ken: Does this mean that you are even willing to entertain some of the current biological notions of aetiology for what is referred to as schizophrenia?

Michael: Of course! Of course! But this is not relevant to what I do.

Ken: So, what do you do? In taking the position that you do on psychiatric discourses, isn't there a risk that you wind up excluding yourself from participation in this field? Isn't it possible that, in this way, you will cancel out your own contribution? Doesn't this leave you with nothing to say?

Michael: Certainly not. I am simply talking about standing outside of the territory as it is defined by psychiatric knowledge, and as it is structured by pathologising discourses. I am not talking about standing apart from people and their experiences, including those experiences that are so often taken up into pathologising discourses.

Ken: Okay, what are our options?

Michael: I think that we can assist people to challenge the hegemony of the psychiatric knowledges. We can work with them to identify the extent that their own lives are "knowledged". We can engage people in conversations that are honouring of their knowledges of life, and that trace the history of their knowledgeableness. We can join people in conversations that provide the opportunity for them to build on these knowledges, and that assist people to develop plans for applying this knowledgeableness to those experiences that they find troubling.

We can make it our business to work collaboratively with people in identifying those ways of speaking about their lives that contribute to a sense of personal agency, and that contribute to the experience of being an authority on one's life. And we can assist people to draw distinctions around these ways of speaking and those other ways of speaking that contribute to experiences of marginalisation, that subtract from a sense of personal agency, and that undermine an appreciation of one's authoritativeness.

Rather than referencing what we do to the sort of formal systems of analysis that we have already discussed, we can strive to build on those developments in our work that are more referenced to people's experiences of life, including of psychotic phenomena. We can find ways of attending more directly to people's experiences of life.

And we can join with people in challenging those relations of power that inform the subject/object dualism that I referred to earlier in this conversation.

Ken: Take this last point. Say something more about how this might be achieved.

Michael: I'll float one example here, one that relates to the idea of returning the "gaze", or turning the gaze back on itself. For those people who are the recipients of ward rounds, for them to research these ward rounds can be very empowering. This might engage them in a study of who can speak, under what circumstances they can speak, which ways of speaking are acknowledged, which ways of speaking are disqualified, whose authority is privileged, the effects of the privileging of this voice, and so on. I find that many people are quite taken by the introduction of this idea, and that it has a positive effect even if it is not taken up in any formalised way. It appears that even to think the unthinkable goes some way towards undoing the effects of the marginalisation to which people have been subject. Of course, there are many other ways in which the gaze can be returned.

Ken: This is a subversive idea if I ever heard one.

Michael: Yes, this might be quite subversive. But practices of returning the gaze do not have to be covert, and they are not necessarily antagonistic to the efforts of the staff of psychiatric institutions. In fact, these practices can serve mental health professionals well in their efforts to establish contexts that are healing. In that these practices of returning the gaze can have the effect of rendering transparent many of the otherwise taken-for-granted ideas and practices of psychiatric contexts, they can be of great assistance to staff who experience a commitment to confront the moral and ethical responsibility for the real effects of their interactions on the lives of those people who are seeking help. When mental health professionals accept the fact that they can never be certain that they are not reproducing, in their work, the circumstances that provide the context of the very problems for which people are seeking help, they will experience a degree of relief in the feedback and the possibilities for action that are afforded by these practices of returning the gaze.

Ken: You also mentioned possibilities for being more experience-based in working with people who have defined psychiatric conditions. So, could you give me an example of what this experience-based work might look like with schizophrenia? And could you also say what distinguishes this from accepted approaches to this phenomenon?

Michael: In regard to the generally accepted approaches, I have noted a strong bias in regard to the psychotic experience itself. This is an anti-experience bias. I believe that the idea of talking to people about their psychotic experiences has had rather bad press over the past few decades. Within this context, it is not surprising that some of the proposals that I have put forward on talking to people about their subjective experience of psychotic episodes have provoked disquiet.

Ken: Maybe some fear that you would be reifying the delusions instead of talking people out of them. How has this sort of response impacted on your work?

Michael: It hasn't really. Some have expressed their apprehension about my practices of relating to psychotic experience, and, at times, have been somewhat perturbed by my unwillingness to desist in my further exploration of ways of talking to people about their experience of psychotic episodes. However, I have never found the content of such responses to be at all persuasive.

Ken: In some of your workshops, you have referred to the work that you do in assisting people to revise their relationship with their auditory hallucinations, or their "voices". Is this one of the developments that has come from this exploration of psychotic experiences?

Michael: Yes it is. Assisting people to revise their relationship with their voices is usually a very significant part of the interactions that I have with people who have the diagnosis of schizophrenia. The successful revision of this relationship invariably has a powerful effect on the quality of these people's lives, and, in my experience, it generally plays a considerable role in reducing their vulnerability to relapse as well.

Ken: If this is so, is this a practice that is being taken up more by mental health professionals?

Michael: Yes. I have contact with many mental health professionals who have been taking these ideas up in unique contexts and in unique ways. As an example of how this is being done in working with groups of people who have psychiatric diagnoses and who are considered to be "chronically ill", I would refer you to the *Worthy of Discussion* groups of Gaye Stockell and Marilyn O'Neil from Sydney, and to the developments that they and their colleagues have been putting together in establishing more collaborative approaches in the rehabilitation context.

And I have contact with others who are enthusiastically exploring the fit between some of these ideas and practices, their own original contributions, and some of the more established ideas and practices in this field. For an example of such work I would refer you to Chris Beels and Margaret Newmark of New York, and to David Moltz of Portland, Maine.

As well, I know some administrators, managers, and clinical directors who have been effective in changing the face of the broader provision of psychiatric services by incorporating the sort of ideas and practices referred to here with a number of other related ideas and practices. A good person for you to talk to, who has achieved a great deal in this area, is Alan Rosen of Sydney.

But there are many other initiatives apart from these. One quite recent initiative is the work that Stephen Madigan, David Epston and the Anti-Anorexia League have been doing together in British Columbia - work that is having what I understand to be a transformative effect on policy with regard to the treatment of anorexia nervosa and bulimia.

Ken: These developments all sound exciting, and I would like to learn more about them. So I take it you haven't been too discouraged in your work in this area?

Michael: Definitely not. Over the years, I have experienced a good measure of support and encouragement from many people, and this has been sustaining.

However, I will say that my efforts to share more generally, with others, what people have had to say about this work have yielded mixed responses. So, at times, I haven't found things all that straightforward.

Ken: Give me an example of what you mean.

Michael: Well, in regard to the work that I have been developing on the revision of people's relationship with their voices, for some years, in certain circles, I did experience constraints in presenting my findings. These constraints were partly born of scepticism and of doubt, and were partly political in nature.

However, several years ago, articles began to be published in mainstream journals that called attention to the need to consider the subjective experience of those persons who received a diagnosis of schizophrenia, and that also called attention to the significance of the quality of the person's relationship with their voices. In fact, one journal devoted an entire issue to these explorations (see the *Schizophrenia Bulletin*, Volume 15, Number 2, 1989). While these articles did not describe processes that contributed to possibilities for people to revise their relationship with their voices, some of the findings were supportive of what I was doing, and, since the publication of articles like these, I have found it somewhat easier to talk about this work in psychiatric contexts.

Ken: So how do you explain this - that having a different relationship with one's voices can make a significant difference in terms of the severity of the psychotic episode?

Michael: In part, I believe that it relates to culture. Although it seems relatively easy for us to entertain the idea that much of what we think and believe, and much of what we do, is informed by culture, for some reason it seems rather more difficult for us to entertain the idea that psychotic phenomena are similarly informed; that, regardless of aetiology, the content, form and expression of psychotic phenomena, such as auditory hallucinations, are shaped by culture. When it becomes less difficult to entertain this idea, it becomes possible for us to appreciate the extent to which culture is just as shaping of the lives of people who have whatever it is that schizophrenia is.

Ken: Give me an example of this.

Michael: There is nothing about physiology or genetics that would predispose the voices of schizophrenia to attack their female subjects on the basis of their sexuality, or to call their male subjects "wimps". And there is nothing about physiology that would predispose the voices of schizophrenia to see others as adversaries, and their subjects as possessions. Those auditory hallucinations that people find most troublesome are so often distinctly patriarchal in their attitudes and their techniques of power. This is so for the voices that harass men and those that harass women. These voices are overwhelmingly evaluative of people; they are critical and disqualifying; they rate highly on expectations of people and low on acknowledgement.

Ken: You state that these voices are distinctly patriarchal. Could you say more about how they speak?

Michael: Okay, but I would like to emphasise the fact that I am not referring to all of the voices of schizophrenia here. In this work, it is essential to assist people to distinguish those voices that are controlling and dominating from those voices that are supportive, or that at least have the potential to be supportive.

Ken: Alright, but I would like to come back to this distinction later.

Michael: Those voices that are troublesome are highly opinionated and quite convincing. They rely on certain devices in order to speak impressively, in order to secure unquestionable authority, in order to establish claims to objective knowledge, in order to convince their subject that they alone can grasp the truth of people's natures, desires, purposes, and so on.

Ken: Can you say more about these devices? They sound scary.

Michael: The impressive ways of speaking to which I am referring are "at large", and we could refer to them as the "disembodied" ways of speaking. I am sure that these will be familiar to the readers of the transcript of this interview. These ways of speaking have been called disembodied because they disclaim any reference to context, because they allow one to establish knowledge claims that are considered to be context-independent. They have the effect of elevating specific knowledge claims to a certainty or "truth" status, and of disqualifying those knowledges that are represented in more situated ways of speaking.

Ken: Ah, yes - those who claim to speak the "truth" about all situations, regardless of context, an all-too-familiar experience that many of us have been subjected to. Still, I think that recent developments in the field have attempted to expose these "temptations of certainty". Could you say more about this kind of a-contextual way of speaking.

Michael: The devices that are associated with these "expert" ways of speaking include those that (a) obscure the motives or purposes that are associated with one's speech acts, (b) delete all reference to the personal experiences through which one's knowledge claims are generated, (c) exclude information about the personal and interpersonal struggles and dilemmas that are associated with the construction of one's preferred realities (this includes the erasure of the personal experiences of contestation and argumentation through which one's knowledge claims are established), (d) divert attention from the personal investments that are informed by one's location in the social worlds of gender, race, culture, class, work, sexual preference, and so on, and (e) delete all reference to the history of controversy and dissent that surrounds all "global" knowledge claims.

Ken: And what are the implications of this in this work?

Michael: Well, disembodied speech acts can be very disempowering of those who are subject to them. They are quite capturing. They severely limit and constrict possible responses. However, the persuasiveness and impressiveness of such speech acts can be undermined by the principle of embodiment; that is, by situating these speech acts within the context of the speaker's (a) motives and purposes, (b) personal experiences, including those that relate to dilemmas and other struggles that the speaker has experienced in the process of attributing meaning to their experiences of life, (c) investments that are informed by their location in the social worlds of gender, culture, race, class, sexual preference, and so on, and also by bringing forth the history of controversy that surrounds the speaker's objective knowledge claims.

Ken: Knowing your work as I do, I'll bet that you have some interesting questions that would uncover and deconstruct some of these truth claims.

Michael: Yes. We can ask questions that insist on embodiment, questions that require speakers to situate their opinions.

Ken: Could you give some examples of these questions?

Michael: Okay. To encourage speakers to situate their opinions in the context of their purposes, we could ask questions like: *So you have a strong opinion about what I should do. Tell me, in voicing your opinion in this way, what effect do you hope this might have on what I do?* Or maybe we could ask: *If you were to succeed in influencing what I do on this occasion, how would this fit with your overall goals for my life?* Or perhaps: *I think that I have some understanding of how you would like your opinion to shape what I do right now. How does this fit with your general purposes for my life? How does this fit with your plans for my life?*

To encourage speakers to situate their opinions in the context of their lived experience, we could try something like: *Could you tell me about some of your personal experiences of life that have played a central role in the formation of this opinion? This would be helpful to me, as I would then know more about how to take your opinion, and I might be able to identify those parts of your views that could fit for me. Perhaps I could then talk of some of my own experiences of life, and share with you some of the conclusions that I have reached from all of this.*

To encourage speakers to situate their opinions within the context of their location in the social world, we might try something like: *In which circles are these sort of opinions most strongly held? Do all of the people in these circles agree with this opinion? If some of these people were here with* *us, how would they go about supporting your opinion? What do you think would happen if, in their presence, you were to dissent? What sort of pressure do you think you would experience to conform, to recant? What consequences do you think you would be facing if you didn't agree to do so?*

But this is just a small sample of the possibilities for ways of responding that are deconstructing of the "truths" that are championed in disembodied speech acts. And I want to emphasise that these questions do not require an answer in order to be effective. In asking such questions, those who are subject to disembodied speech acts become less captive, and are confronted with new possibilities for action.

Ken: Those are great questions! I have some ideas about how I can put some to use right away. Members of my team often come across persons in social service or medical circles for whom these questions would be very appropriate. Can you tie these ideas back to the question of working with people who experience auditory hallucinations?

Michael: As I have already mentioned, when these voices are most troublesome, they speak impressively and persuasively. At the times that these voices are most troublesome, they succeed in convincing their subjects that they speak with authority, with objective knowledge; that they speak of the truth of life and of the world, of the truth of their subject's identity, of the truth of the motives of others, and so on. These impressive voices so often succeed in capturing their subject, and in disqualifying their subject's special knowledges of life. And this is usually traumatising and disempowering of everyone concerned.

In these circumstances it makes sense to de-authorise these impressive voices, to disempower them, and this can be achieved through the embodiment of their "truths". We can encourage the people who are the subjects of these voices to insist that the voices embody their demands, requirements, opinions, investments, and so on. Such embodiment can be achieved by assisting those who are in the subject position to situate these voices within the context of the voices' purposes, their experiences, and their history.

Ken: You speak of these voices as if they are independent entities.

Michael: Yes. In fact, in this work, the deconstruction of the "truths" of these voices can be achieved best through the personification of them. Or perhaps I should say that this is achieved through the extension of this personification, as it is not at all unusual for those people who are the subjects of these voices to have personified them in advance of our meeting - except that the purposes of these voices have not, until this time, been at all transparent.

Ken: Many people understand your work primarily involving various aspects of externalizing conversations with people - in which the problem is not only externalized, but personified in unique ways. This fits with other theorists and clinicians who speak of internalized voices and "objects" or representations of significant persons and relationships in our lives. So you externalize the hidden, more pernicious, aspects of what previously had been internalized or introjected. Is this way of personifying the problem a regular part of your practice?

Michael: Let me answer your question this way. This practice of personification is but one way of re-voicing the problem, and, for me, this re-voicing of the problem is an important aspect of the work that I do. I know that if we engage with people in the re-voicing of the problems that they consult us about, this provides them, and us as well, with the opportunity to establish an appreciation of the politics of the person's experience of life.

Ken: So, how do you proceed, in practice, with this re-voicing of the problem?

Michael: Mostly via the formulation of questions like:

- *What is it that the voices are trying to convince you of at this time? What are they trying to talk you into? How does this fit with their overall* *plans for your life?*

- *How do the voices expect their assertions, their "shoulds", to affect what you do? If they succeed in forcing their will on your life, how do you imagine this might influence the direction of your life?*
- *Are these voices for you having your own opinion, knowing what you want, or are they against you having your own opinion?*
- *I do appreciate that these voices throw you into confusion. In whose service is this confusion? Does it contribute to their goals for your life, or does this favour or clarify your own goals?*

As you can see, through questions like this, distinctions can be drawn around different desires, purposes, intentions, goals, and so on. These distinctions make it more possible for people to determine the extent to which these fit with the designs of the dominant voices, and the extent to which they fit with the sort of designs that are preferred by the person concerned. Even confusion is found to be in the service of these voices, rather than in the service of the person. In drawing such distinctions, persons achieve some degree of clarity about a preferred account of what they want for their life, and they are no longer so much at sea.

Ken: I like these questions. Not only do they externalize the voices, but they raise the question of whether or not they support opinions that are favoured by the person, or some other opinion that is different, and often opposed to the one that is preferred. One of the things that I find attractive about your work and writing is the attention you pay to relational politics and the techniques of power. Do you see a place for putting these ideas to work here?

Michael: Definitely. Exposing and describing the tactics that the voices employ to achieve what they achieve can be very helpful. These tactics can include all of those that make possible the privileging of one knowledge above others. And, when the chips are down, when their authority is at risk, these tactics also include various forms of abuse, terrorisation, subterfuge, treachery, pettiness, and so on.

Ken: That's interesting. Just how far are you willing to go, or how far are you prepared to extend, this re-voicing of the problem?

Michael: To reiterate, these voices rely upon time-honoured and disembodied speech acts for their influence. They draw attention to the motives of others, while disguising their own. In going to some lengths in the personifying of the voices, we open the possibilities for the deconstruction of, and unmasking of, all of this. In rendering transparent the voices' purposes in this way, people are assisted to revise their relationship with their voices. This personification also makes it more possible for us to assist people to monitor the progress of this revision in their relationship with their voices:

- *At this very moment, how are the voices coping with this exposure? To speak of them in this way, to unmask them in broad daylight, how does this affect them? Do you think that this is playing a part in reducing their influence, or playing a part in increasing this?*
- *Are the voices protesting this discussion? Has this unsettled them? Is this threatening to them? How are they reacting to the threat? Are they trying to "up the ante"? What do you think it means that they are threatened by this conversation?*
- *What is it like for the voices to have to listen to your thoughts for a change? What is it like for them to know that you are developing a disrespect for them and a mistrust of them - that you are on to their tricks of persuasion? How does this affect your position in your own life? Does it strengthen it, or weaken it?*

And so on.

Ken: Have others found these practices to be rather unusual?

Michael: Yes. And, as well, I want to be transparent about the fact that these practices have, as I have already mentioned, aroused some concerns. It has been said that I am somehow playing a role in the verification of what amounts to hallucinations, and thus culpable in the reinforcement of them. It has been argued that the problem with auditory hallucinations is that they are already externalized and that people need to own them, to integrate them - that the voices of schizophrenia really represent parts of the person that the person needs to integrate, thoughts that the person needs to come to terms with as their own, and so on. But these criticisms are based on modern notions of a "self" that is the centre of and source of all meaning, on notions of a unitary and essential self. And I do not believe that there is any hope whatsoever of sustaining this modern notion of the self.

Ken: So, if I understand you correctly, you encourage people to confront the voices. Does this ever take a form of the two-chair work that is common to Gestalt approaches?

Michael: No, definitely not. I am proposing something that is on the other side of these approaches - on the other side of such approaches at the levels of ideas, purpose, and practice. As I have said, the work to which I am referring is definitely not informed by the modern notions of the self, or by fashionable cultural notions about states of "wholeness" that might be achieved through "integration".

And there is no confrontation. Situations of direct conflict with these voices are avoided. In the practices that I am outlining in this discussion, there are no stand-offs. Highly emotive and stressful interactions are never encouraged. This would be entirely counter-productive. Rather, this work encourages people to take up an observer or self-reflexive position in relation to their own lives, a position in which they become the narrator of events in their relationship with the voices. Initially, this assists people to "suss out" the voices, and engages them in piecing together an exposé.

Ken: So, rather than integrating the so-called "split-off" parts of a single "self", as we might see in Gestalt approaches or even psychoanalytic approaches, you seem to be working to exclude the voices from people's lives.

Michael: The goal of this work is not to get rid of the hostile voices, but to assist people to revise their relationship with them, so that the voices' degree of influence is lessened. When people are in the subject position in regard to hostile voices, we can predict a deteriorating or relapsing course. When people break from the subject position, or when the voices are entered into the subject position, then we can predict improvements in the quality of people's lives, and fewer relapses.

However, as this work proceeds, it is not at all unusual for people to begin to report that the hostile voices absent themselves from their lives for significant periods. Because this is not an explicit goal, this sort of outcome is responded to as one of the bonuses of this work.

Ken: Back to what you were saying about confrontation, aren't there any occasions upon which direct confrontation would be indicated or useful?

Michael: Very rarely, and even then this would not take the form of a fight or a contest. Of course, at times people experience a strong temptation to enter the fray when they are experiencing the voices tantrumming, particularly when this is precipitated by a threat to the voices' position - when there is a chance that the voices might lose their "foothold" in their subject's life. But people are not encouraged to reciprocate. Instead, they stand back, consult their documents of identity or read transcripts of therapy sessions, and let these tantrums play themselves out. It is from this position, outside of the fray, that people become aware of various options for resistance.

Ken: You mentioned earlier that it can be helpful to assist persons to discriminate those voices that are supportive, or at least potentially supportive, from those voices that are hostile. Say more about this.

Michael: I believe that people who are subject to psychotic phenomena that are traumatising can do with all the support they can get, even if some of this support is to be found within the psychotic experience itself. It is not unusual for people in these circumstances to report that some of the voices they experience seem genuinely concerned for their wellbeing, even if they are at times somewhat misguided in their attempts to demonstrate this concern. Now, it is possible to assist people to more clearly distinguish these friendly or potentially friendly voices from the hostile voices, and to develop a stronger alliance with these more supportive voices, one in which they become better informed about what is in the person's best interest.

Such alliances can play a significant role in that they provide people with support and with the experience of a solidarity of purpose. This renders them less vulnerable to the insecurity that the hostile or dominating voices provoke and rely upon to achieve a position of influence in the person's life.

Ken: How do people go about developing a stronger alliance with the more supportive voices?

Michael: Well, after the identification of those voices that are friendly, or at least potentially friendly, people can be assisted to elaborate on the character of these to the point that they take on the identity of an invisible friend.

Ken: And when they can say something about the character of the friendly voice, the voice takes on greater depth and complexity, and is able to be more easily sustained and adopted. Would you say this is a key part of this work?

Michael: No. It is simply helpful, but by no means essential. And, of course, there are many people who do not experience such friendly or potentially friendly voices.

Ken: Are there any other ways that alliances could be developed which would help people who are vulnerable to hostile voices, say, for people who do not experience friendly or even potentially friendly voices?

Michael: Many. For example, we can explore the possibilities for the generation of relationships with invisible friends. It is possible to work with people around the invention of an invisible friend, and at times it is even possible to resurrect people's relationships with invisible friends. Do you have any idea of how many children have friendships with invisible friends? Children are generally more postmodern than adults in that they have a stronger appreciation of the multi-storied nature of personhood. Just ask around. Ask children, or ask some of your adult relatives or friends about whether they had invisible friends in childhood. You will be surprised at the prevalence of these friendships. And do you have any idea of what a difference friendships with invisible friends make to children's lives?

Ken: It's not something that I think a whole lot about.

Michael: Neither did I, but some years ago, in response to a conversation with Cheryl White about invisible friends, I began to ask people questions about this. As Cheryl had predicted, I was surprised by the responses I received.

Ken: I guess that they provide support and reassurance, cure loneliness, and so on.

Michael: You can also pass the buck to them when things get tough. And invisible friends do more than all these things. They are very empathic and compassionate, and are prepared to go through all manner of experiences with children, even to join children in suffering. I am sure that you have heard of children getting a great deal of solace from being joined in illness by invisible friends. Invisible friends make it so much easier for children to take the things that they have to take. And children can tell invisible friends secrets and, in so doing, give themselves a voice in this adult world where there is so little space given to children's voices.

Ken: I'm reminded of a popular comic strip here in the United States, *Calvin and Hobbes* - about a boy, Calvin, who is about six or seven years old, and his stuffed tiger, Hobbes, who is quite animated and lively, and plays a significant part in Calvin's life. How do you connect these ideas to your work on helping people revise their relationship with the voices heard in schizophrenia?

Michael: In this culture, at a certain point, children get talked out of their relationship with their invisible friends. This is considered to be developmentally-appropriate. However, I do keep in mind that there are many cultures in which a person's relationship with the equivalent of invisible friends is preserved, and in which their ongoing contribution to the person's life is acknowledged.

In my work with people who are harassed by the voices of schizophrenia, I sometimes learn of a childhood relationship with an invisible friend. I can then ask these people questions about what these invisible friends meant to them, about how these invisible friends contributed to their lives in ways that were sustaining, about the circumstances of the loss of this relationship, and so on. I can ask people questions about what they think it was that they brought to the invisible friend's life, and to speculate about what the separation meant to the invisible friend. We can then explore the possibilities for reunion, and talk about how such a reunion might be empowering to both parties. And then we can put together plans for the reunion. I have attended many such reunions, and have found them to be very moving and "warming" occasions.

Following these reunions, people can get their heads together with their invisible friends and document the hostile voices' usual habits of speech and action, develop predictions in regard to future attempts of these voices to establish supremacy, work on plans for how they might respond to this as a team, and so on.

Ken: Sounds fascinating! Although we have been mostly focussed on schizophrenia, I can see how these ideas have relevance to many other so-called psychiatric disorders.

Michael: They do. For example, take persons who are diagnosed with bipolar depression. We can engage these persons in externalizing conversations that have the effect of deconstructing both the grandiose ideas and the voice of depression. In the process, these people experience a degree of alienation in relation to these ideas and these voices, find that they are more able to monitor their emotional status, develop early intervention skills in reclaiming their lives from the destabilising effects of these ideas and voices, and become less vulnerable to acute episodes. But this is another story.

Ken: In the original interview I asked you about your theory on health/normality. In response, you said:

> *I think that all theories of health and normality are somewhat problematic because, regardless of their origins, they all wind up specifying lives and relationships, and all are entered into, albeit mostly inadvertently, in the service of subjugation. It is not possible to have a theory of normality without a positivist view and a utopian notion, and I do not believe that this can be sustained. A brief reflection on the history of ideas of health/normality is very discouraging of these ideas.*

So the work that you are talking about stands outside of most of the established conceptions of health and normality?

Michael: I believe that it does. But in some ways it is very helpful for us to know what the ideas and the practices of these notions of health and normality are. Upon identifying and clarifying these ideas and these practices, as well as the purposes to which they are put, people find themselves in a better position to determine possibilities for resisting what these notions incite them to do to their lives.

This knowledge also makes it possible for us to join with people in an exploration of those aspects of their life that they might be able to appreciate but that don't fit with these notions of health and normality. As some of these aspects become more visible to people, and as they become more embracing of these aspects, they are more able to honour their refusal to subject their lives to the ideas and practices that are informed by dominant notions of health and normality.

Ken: What is so important about the identification of and the honouring of this refusal?

Michael: Many of the people whom I meet who have a history of "schizophrenia" perceive themselves to have failed rather spectacularly in their attempts to be a person; that is, in their attempts to approximate the ways of being that are informed by dominant notions of health and normality. Other people in the community perceive this to constitute failure as well, and thus contribute to the sense of otherness and the marginalisation that is so keenly experienced by people who have histories of "schizophrenia", "manic depressive illness", and so on.

In response to all of this, many people who have psychiatric diagnoses wind up missing out on the small grant of moral worth that is accorded to others in our communities, and, as well, they give themselves a particularly hard time over not "making it". As if this isn't stressful enough, they so often go on to subject themselves to a great deal of pressure in their attempts to craft their life according to what these notions of health and normality specify. They wind up perpetually "stretched". These are the sort of circumstances that are favourable to acute episodes.

Ken: In some ways, we all get caught up in evaluating our lives on healthy/sick, normal/abnormal continuums.

Michael: Yes. But many of us have a much greater chance of approximating those ways of being that are defined as healthy and normal than do others. Many of us are relatively successful at torturing ourselves into a state of "authenticity" and, in so doing, reproducing the "individuality" that is so venerated in this culture - although we all secretly know that we are not quite as together in regard to all of this as we appear to be to the world. But, psychotic expressions present an anathema to those cultural ways of being that we refer to as "self-possessed", "self-contained", "selfactualised", and so on. Psychotic experience, in this culture, rules people out of contention in the stakes for the achievement of personhood.

Ken: So you have talked about working with people in the honouring of the aspects of their life that they can appreciate and that don't fit with the dominant notions of health and normality. You have also talked about the importance of interpreting these aspects in ways that make it possible for them to be read as forms of refusal or as acts of resistance. Does this reopen the "stakes for personhood" as you would say it?

Michael: Yes it does. Stakes in the achievement of alternative versions of what it means to be a person.

Ken: Do externalizing conversations come into this?

Michael: They do. For example, the various ideas and practices that are associated with dominant notions of health and normality can be externalized as "expectations" and "ambitions". The requirements of these expectations and ambitions, their various incitements, and, as well, the terms that they dictate for people's lives, can be explored. This enables people to separate their lives and their identities from these ideas and practices, and opens space for what had previously been interpreted as failure to be reinterpreted as resistance or protest. In breaking their lives from those ways of being that are informed by dominant notions of health and normality, people experience a freedom to explore other ways of being in the world.

Ken: Having this kind of freedom to explore other ways of being would probably reduce a lot of stress in these people's lives - and maybe even their vulnerability to future acute episodes.

Michael: Very significantly.

Ken: These externalizing conversations are generated through a process of questioning?

Michael: Yes. This questioning process is maintained throughout this work, even in relation to those events that people read as progress. For example: *Are you doing this at a pace that suits the expectations, or at a pace that suits you?*

Ken: In *Narrative Means to Therapeutic Ends*, you and David Epston provided many examples of therapeutic letters and other documents that assist people to re-author their lives according to preferred stories. Do you use letters and documents in this work as well?

Michael: Most certainly. In times of stress - when we find ourselves under significant duress when facing situations of adversity - we are all vulnerable to being separated from our knowledgeableness. At these times, we often experience a dearth of creative responses to the situations we find ourselves in; our usual problem-solving skills don't seem available to us, and our options for action seem to evaporate. Our focus of attention can become very narrow, we can begin to lose our sense of identity and, at times, when the stress that we are subject to is particularly acute, we can undergo something akin to paralysis.

Now, those people who have experienced psychotic episodes are ever so much more vulnerable to being dispossessed of their knowledgeableness and their preferred sense of identity at such times. And it is this dispossession that sets the scene for the experience of great personal insecurity and distress, and for further acute episodes. So it makes a great deal of sense for these people to carry with them, at all times, documents of their identity. These are documents that they can consult under those circumstances when they are losing sight of their knowledgeableness, when their sense of identity is at risk.

Ken: What do these documents look like?

Michael: There are many aspects to these documents, and many possible forms. Such documents can include some historical account of the person's ability to intervene, on his or her own behalf, in his/her own life. This is an account of personal agency, an account that emphasises what could be called the person's "agentive self". It includes details about what the person has been up against in the performance of this personal agency, and, against this background, emphasises the significance of any more recent steps that the person has been taking toward having more to say about how their life goes.

These documents are grounded in hope; for example, they often include details about the sort of personal qualities and other characteristics that were available to the person in the earlier years of their life, and speculation about how, when, and under what circumstances these might resurface in the service of the person's own plans and goals. These documents can also include details about any recent developments in the person's problem-solving skills.

Because other people's responses to the sort of identity claims that are reflected in these documents are of critical importance, those people who might provide an appropriate audience to this alternative account of the person's identity are specifically referred to in these documents. This is achieved in a way that is less likely to leave the response of this audience to chance - the wording is put in such a way as to invite acknowledging responses from this audience.

These documents are ever available to the person to consult, and are particularly valuable to them at times of stress and during crises. These are the times at which the person concerned is at risk of being dispossessed of their knowledgeableness. To facilitate this consultation, these documents usually include a self-referencing paragraph, one that further disempowers the voices through exposé, and one that invites the person to respond to crises with further revisions of their relationships with their voices. But this is not all, and perhaps I could here include an example of one of these documents.

Bev gave permission for this document to be reproduced here on the understanding that this might contribute to possibilities for others who experience voices. As she would be interested in feedback about whether

Document of Bev's Identity

In the past week, in the face of great odds, Bev was able to hang in, and, in confronting a great challenge, she found the resources to rise to the occasion. In this way she eventually got the upper hand, and reclaimed the territory of her own life. For passing this significant test, Bev gave herself six out of ten, Michael gave her seven out of ten, and Rosie gave her seven out of ten (Bev had requested this assessment).

Upon reflecting on this achievement to determine what sort of personal qualities Bev was depending upon, those of PATIENCE and STRENGTH came immediately to mind. These qualities have been available to Bev historically, and she has relied upon them to see her though difficult times. The fact that they are resurfacing now is cause for celebration.

There were other qualities that were available to Bev historically, and these include FORTITUDE, COURAGE, RESILIENCE, and STAMINA. It could be expected that these will also resurface and that Bev will be able to put them to work in further challenges to the fake authority of the voices. All of the qualities mentioned so far would be appreciated by Bev's mother, father, and two sisters.

In addition to this, recent events suggest the development of some entirely new personal skills. These are in the area of REACHING-OUT, SELF-APPRECIATION, and SELF-EMBRACING. Bev's mother and her sisters would be delighted with this news, and would recognise the significance of this personal achievement.

There are developments that also suggest that Bev is breaking from the grief that she has held for so long in relation to her father's death. This is significant because she realises that her father's image should be important, but that it should not dominate her life.

Because the truth is very disempowering of hostile voices, whenever they try to hassle Bev she will read this document to them. This will confront them with their deceit and the petty nature of their claims, and will provoke them to take a back seat in her life.

this turned out to be the case, if appropriate, readers of this transcript might consider writing to her, c/-Dulwich Centre.

This document of identity was shaped by Bev's requirements, and they do not always take this form - for example, they can be set out in a series of points.

Ken: You said that these documents are always available for consultation?

Michael: Yes. It is not uncommon for the people who consult me to carry several documents of this sort on their person at all times. This way, they are ever available to be consulted. This considerably alleviates people's anxiety in the face of the trials and tribulations of everyday existence, and renders them less vulnerable to acute episodes.

Ken: It seems that a lot of the ideas and practices that you are talking about here would really help reduce the possibility that people will think of themselves as failures. They have on-hand written proof of an alternative story of their lives. Still, I wonder what happens when they are in such an acute crisis that hospitalisation is needed. What then?

Michael: You are right about the emphasis that I place on reducing the possibility that people will perceive themselves as failures. In our culture, the opportunities to experience failure are boundless and are ever-available. And, as already discussed, some people are more vulnerable to this than others and, for them, the experience of failure very significantly increases their vulnerability to what is often referred to as relapses. This has devastating consequences to their quality of life and to their course in life generally.

In the light of this, it makes sense for us to make it our business to ensure that the contexts of our work are structured to reduce the possibility that people might read failure into their responses to the world. This should be as true for the context of hospitalisation as it is for any other context. Unfortunately, however, the receiving frame that is in place for most admissions to psychiatric hospitals is one that reads the events that precipitate hospitalisation as regress. People are admitted as a result of having "breaks", because they are "decompensating", and so on. Upon admission to hospital, the events of people's lives are interpreted in ways that give rise to mostly negative connotations. To interpret the crises that precipitate admission to hospital as regress contributes significantly to despair, demoralisation and, of course, to distress - for those people who are being admitted, and for those who are in family, kinship, and friendship networks. Relatives and friends often experience feelings of inadequacy over not having "done better" in supporting the person who is admitted to hospital, and it is not at all unusual for them to experience substantial guilt at these times. As well, the negative connotations that are associated with hospital admission fuel, for everybody concerned, a sense of hopelessness about the future, and a personal dread that is based on predictions about the draining nature of the experiences that they have ahead of them in their relationship with the person who is being admitted. So, interpreting the crises that precipitate admission as regressive has profoundly negative effects on the lives and the relationships of all concerned.

Ken: But in proposing an alternative story about admission to the hospital, you are not suggesting that hospitalisation be understood as something to celebrate, are you?

Michael: No, definitely not. And at these times of crises it is important that people's distress be appropriately acknowledged. But I believe that the sense of failure, and the associated experiences of despair and demoralisation that are so often the outcome of these sort of admissions to hospital, are far from inevitable. In fact I believe that these experiences are mostly avoidable. We can establish different receiving frames for these admissions, ones that inform alternative interpretations of the crises that precipitate admission, ones that shape more positive outcomes for all involved - ones that undermine the possibilities for people to experience despair, demoralisation and a sense of failure under these circumstances.

So, it turns out that while people's experiences of distress associated with the events leading up to hospitalisation, and over the hospitalisation itself, can be powerfully acknowledged, the meanings associated with such admissions are open to negotiation. In fact, regardless of the situation, these meanings are always negotiated, and the particular meanings that are derived from this have an entirely significant effect on the outcome.

Ken: What is an example of one of these alternative receiving frames that you are referring to?

Michael: The "rite of passage" metaphor provides such a frame[1]. My understanding of this metaphor is derived from the work of the anthropologists van Gennep (1960) and Turner (1969). According to this work, there are three phases to the rites of passage that facilitate transitions in life. These are the "separation" phase, the "liminal" or "betwixt-and-between" phase, and the "reincorporation" phase.

I don't believe that this is the place to review in detail the work of these anthropologists, which is mostly about the structures that facilitate transitions in people's lives in traditional cultures. So, I will restrict myself to just a few comments about their rite of passage metaphor.

According to this metaphor, the first phase of a rite of passage facilitates, through communal ritual process, a novice's separation or detachment from a particular status and location in the social order - or, if you like, from a particular "state" of life. In the second phase, the novice enters a space that is between known worlds, one in which nothing is as it was, one that features a primary condition of ambiguity, one in which considerable confusion and disorientation are to be experienced. Everything that the novice had previously taken for granted can no longer be taken so. Then, after a period of time, it is deemed that the novice is ready to rejoin the familiar world, but at a different location in the social order, one that brings with it new responsibilities and freedoms, new habits of thought and action. This is the reincorporation phase, and in traditional cultures it is marked by community acknowledgement through ceremony. The novice is a novice no longer, and has arrived at a position in life that was not

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[1] This metaphor has been employed by others for similar purposes in modifying the receiving frames for admission to residential care facilities (see Menses & Durrant 1986).

available to them beforehand. Communal acknowledgement plays an entirely significant role in the confirmation of, and authentication of, the new identity claims that are associated with reincorporation.

If we were to take this metaphor as a receiving frame for hospitalisation, then admission would be renamed discharge, and discharge would be renamed admission. At the point of hospitalisation it can be assumed that the person is being discharged from a particular status or location in the social world that was no longer appropriate for them to occupy, and this would inform a series of questions about what the person might be separating from in terms of expectations, roles, responsibilities, duties, obligations, habits of thought and action, affiliations, particular circumstances or conditions of life, etc. - that, for whatever reason, are no longer appropriate or acceptable. As stress is a significant feature in the precipitation of acute episodes, then many of these questions can be oriented to the identification of what might have been stressing of the person's life, of what had been stretching them beyond what was appropriate for them.

Questions of the sort that I am referring to here can be addressed at a meeting of family and friends around the time of admission. At times, the person who is undergoing the acute crisis is not able to be "present" for such a meeting, and in these circumstances the speculative responses to these questions can be checked out with the person at the point at which they become more "available".

Ken: I would guess that the rite of passage metaphor as you use it here could make a significant difference in the way that people might understand their hospitalisation and "inpatient" phase.

Michael: This metaphor provides for a reinterpretation of the confusion and disorientation that is almost routinely experienced by people at these times of crisis, for it proposes that the "inpatient" phase is a liminal or betwixt-and-between phase. People can come to an appreciation of the fact that there is always some distance between the point of separation from something, and the point of arrival at something else, and that in this space it is only reasonable to expect a very considerable degree of confusion and disorientation. Within the context of this receiving frame, these experiences cease to be read as regress, but as the virtual inevitable outcome of journeying to a new place in life.

To facilitate this reading of experience during the period of admission, staff can spend time with the person and members of his/her kinship and friendship networks over (a) further speculation about what the person might be separating from, (b) what circumstances of life might be more suitable for him/her and more favourable to quality of life, and (c) the investigation of any clues that might provide some thoughts about the ways of life that might be available for the person to step into at the completion of this particular transition.

Ken: And I suppose that the discharge from hospital would be the "reincorporation phase"?

Michael: Yes. Family, friends, acquaintances, staff, and so on, can be invited to another gathering which is described as the re-admission meeting. At this meeting, an opportunity is provided for the person to speak as an authority on their own life and to give an account of their journey, one that includes information about what this has clarified for them in regard to the circumstances of life that would favour quality of life, and that would suit them better personally. In this context, the others who are present are encouraged to respond in ways that are acknowledging of the person's status as an authority on his/her life, of the person's knowledgeableness. As well, all of those present at these gatherings are encouraged to explore any alterations that might be necessary in their relationships to the person in order to accommodate these changes.

Ken: How does this affect the course of hospitalisations that many people are going through?

Michael: On those occasions that I have been able to structure this sort of receiving context, which is nowhere near as often as I would have liked, it has definitely had the effect of reducing the length and number of hospital admissions. But the sample is small, and I have not had the opportunity to follow this up further in recent years.

What is most important about establishing this alternative receiving frame is that people learn to read their experiences of distress and confusion differently. And this even makes it possible for them to respond differently to their milder experiences of psychotic phenomena - those that do not precipitate hospitalisation. These experiences come to signify a liminal phase that opens the possibility for people to take further steps to determine a lifestyle that would suit them. This very significantly undermines the despair, insecurity, and panic, which are all complicating in the sense that they intensify the psychotic experience. In the place of this despair, insecurity, and panic, we see the development of a certain sense of curiosity about the outcome of the transition, and of the sort of hope that helps people through these crises.

Ken: What about future hospitalisations? Would they tend to undermine the validity of this rite of passage metaphor?

Michael: Not if these are predicted, which they reasonably can be. The idea that life is comprised of a series of transitions is not at all novel in our culture. And it can be openly assumed that the people who have experienced hospitalisation in a context that is informed by the rite of passage metaphor are likely to go through further transitions marked by the phases of separation, liminality and reincorporation. And if the circumstances of these hospitalisations are favourable, this turns out to be not such a bad context for the negotiation of these liminal phases of a person's life.

So, when people have a history of many and frequent admissions, at times it makes lots of sense to sit down and talk with them about the wisdom of scheduling future admissions in advance of psychotic episodes. This scheduling can be determined by reviewing previous admissions to determine the average time elapsed between admissions, and by bringing the scheduled admission ahead of this by a slim margin.

Ken: So, what happens during these subsequent admissions? How are they structured?

Michael: In exactly the same way as those we have already discussed. The admission is seen as an opportunity to take time out to review one's life to determine which aspects of it might be incompatible with those ways of life that the person is most suited to. This provides for people the opportunity to identify what circumstances of life might be stressing of them, and which of these circumstances they might be ready to break their lives from.

Ken: So this doesn't mean that the person winds up being hospitalised more often?

Michael: The therapeutic practices that we have been reviewing throughout this interview all have the potential to reduce admissions to hospital. And this is no less true for the practice of scheduled admissions that I am describing. The sort of admissions that I am proposing actually work against acute episodes. And, as people experience fewer disabling episodes, they begin to modify the schedule by reducing the length of admissions and by stretching the interval between admissions.

Ken: How realistic is it to believe that institutions like psychiatric hospitals are going to be interested and able to do what amounts to turning their procedures upside down?

Michael: I think that the potential to achieve this is significant. There are many administrators and clinical directors out there who are looking for some viable alternatives to the established practices of hospitalisation, alternatives that are likely to contribute to the quality of life of the people who are the recipients of their services, and alternatives that are likely to deal with the high levels of malaise and demoralisation experienced by the staff of these institutions.

Ken: In this country [USA] insurance companies are having a lot more to say about treatment generally, including hospital admissions and the length of admissions. What happens to the possibilities to practice what you are suggesting under such circumstances?

Michael: I don't really know enough about the "ins" and the "outs" of what is happening here to comment much. Obviously what I am proposing here could be as much in the interests of insurance companies as it is in everybody else's interest. But I don't know how well wisdom sits with insurance companies.

Ken: Throughout this interview, your responses to my questions have conveyed a strong sense of the possibilities that are available to mental health professionals in this work. But what are the options for mental health professionals who want to take up the sort of possibilities that you have outlined in this interview, but who do not have the backing of their institutions, and who are not in positions of significant power?

Michael: Rarely do the institutions of our culture succeed in establishing states of pure domination. Because of this, in most institutions, spaces or gaps can be found through which workers can express their moral agency. And, in stepping into these gaps, we can all play a role in the transformation of the institutions that we work for.

We can ignore the arbitrary boundaries of these institutions, and we can go out and meet with people and encourage them to draw distinctions around which ways of speaking about their lives are respectful and honouring of their knowledges, and which ways of speaking about their lives are marginalising and disqualifying of this knowledgeableness. We can join with people in developing ideas for informing the institutions of this, and for recruiting the active participation of these institutions in the further development of practices that these people consider more personally empowering. I have seen those people who are the "consumers" of psychiatric services enter into this educative role with a great deal of benevolence and empathy for the staff of the institutions concerned.

Ken: This has been rather a long interview, and perhaps we should draw it to a close. Would you like to make some parting comments?

Michael: Yes. despite the length of this interview, what we have been talking about is a partial account of this work. There are many other considerations.

Ken: Any that you would like to briefly name here.

Michael: Yes. The provision of appropriate community support to people with psychiatric diagnoses is a consideration of critical importance. For those readers who want to review this dimension, and who haven't yet begun, I would suggest consulting Chris Beels' "Invisible Village" (1989). It is a great starting point.

Ken: I've really enjoyed this interview, Michael. I think a lot of what you have said really challenges the ways in which so-called psychiatric patients have been labelled, shunned, categorised, written-off, and otherwise marginalised, or, in your own words, subjugated - and the use of this term gives the whole process a more political flavour - which is what you have so refreshingly brought to our attention. Thank you.

Michael: And I've enjoyed this opportunity to renew my contact with you, and to further discuss this work..

REFERENCES

Beels, C.C. 1989:

"The invisible village." In Beels, C.C. & Bachrach, L.L. (Eds), "Survival strategies for public psychiatry", Vol.42 (Summer, pp.27-40) of **New Directions for Mental Health Services**. San Francisco: Jossey-Bass.

Menses, G. & Durrant, M. 1986:

"Contextual residential care." **Dulwich Centre Review**. Adelaide: Dulwich Centre Publications.

Turner, V. 1969:

The Ritual Process. New York: Cornell University Press.

van Gennep, A. 1960:

The Rites of Passage. Chicago: University of Chicago Press.