Mediating madness: mental illness and public discourse in current affairs television

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MEDIATING MADNESS: MENTAL ILLNESS AND PUBLIC DISCOURSE IN CURRENT AFFAIRS TELEVISION.

BY
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SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY OF LOUGHBOROUGH UNIVERSITY

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Abstract

This thesis examines the public character of television and the various ways it works as communication. Drawing on a case study of recent British current affairs programmes dealing with mental health issues it explores the interplay between television form and content. The first part acknowledges television as the pivotal medium of the contemporary public sphere and situates its various organisations of language and imagery at the heart of programme makers' attempts to produce meaningful and entertaining programmes. Against the grain of those who see television as an arational technology, a case is made for its relevance as a vocal space for all citizens. However, in the historical context of British broadcasting, the differential distribution of communicative entitlements entreats us to view access to discursive space as a principle which soon runs up against its limits. The second half of this thesis explores the shortcomings of this system in relation to 'expert' and lay people's access to a public voice on mental health issues. The recent transition from the asylum to Community Care invites an intermingling of voices in which the authority of this or that brand of professional knowledge cannot be taken for granted. The re-entry of ex-mental patients into the community also provides programme makers with opportunities to promote new forms of social solidarity based on 'thick descriptions' of the person rather than the patient. The case-study presented here suggests however, that participation in televised forms of debate and argumentation does not match the promises of post-modern rhetoric. Despite the airing of new voices and the presentation of new controversies, British television's treatment of mental illness continues to revolve around established hierarchies of knowledge and a depiction of the (ex-)mental patient as less than a fully cognizant citizen. Visual techniques play a crucial role in this process. By recycling familiar images of madness as dangerous and unpredictable, people with a history of schizophrenic illness remain enmeshed in a web of psychiatric 'otherness' which undermines their credibility as speakers.
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Introduction
The roots of this thesis lie in the professional and academic experiences of two very different people. The first, a nervous, though excited, eighteen-year old student psychiatric nurse about to embark on a very ‘adult’ career caring for the mentally ill. The second, a slightly maturer undergraduate pursuing studies in media and communication. Both these figures have left an indelible mark on what follows.

Readers will perhaps not be surprised to learn that I am writing of myself. Three years training as a student nurse and one year spent as a registered mental nurse not only provided me with a ready supply of “gallows humour” about my role as a psychiatric nurse, but also a lasting interest in the social and cultural questions raised by the mentally ill and in particular their representation in the media.

Throughout my nurse training I encountered numerous criticisms within professional nursing and medical writing, as well as in general conversation with friends and colleagues, about the media treatment of mental disorder. The following example from a popular nursing text-book is not untypical: ‘The media have enthusiastically capitalised on public fear, credulity and superstition and contributed in no small way to a negative ‘mythology of madness’ which has perpetuated destructive and absurd stereotypes about mental disorder’ (Lyttle, 1986: 88). Although such comments added little of substance to my growing interest in this topic, they did help to fertilise the germ of an idea that I might one day research this issue more closely.

A year after qualifying as a nurse I began a degree course in Communication Studies. Towards the end of my second year I began to search for published work on the British media’s treatment of mental illness with a view to writing a final year dissertation on the topic. I found only one article, dating back to 1957, and
pragmatically decided to abandon the idea in favour of a 'better resourced' topic. My idea of exploring 'mental illness and the media' was postponed but not abandoned. After graduation, and with some time on my hands, a more substantial literature search on the topic again yielded little. Whilst this was frustrating the thought then occurred that here was an exciting research opportunity.

Initially, my intention was to produce a definitive analysis of mental illness representations across the whole range of British media thus heroically filling the sizeable knowledge gap I had encountered. Fortunately, the guiding hand of supervision rescued me from such lofty ambitions and oriented me towards a more sensible and manageable project. Looking back now, on those first weeks and months of research design, my eventual choice of television as the central focus for my thesis appears inevitable.

Like others of my generation, television has been a constant in my life. Throughout my childhood and teenage years, and into my adult life, my relationship with the 'box in the corner' has proved enduring. It would be hackneyed to claim that television is like one of the family but like individual members of my family, it has the capacity to make me laugh or cry, give pleasure or pain, make me think critically or sometimes not even think at all. Choosing to study television, then, pays homage to its centrality in my own life but also in the life of the nation.

Television is the popular cultural form par excellence. That it is both the nation's main leisure activity and its major forum for public debate, fascinates me. Understanding how television does what it does, how it actually communicates its myriad contents, inevitably led on to my central interest in understanding its
contrasting forms of presentation. The main aim in this thesis, then, is to pursue my fascination with the medium’s forms through an analysis of its performance as a forum for public debate about mental illness. Drawing on case-studies of the representation of mental illness within the major forms of contemporary current affairs television the thesis attempts to understand broadcast TV as both a system of signification and an organised arena of public representation.

**Television in Context**

This is a particularly interesting moment to explore this area since the last few years have seen major, and more or less simultaneous, shifts in both the television and mental health systems, and also in the relations between them. In the field of mental health, we have seen a shift from asylums to care in the community. Within the television system, we have witnessed the emergence of a ‘new populism’.

As applied to television, populism draws our attention to two trends:

1. The intensified search for ratings, prompted by the arrival of a more competitive, commercialised broadcasting environment. Coalition building in order to maximise audiences has become an even more pressing economic imperative. This has precipitated an increasing break with the varieties of paternalism associated with the ethos of public service. Programmes are now increasingly organised around what audiences demand rather than what they need. There is an accelerating shift of emphasis from analysis to entertainment.

This movement has produced a decentering of professional expertise and an increased emphasis on common sense and everyday experience. As a number of commentators
have argued, this is particularly evident in the participatory talk shows which now occupy many of the spaces previously monopolised by current affairs programming.

2. The intensification of populist television is not confined to building coalitions at the level of the viewing audience. As the talk shows illustrate, it also includes ordinary people as central contributors, and in its more radical forms, exemplified by *Video Diaries*, as producers and editors.

**Questions of Representation**

The arrival of populist television in all its variants, reopens questions around representation. In approaching this issue it is important to hold on to both the main sense of the term in English. Representation raises;

1. Questions about *social delegation* - who is entitled to speak on whose behalf? What responsibility do they owe to their constituents?

2. and, questions about *cultural forms and genres* - how should the interplay of discourses and the relations between speech and image be organised within the programme?

The rise of populist forms of representation decentres and challenges what we might call the classic forms of documentary and current affairs (strongly allied to the notion of public service and the viewer-as-citizen). Classic forms have several characteristics:

- they are problem or issue oriented
they set out to investigate not only the state of things, but their causes, and to evaluate possible interventions

the contributions of experts are therefore central

ordinary people appear as primarily raw data - they either exemplify a problem or are cast as victims.

In contrast, populist forms:

centre on the articulation of everyday experience. They are built around first-hand testimony

experts are either absent, marginal or denigrated.

Populist forms of television offer descriptions of experience - of varying 'thickness' - but they usually provide little or no analysis. They invite viewers to share an experience (to identify with the speaker) but they do not provide formal certificated knowledge or mobilise political evaluations. As a number of critics have argued, this presents problems for television's role as the central institution within the contemporary public sphere.

Mental Illness in Context

The move towards populist programming within television has coincided, in Britain, with a major shift in the organisation of the mental health system - from asylums to community care. By altering the discursive field around mental health in important ways, this development has presented programme makers with a range of new
challenges and opportunities. Not only are those involved in community-based mental health care more accessible than the personnel of the old asylums the mentally ill themselves are also more visible and publicly vocal than they were. They can be talked to and talk for themselves in a variety of settings.

At the same time, mentally ill people present a unique conundrum for programme makers not shared by any other minority group lobbying for greater access. In the case of schizophrenics for example, their claims to speak authoritatively about their experiences are substantially undermined by the dominant public perception of them as 'unreliable' witnesses, subject to hallucinations, delusions, 'flights of fantasy' and violent tendencies. This prevailing image of the mad as unable to advance a 'rational' or competent argument poses problems for populist television's attempt to construct programmes about mental illness and mental patients around first-hand testimony.

*Mental Illness and Populist Television*

The more or less contemporaneous shifts in the television and mental health systems invite consideration of the terms on which mentally ill people are given a public voice. In order to address this issue, the thesis presents detailed exploration of 'classic' forms of current affairs television alongside more recent populist forms.

Populist television appears, in principle, a suitable arena for housing first-hand testimonies about the experience of mental illness and community care. Free from the dead weight of paternalism, so the argument goes, the potential is that a *process of recognition* might ensue in which mentally ill people speak, not as illustrations of medicalized deviance, but as citizens of the wider national community. At the very
least, one might anticipate that certain forms of populist television (such as Video Diaries) herald a more relaxed encounter between ‘rational society’ and those historically and culturally defined as ‘irrational individuals’.

However, populist television also generates concern about the place and function of expertise in public debate. Certainly, paternalism’s established hierarchies of insight and knowledge appear squeezed by the promotion of vernacular discourses. This generates problems vis-à-vis populist television’s ability to underwrite viewers’ rights to knowledge about mental health related issues. Together, the re-organization of the mental health system, and the shift towards populist forms of public representation, generate uncertainty about the role of analysis and explanation in public debate about mental illness. How this problem is handled both within and across a range of current affairs programming forms a substantial component of the second half of the present thesis.

An Outline of the Thesis

Underpinning this study of television’s performance as a public forum is the core assumption that for all its inadequacies and failures, the medium has significantly contributed to democratic public life. The first chapter builds on recent debates in social theory concerning the conditions of public debate in the contemporary world, paying particular attention to the influential Habermasian ideal of the bourgeois public sphere and the limitations this dialogical model presents for an adequate understanding of television as a public forum for organising discourse and imagery.
Following a discussion of TV documentary’s attempts to re-present knowledge and truth, the chapter goes on to explore radical objections to the medium’s representational practices. The work of Baudrillard and Postman serve as important illustrations of a recent tendency within critical theory to downgrade and distrust television as a space for reordering discourse and images. The chapter rejects such criticisms and makes a case for acknowledging public broadcasting as a significant cultural achievement which, in principle, allows all citizens access to a public voice.

The theme of the citizenry’s access to a public voice is taken up in Chapter Two. Here, we outline the general principles of public service broadcasting and link them to the current tendency within media studies which views public broadcasting as the modern embodiment of the public sphere ideal. The chapter interprets the history of professional programme making within the British public broadcasting system as a progressive opening up of opportunities to access a common discursive space.

At the same time, the chapter also explores the difficulties of constructing a public voice. It is argued that professional notions of how best to organise public discourse has resulted in a constant struggle over what constitutes a fair and equal distribution of communicative entitlements. The chapter explores the long-standing tension between ‘access’ and ‘exclusion’ firstly within radio and, later, television. It concludes by exploring the rise of populist programme forms and the discursive opportunities they give to marginal or excluded voices.

Chapter Three traces the rise of modern psychiatry against the backdrop of the movement from asylum systems to the current ascendancy of multi-disciplinary, community-based, care. The controversial nature of the psychiatric enterprise
provides an essential backdrop to understanding the competing medical and social models of mental illness mobilised in public discourse.

The lack of consensus surrounding the meaning of ‘mental illness’ finds its apotheosis in the disputes around the concept of schizophrenia. The chapter considers the long-standing opposition to this most contested of medical categories. This acts as a prelude to a broader discussion of other contested issues within the contemporary mental health field, including: the provision of community care; the labelling of voice hearers as mentally ill; the use of drugs to treat mental disorder; and racism in psychiatry.

The aim of the fourth chapter is twofold. It seeks, firstly, to locate contemporary media representations of madness within the general Western artistic tradition of portraying madness as radical difference and the mentally ill as ‘others’, set apart from ‘normal’ society. Secondly, it provides a bridge between the general issues raised in the first part of the thesis and the specific case-studies of contemporary television’s organisation of discourse about mental illness which follow. The chapter develops a number of methodological points about qualitative cultural analysis and argues that television programmes are distinct cultural forms and should be analysed as such. It concludes with a synopsis of the individual programmes, which are analysed in detail in the chapters which follow.

Chapter Five presents an analysis of the ways that television current affairs programmes mobilise and relate to the voices of psychiatric expertise. It starts from the reorganisation of community-based mental health services which has, it is argued, helped decentre the psychiatric profession as the sole source of relevant expertise and
authority on the causes and treatment of mental illness. It then explores how far different forms of actuality programming accept or reject a traditional 'hierarchy of expertise' in which medical knowledge is placed at the top.

Drawing on examples from a range of contrasting programmes the chapter shows that a plurality of expert voices are given an opportunity to speak. By paying attention to the mediating role of programme form and formats, the chapter explores how competing discourses of expertise are granted credibility and precedence both within and across particular programmes. While there are any number of people with strong claims to “know about” mental illness, the chapter seeks to argue that the regulating impact of a programme’s form is the crucial factor in determining who is (or is not) defined as an ‘expert’.

Chapter Six advances the argument that those with a diagnosis of schizophrenia are still perceived within the frame of mental patienthood despite their return to ‘the community’ and their reinstatement as ‘ordinary’ citizens. It tests this proposition through a detailed analysis of the terms on which schizophrenics are given a voice within the current affairs programmes chosen for detailed study.

The chapter illustrates how a range of contrasting current affairs formats give voice to the schizophrenic experience. However, it also reveals how, in giving public accounts of their experiences, they are often rendered vulnerable to censure and disapprobation.

Chapter Seven argues that the key to understanding television as both a significatory system and a forum of public representation lies in the shifting relations between speech and image. Focusing on the visual depiction of madness in the case study programmes, the chapter explores the continuities between traditional iconographies
of madness and contemporary television. The chapter shows how long standing representations of madness as 'difference' are recycled by programme makers thus helping to undermine the credibility and competence of schizophrenics when they are given a public voice.

(Re-)Constructing Public Voices: A Reflexive Issue

Throughout this thesis the notion of a 'public voice' is very much to the fore and (as just outlined) the three core chapters explore in detail how the public voices of mental health professionals and their patients are managed within the television system. But amongst the plethora of voices presented one voice remains elusive. My own. With psychiatry's transition from the closed, secretive, world of the asylum, a wide range of actors have emerged to tell their stories of psychiatry's past, present and possible future. I am no exception. This thesis aims to tell a story concerning how the public voices of those with specialist knowledge and/or grounded experience of mental illness are presently treated by programme makers. In order to tell this story I have necessarily established myself as a voice of authority within the text. In other words, I have become an authoritative interpreter of other people's authoritative interpretations of psychiatry and mental illness. In order to achieve my goal I have selected extracts of testimony and visual images that best suit my own argumentative and rhetorical interests.

Consequently, my analysis is not neutral. In this it is not alone however. By drawing attention to the constructed nature of my argument I hope to highlight the constructed nature of all arguments, including those arguments whose construction within the television programmes under consideration here form the core of this thesis. I refer
not simply to the arguments of those whose testimonies have been directly presented here, but to the arguments of those programme makers whose work I have chosen to analyse. As a former nurse with an academic interest in television's representation of social issues I am very aware that I have a particular stake in making sense of how television makes sense of mental health issues.

The problem of reflexivity reminds us that all attempts at understanding are an expression of our preconceptions every bit as much as it may contain (we hope) a kernel of truth. Writing about other people's writings about the experience of madness, Roy Porter (1987: 233) wisely notes that there is no definitive reading of a text: 'Texts', he says, 'are up for grabs. I have offered one interpretation. I must leave my interpretation to the interpreters, my analysis to the analysts'. With genuine thanks to Porter, I propose to do the same.
Chapter 1

Television and Public Discourse
Television and Public Discourse

Introduction: The Communicative Character of Television

Television has become, for better or worse, the pivot of the public sphere in contemporary society. Underpinning its centrality is its ability to communicate, something, anything, to those viewing. This is both simple and complex. Of course television "communicates". This is its function. That is what it does. But how television works as communication, how it addresses its audiences, is a matter of interest since it is the basis of the medium's social, political and cultural power. It is the meaningful organization of words and images into programmes that are both listenable to and watchable that drives our desire to engage with its output (Scannell, 1996). Consequently, enquiring into the communicative character of television is crucial for understanding the nature of the contemporary public sphere. Through a formal analysis of television's particular organisations of signification we can begin to come to terms with its significance as a medium of 'public communication' and a key resource for common knowledge and discussion.

Unfortunately, the analysis of television as a communicative medium has tended to take second place to debate about 'television as ideology' or 'television as social control' within media and cultural studies. These perspectives have tended to homogenise television, as in statements which begin: "television is..." or "television causes...". As Scannell (1992: 339) points out, 'The effect of this approach is to read off all the output of... [television] as if it works in the same way, as if there were no difference between the 'discourses' or 'practices' of news, documentary, drama or entertainment'. One possible explanation for this is the sheer ubiquity of television, its taken for granted presence (and pleasure) in everyday life. In contrast, the present work emphasises the variety of televisual forms and genres and sets out to explore the
differences in the way they organise available discourses and systems of visual representation taking recent debates on the care of the mentally ill as a particular focus.

The study of television as communication is part of a wider theoretical concern with understanding the discursive practices of contemporary society, including their performative aspects in general and television discourse in particular.

Nowhere have these issues been more strongly contested than in the ‘debate’ between Jurgen Habermas and Jean-Francois Lyotard concerning the status of knowledge in the modern/post-modern era. What is at stake here is nothing less than the possibility/impossibility of arriving at a ‘successful’ outcome of communication-in-practice in which interlocutors arrive at some consensus on ‘knowledge’ and ‘truth’, however provisional.

Lyotard: The Post-modern Condition

Lyotard’s analysis of the condition of knowledge in contemporary capitalist society, advanced in his seminal book The Postmodern Condition (1986), distinguishes strongly between ‘narrative’ and the ‘scientific’ modes of thought. While the former embraces the legitimizing function that myths and stories have played in giving meaning and significance to our lives, the latter rests solely on appeals to the ‘facts’. According to Lyotard (ibid: 29) this appeal is doomed to failure since ‘scientific knowledge cannot know and make known that it is the true knowledge without resorting to that other, narrative, kind of knowledge, which from its point of view is no knowledge’. In making this argument Lyotard signalled both his rejection of Enlightenment social theory and philosophy, and his abandonment of the
'metanarratives of modernity' including the 'progressive spirit of understanding' and 'humanity as the hero of liberty' (Silverstone, 1986).

Instead of delivering progress, the metanarratives of modernity (Reason, Science, Wealth, the Proletariat) have, Lyotard argues, legitimated everything 'from war, revolution, nuclear arsenals and concentration camps to social engineering, Taylorism, Fordist production models and the Gulag. The collapse of faith in these meta-narratives heralds what he calls the 'post-modern condition' (Hebdige, 1989: 79). More pointedly, he sees metanarratives as terroristic attempts to impose a unitary meaning or truth on societies whose dynamic and constantly evolving character eludes such attempts at 'total' comprehension. For Lyotard 'it is sufficient simply to point to the dark deeds of the 20th century, in particular the bloody acts of Fascism and Stalinism, in order to blacken the entire Enlightenment project' (Dews (ed.), 1986: 27).

Lyotard's definition of post-modernity as 'incredulity towards metanarratives' supports a celebration of fragmentation and plurality, and sees the field of contemporary knowledge as characterised by heterogeneous claims, in which science is no longer guaranteed a privileged place. Underpinning this perspective is a comprehensive rejection of the Enlightenment concept of reason and of the 'unities' of representation, of meaning, of theory, and ultimately of the self. Lyotard's post-modernism is above all an assault on unity and totalisation and a turn towards 'local' factors or explanations.

Lyotard goes on to suggest that the metanarratives of modernity have been caught up in this shift and are now 'irreparably fragmented into a multiplicity of "language-games" whose truth-claims are localised, and which are played with an ironic
consciousness of their relativity' (Dews, 1986: 68). By drawing on the Wittgensteinian notion of the 'language game', he attempts to counter the coercion that he sees inherent within critical theory's search for systematicity and universality - a position he identifies with Habermas. In contrast, the notion of the language game offers a vision of society as unstable, heteromorphous and dispersed.

For Lyotard, knowledge is always produced within particular 'discourses' targeted at specific audiences each of which have their own criterion of accreditation. As Boyne and Rattansi (op. cit.: 18) make clear:

in discussing post-modern science as 'the search for instabilities', Lyotard suggests that social development in the post-modern epoch... will be a pragmatic matter of inventing new rules whose validity will reside in their effectivity rather than in their compatibility with some legitimating discourse.

His concern with the "what happens" of language reveals an emphasis on communicative performance. The legitimacy of knowledge no longer lies in outdated or defunct metanarratives but in the 'agonistics', the rhetorical jousting, of interlocutors within localized contexts of interaction.

For Lyotard, the domination of science is no longer sustainable in an age that recognises no agreed criteria of justification in any sphere of human knowledge. Rather, it becomes one discourse amongst many. His aim is to go beyond a modernist reliance upon 'expert' testimony and to look instead towards difference and a toleration of the irreducible plurality of local narratives, whose survival owes less to some generalisable notion of 'truth' and more to a pragmatic ability to certify themselves as true through their effectivity in actual speech situations. This desire to
Television and Public Discourse

take difference seriously is acknowledged as one of post-modern theory's greatest strengths (K. Thompson, 1992).

Habermas: in defence of modernity

In a project spanning nearly four decades Habermas has emerged as the foremost defender of the Enlightenment legacy. His defence rests upon a truly massive research undertaking unrivalled in post-war social theory. He offers a critical theory which has as its aim nothing less than the re-structuring of social institutions so as to maximise the scope for what he calls "rational collective will formation". The problems which he grapples with are of major importance since they concern the vitally important questions of collective decision-making and the establishment of a common political will. His critical theory raises the central problem of how to establish within the fibres of civil society, channels of communication that are free from both market and state interference and which are guided only by a democratic commitment to the 'public good' (Tomlinson, 1983).

Habermas has pursued the idea of communicative rationality in an attempt to overcome the theoretical impasse experienced by the early Frankfurt School theorists in their attempt to adapt Marxism to the predicaments of twentieth century culture (Held, 1976). Adorno and Horkheimer were concerned with confronting what they saw as the 'degradation of reason'. Far from being a critical tool in the service of humanity, reason had become, in their view, a central source of domination - an 'instrument' - in the service of capitalism. A major criticism of this position is that they painted themselves into a theoretical corner from which no practical emancipatory project could develop. In response, Habermas sets out to provide not
only a critical understanding of the repressive dimensions of instrumental reason, but to suggest ways we might overcome it and develop an emancipatory dynamic.

He begins this task with a consideration of language as the unique and universal medium of human social life. This is summed up in the following passage from his inaugural lecture which has guided his theory of communication ever since:

The human interest in autonomy and responsibility is not mere fancy, it can be apprehended *a priori*. What raises us out of nature is the only thing whose nature we can know; Language. Through its structure, autonomy and responsibility are posited for us. Our first sentence expresses unequivocally the intention of universal and unconstrained consensus (Habermas quoted in Tomlinson 1983: p. 78).

According to Habermas, the very fact we are language users means we are able to reach an understanding with other people. However, in his view, as capitalist society has developed so communication has become colonised by a ‘technical interest’ which unfolds through work and instrumental action, and in particular, the development of technology. In order to control this dynamic it is necessary that people communicate with one another, generating what Habermas calls the ‘communicative interest’. In his view however, the communicative interest has become marginalised within late capitalism, which is problematic since the purpose of the technical and communicative interests he argues, is to enable a third interest - the emancipatory interest - to emerge, the goal of which is the achievement of the “good life”, free from domination. Following Marcuse’s critique of ‘one-dimensional society’ (Marcuse, 1964) Habermas argues that the technical interest, which should
function in the best interests of society, has been commandeered by the pursuit of profit for its own sake and operates instrumentally.

While Habermas's basic concerns are clearly indebted to his intellectual forbears in the Frankfurt School, he is also critical of them. He believes that because the tradition of critical theory instigated by Adorno and Horkheimer neglected the communicative and emancipatory interest, it produced a one-sided account of contemporary society. According to Habermas, their desire to focus critical attention on instrumental reason led them to operate with a skewed conception of rationality. Habermas seeks to address this imbalance by asserting the primacy of the communicative and emancipatory interests. Indeed, for him, the emancipatory interest is inherent within the communicative interest. The cornerstone of his theoretical model is the distinction he makes between instrumental rationality and communicative rationality. It is the latter concept, grounded in an appreciation of 'negotiated intersubjectivity and normative thinking' (Dahlgren 1995: 99) that connects him securely to the positive foundations of the Enlightenment project and places him in opposition to the post-modern analysis offered by Lyotard.

Habermas's opposition to Lyotard is grounded in his theory of communicative action. This is designed to be both a universally valid account of the conditions of meaningful social interaction and a yardstick for measuring the performance of social interaction free from the distorting and paralysing effects of power. The guiding idea is that consensually regulated conflict is the highest developmental phase of societal learning. Drawing on the speech act theory of Austin and Searle, Habermas has sought to give substance to the consensual nature of speech acts:
Every speech act... involves certain validity claims, which express the speaker's intentions to be understood, to tell the truth, to do so sincerely, and in an appropriate manner. The objective of any speech-act is to come to an understanding, that is, 'to bring about an agreement that terminates in the intersubjective mutuality of reciprocal understanding, shared knowledge, mutual trust, and accord with one another' (Callinicos, 1983: 142).

Extending a paradigm offered by Chomskian linguistics, Habermas has elaborated what he calls a 'universal pragmatics' the task of which is 'to identify and reconstruct universal conditions of understanding' (Habermas quoted in Tomlinson, op. cit.: 76). Universal pragmatics aims to define the terms for 'communicative competence'. This involves the negotiation of 'validity claims' concerning: the truth of statements, the appropriateness of what is said, the comprehendability of what is said, and the sincerity of the discursive engagement. Ordinarily, these claims are taken for granted and remain unquestioned. However, they may be taken to task by interlocutors. Once challenged, the tacit claims to truth and appropriateness must be made good in order for communication to proceed towards consensus. This model anticipates a resolution of questions/conflict even if in practice this is not feasible. That is to say, it anticipates a situation in which speech is free from coercive influence and all that prevails is the 'force of the better argument'.

The conditions for this are contained in what Habermas famously calls the 'ideal speech situation'; a situation which is characterized by its regulation of speech acts according to a general requirement of 'symmetry'. It must allow all parties an equal opportunity to initiate or interrupt lines of argument, to make or question assertions, to give or demand explanations, and to express and elicit subjective feelings and
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emotions. Like the presupposition of consensus, this is an ideal, counterfactual, situation. Nonetheless, Habermas’s point is that it functions as an optimal formal standard for discursive interaction and provides an anchor in the pragmatics of communication, for ideology critique (Tomlinson, 1983). This is underlined by Habermas’s interpretation of ideology as ‘systematically distorted communication’.

Habermas’s stress upon the primordiality of communication and its role in the regulation of conflict through the construction of consensus is for Lyotard, anathema. His opposition is predicated on his belief that ‘the connection between legitimacy and consensus found in Habermas does violence to the heterogeneity of language games’ (Holub, 1991: 140). His critique center’s on Habermas’s attempt to regularize communication as a normative ideal. By generalising his theory of a universal pragmatics and his notion of an ‘ideal speech situation’, Lyotard believes Habermas does grave injustice to the multiplicity of language games whose claims to truth are always localized. For Lyotard, legitimation is local and provisional and consists in permitting the generation of new ideas both in science and at the level of social practice. A politics based on his notion of ‘paralogy’ (the creation of new language “moves” and the interruption of consensus) ‘would respect both the desire for justice and the desire for the unknown’ (Lyotard, op. cit.: 67).

Habermas and Lyotard: consensus versus dissensus

Lyotard’s objections to Habermas’s communicative theory rests on the view that Habermas is really only offering another outmoded metanarrative of emancipation and that totalising theories are now defunct in the face of localized narratives which simply “do their stuff” (Rorty, 1985). Against this, Habermas argues that the problem posed by ‘incredulity towards metanarratives’ is one of ‘context-dependency’ that
leaves us unable to distinguish the rational from the non-rational. For him, this is unacceptable since it betrays the social hope central to liberal politics: the possibility of developing universal standards of *critique* with the aim of constructing rational proposals for change to existing institutions (Tomlinson, op. cit.). It is for this reason that Habermas disparagingly labels Lyotard a ‘neo-conservative’. Rorty sums up the difference between Habermas and Lyotard thus:

...we find French critics of Habermas ready to abandon liberal politics in order to avoid universalistic philosophy, and Habermas trying to hang on to universalistic philosophy, with all its problems, in order to support liberal politics. To put the opposition another way, the French writers whom Habermas criticizes are willing to drop the opposition between “true consensus” and “false consensus”, or between “validity” and “power”, in order not to have to tell a metanarrative in order to explicate “true” or “valid” (Rorty in Bernstein (ed.) 1985: 162).

Lyotard’s assertion that language does not contain a universalist dimension is part of a wider criticism of Habermas’s views on legitimation and consensus. According to Lyotard, ‘legitimation cannot be tied to universal consensus... because the pragmatic realm of language games is ungoverned by... pre-established rules’ (Holub, 1991: 141). The heterogeneity of localised communicative performances would be lost in speech situations where pre-established rules govern interlocutory action. Consensus for Lyotard is therefore only a particular *state* of discussion, not its *end*. Such a view is predicated on the idea that a post-modern ‘science’ should be concerned with the undecidability of utterances, the setting of limits to precision, with conflict arising from a lack of complete information and so on.
His desire to avoid the universalist stance he associates with Habermas, leads Lyotard to adopt a position that holds that truth is nothing more than an argument which convinces a given audience at a given time. By denying the possibility that we might arrive at mutual understanding and consensus formation through the argumentative redemption of validity claims, Lyotard allows the potential for a 'false consensus' to arise. Not surprisingly, Habermas's progressive liberal stance means that he is suspicious of this position. Lacking systematic notions of, for example, 'objectivity' or 'truth', such a consensus seems to him only to serve the interests of those who, to put it bluntly, can shout the loudest. In other words, it appears to serve the interests of the minority who control the material and symbolic resources of power.

At stake is the continued possibility of mounting a commitment to principled intellectual enquiry in pursuit of the 'good life' and a 'better tomorrow'. While Habermas's universalistic tendencies have been attacked even by sympathetic critics (e.g. Benhabib, 1992), his defence of the Enlightenment project has found support from those concerned that Lyotard's position advocates embracing relativism as a necessary consequence of accepting his version of plurality-in-the-world (McLennan, 1992). According to Lyotard, Habermas's cardinal error is to insist on forcing the heterogeneous character of small-scale discourses or language games into a universal mould, thereby distorting them. However, from a position broadly supportive of Habermas, Dews (1986) accuses Lyotard of a 'chronic confusion' between language games and validity claims. The confusion arises, Dews argues, from Lyotard's rejection of the possibility of their being a 'metalanguage'.

While Habermas acknowledges the existence of a plurality of language games, Dews argues that this in no way negates the possibility that validity claims can cut across
this multiplicity: 'there will be clashes of viewpoint concerning cognitive, moral and aesthetic questions, but we cannot claim that these conflicts are in principle unamenable to discussion and possible resolution' (ibid: p. 23). In fact, language games can only operate against a background assumption that interlocutors can and will redeem validity claims if challenged.

In the earlier sketch of Lyotard's objections to Habermas's theory of consensus we noted his view that it entails a 'terroristic' attempt to homogenise the essentially heterogeneous nature of language games. Crucially for Dews, and this is the point missed by Lyotard, the Habermasian notion of consensus is expressly concerned with the conditions of plurality: 'the regulation of the effects of social practices on each other in the light of the freely expressed interests of all those concerned' (Dews, op. cit.: 24). Developing this point, Holub has argued that although Habermas would admit 'on the empirical level, where pragmatics has traditionally been located, [that] there are innumerable 'games' played by rules that one cannot know in advance' (Holub 1991: 141), the crucial point is that as well as an empirical level, pragmatics also contains an implicit universal dimension; the validity claims to truth, appropriateness, comprehendability and sincerity. Lyotard mistakes these as 'metaprescriptives' governing actual utterances while Habermas regards them as anthropological universals inherent within language itself.

A second powerful criticism of Lyotard by Holub concerns the former's privileging of dissension over consensus as the motivating force behind linguistic encounters. Holub suggests that the gap between the two thinkers may not be as wide as Lyotard thinks:

When Habermas writes of the ideal speech situation and of discourse, he tends to emphasize the harmonizing dimension of his theory; but the only way in
which an authentic consensus can be achieved is by allowing all possible
dissenting viewpoints to be raised and argued (ibid: 142).

According to Holub, had Lyotard reflected a little further on Habermas's theory of
consensus he might have recognised that Habermas is not concerned with the
homogenisation of language games (or even with promoting one 'game' over another)
but with the conditions that support plurality in discourse (a position even the most
hardened of post-modernists would find difficult to grumble about). As Holub puts it,
'Habermas's theory of consensus implies and encompasses the dissension to which
Lyotard accords priority' (ibid: 142). We noted above Lyotard's confusion between
language games and validity claims. It is Holub's belief that Lyotard's post-modern
scepticism of consensus produces the self-contradiction typical of all relativisms since
he:

cannot consistently maintain an argument that seeks to convince us that
universally arguments do not aim at our consent. As Habermas points out,
there are certain unavoidable assumptions that accompany any argument, and
the propositional content... cannot contradict these assumptions. In criticizing
Habermas, Lyotard necessarily plays by certain rules that are inscribed in
language itself. Lyotard's claim concerning dissension is thus left with two
equally distasteful alternatives. Either we take the claim seriously and fall into
performative contradiction, or we do not admit that Lyotard is offering an
argument and therefore do not have to bother with assent or dissent (Holub,
ibid.: 143).

The irony of this position Dews argues, 'is intensified by the fact that it is only in the
light of the democratic and humanitarian aspirations of the Enlightenment that
Fascism and Stalinism appear in their full horror’ (Dews, 1985: 38). Consequently, Lyotard’s post-modernist position is dependent upon the hopes and aspirations of the very project it sets out to supercede.

**The Bourgeois Public Sphere**

Habermas’s concern is with the restoration of a communicative structure that will allow for undistorted communication (at least as an ideal). He wants to replace existing social institutions, in which distorted communication occurs, with a reconstructed public sphere in which participants enter into discourse on the understanding that no one has greater opportunity to speak and to be heard than another. Although this is clearly an ideal Habermas believes that in the early bourgeois public sphere we have a glimpse of the type of egalitarian space he has in mind. The salons and coffee houses of seventeenth century Europe created a space in which ‘enlightened’ (male) Europeans could critically engage in political, literary and scientific debate (Hamilton, 1992). Despite the conspicuous absence of women, the non-literate, and the poor (absences that otherwise sympathetic commentators have repeatedly drawn attention to), Habermas believes that immanent within the discursive practices of these institutions is a model for the restoration of a democratic arena for social debate.

He sees their critical potential residing in three main areas. Firstly, the social intercourse generated in the salons opened up a ‘social space’ where the authority of the better argument could preside against the established status quo. Secondly, as the anti-clericalism inherent within Enlightenment thought began to emerge so the ‘aura’ surrounding religious speakers was eroded, ensuring that the social status of participants was increasingly disregarded. Thirdly, Habermas believes that the salons
and coffee houses were in principle inclusive as well as exclusive spaces since those who met the qualificatory criteria of being rational, male and propertied could participate in debate (Stevenson, 1995). Together, these elements produced a desire for public rather than private forms of reasoning predicated on the idea of pursuing truth through communicative interaction. The eventual collapse of the bourgeois public sphere due to the impact of large corporate communication enterprises (most notably the development of a commercially oriented press) eliminated the majority of private individuals from public debate and commentary and with it the possibility of creating free and equal opportunities for democratic decision-making in mass society.

Recently, a number of critical studies of the public sphere thesis have appeared, though not all have been univocal in their support (e.g. Fraser, 1992; Eley, 1991). The main criticisms are firstly, that by favouring the development of a rational, masculine, public sphere he implicitly supports a particular male form of discourse that has little or no place for talk about emotion. Secondly, by promoting the bourgeois public sphere as the site of rational public discourse Habermas neglects the development of a contemporaneous plebeian public sphere as evidenced for example in the formation of the Mechanics institutes run by local trade union branches for their members (E. P. Thompson, 1978). While such criticisms are entirely valid they in no way negate the value of Habermas's thesis, however. The continuing attraction of his basic model of the public sphere lies in its championing of a communicative space independent of both the state and the market and its potential for providing a critique of existing institutional arrangements for public discourse. Charges of poor historical scholarship and class and gender bias do not in themselves undermine the potency of his account of the growing gap between the desire for undistorted communication raised in the idealised notion of the bourgeois public sphere, and the 'tragedy' of its collapse.
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The Contemporary Public Sphere

Habermas’s historical narrative sets the scene for the development of the mass media as the chief institutions of the contemporary public sphere. Having displaced the public as the primary engine of discursivity, the mediated public sphere ‘refeudalizes’ public political communication and transforms it from reasoned debate into pseudo-debate through its association with public relations and marketing techniques. Although critics have pointed to the excesses of this ‘refeudalization’ thesis (e.g. J.B. Thompson, 1994), Habermas’s basic concern is with describing the process by which late capitalist societies display a tendency to ‘squeeze out’ the space for an autonomous public sphere and the degree to which the latter process structurally uncouples decision-making processes from channels of legitimation and ‘collective will formation’. His critique engages with the failure of the mass media to act as an arena within which individuals can gather to rationally debate amongst themselves on matters of collective concern. It is at this point however, that his interest in reaching consensual understanding in the public sphere displays a significant blindspot in relation to television.

Habermas is concerned with providing a critique of the mass media conceived solely as a dialogical arena. Accordingly, he presents the public sphere as an arena of talk. This ignores the crucial point that television is also an arena of imagery. Visual images arguably play an equally important role in the construction of argumentation. Habermas’s contention that a staged display has now replaced a rational public sphere oriented towards consensus, provides no opportunity to understand how images function both as illustrations of argumentation and as forms of argumentation in themselves. This blindspot is by no means unique to Habermas. Most attempts to
understand how the public sphere is presently constructed (e.g. Garton et. al., 1991) pay little attention to television as a medium of moving images as well as speech. In order to fully understand television’s management of social debate we require an approach which recognises the ‘shifting relation between language and imagery in popular representation’ (Murdock, 1993: 536) and the possibilities this creates for a broader conception of television as a ‘forum’ of public discourse.

At this juncture we can return to the notion of television’s ‘communicative character’ which opened this chapter. Scannell, like Habermas, privileges talk as the defining feature of public discourse. Consequently, he too gives short shrift to the role of visual images within the communicative ethos of broadcasting. Indeed, in a footnote to an essay documenting the relevance of talk to understanding the communicative process in broadcasting, Scannell disregards the role of visual images in the formation of television discourse by claiming that ‘[t]elevision is radio with vision added’ (Scannell, 1991: 11). This is not particularly surprising since his own research has been primarily concerned with recovering the history of radio’s organisation of discourse. However, by minimising the importance of television’s visual dimension a weakness in Scannell’s theory of communicative intentionality is revealed. This is all the more surprising because as Corner (1995: 14) notes, ‘it is in the combination of the two, sometimes rather subtle and even slippery, that its public communicative power and its openness to what is often heated public controversy and debate lie’. In short, the communicative power of television lies precisely in its juxtaposition of words with images. We shall illustrate the importance of this point throughout the second part of the thesis.
Television’s ability to produce moving images means that viewers are able to ‘witness’ not only participants in debate but a host of visual representations which underpin (or undermine) the credibility and legitimacy of their arguments. Thus, television viewers’ ability to reflect critically upon a diversity of argumentation and discussion depends as much on how things appear as on what is said. This is particularly important for those ‘forgotten’ or invisible subjects (such as severely mentally disturbed people in psychiatric hospitals or abandoned children in Bulgarian orphanages) who may not have an opportunity to speak directly to others or make known their testimony. Television’s mobilisation of a variety of visual and verbal modes of representation suggests that it is unsuitable as a cultural forum oriented towards generating the clear and consensual position on social issues that lies at the heart of Habermas’s project for a revivified public sphere. At the same time, the development of a wide range of public forms of argument on television suggests that broadcasters remain committed to the pragmatic use of public communication techniques in order to inform and educate audiences across a range of social and political issues and that in generating understanding, feelings might be as important as ‘facts’.

At the heart of television’s attempts to further understanding has been work subsumed under the documentary label. The TV documentary stands as a particular instance of a cultural form that asserts - in the very process of its representing - an authoritative claim to ‘truth’ premised on a very specific ‘fidelity to the real’ (Winston, 1995). This fidelity to the real underpins the use of recorded images and sounds as ‘guarantors’ of evidential probity. The images produced by documentarists working in film or television raise questions about the ‘truth-value’ of what has been produced and which has implications both for the manner in which we are both ‘put in touch with
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The Documentary Enterprise: Telling ‘Truths’

From its beginning, television sought to emulate the achievements of radio and cinema in documenting real events and circumstances with the aim of informing and educating its audiences. According to Corner and Richardson (1986: 141), the television documentary recounts aspects of the real from ‘within a discourse and aesthetics of ‘maximum transparency’”. In other words, it is the visible evidence that documentary film provides which underpins its claims as a source of knowledge and understanding about the world. The claim is that by providing a ‘window on the world’ documentarists show things “as they really are” since “the camera cannot lie”. Embedded in documentary accounts of the world ‘out there’ is the pursuit of ‘journalism’s role in fostering interaction amongst the audience - in helping audience members to interact as citizens’ (Dahlgren, 1995: 28). Similarly, Corner identifies the ‘radical revelatory’ consequences of the documentary, where viewers are ‘put in touch with one another by revealing infrastructural relations of interdependence’ (Corner, 1986: x). Thus, the documentary enterprise is seen as being at the heart of broadcasting’s discursive attempts to tell the whole ‘truth’ despite (or perhaps because of) the infinity of competing claims to truth circulating within the social world.

It is television’s ability to record the images and sounds of actuality (Corner, 1995) which underlines documentary practice as a distinctive kind of seeing and hearing experience oriented towards observational truth claims. In other words, the validity or authenticity of what is being said is guaranteed by what is being shown: the self-evidently ‘true’. Consequently, documentary appeals to the ‘evidential’ cannot be
separated from the technological means of reproducing the images and sounds of actuality. The camera and microphone underwrite the indexicality of what has been recorded in terms of a general 'truthfulness'. It is this 'trace' of the physical world in sounds and images, which underpins the role of the documentary as one of the key cultural forms of the contemporary public sphere. Despite radical variations in the way documentaries organise their truth claims the use of recording technologies enable television viewers to 'witness' a circumstance or an event and then measure what they have seen against the sequential argument(s) carried by the voice track. As Corner (1996: 2) puts it, 'the whole epistemic identity of documentational discourse, its appeal as well as its discursive capacity, changed when the indexicality of recorded image and/or sound was introduced'.

Documentary programming's claim on the real is 'primarily legitimated by its reporting of fact' (Chaney and Pickering, 1986: 29). The 'classic' realist documentary equates facts (including imaged facts) with reality. Facts are given meaning and significance in the mode of their telling. It is important to stress here that Chaney and Pickering are not questioning the possibility of capturing 'phenomenal reality'. Rather their point is that 'reality' as represented in the documentary method is always dependent upon the aesthetic conventions through which it is made available to others. Thus the 'why' of documentary construction (the point of telling an account) cannot be separated from the 'how' of its telling (the form through which an account is told). Once again, this returns us to the importance of understanding the relationship between speech and images on television and the implications this has for the production of knowledge and truth in the major institution of the public sphere.
All documents purporting to offer 'hard facts' operate on the assumption that secure knowledge about the world can be obtained and in turn can be re-presented (represented) rationally and unproblematically to audiences in the form of a convincing argument. For post-modernists the spectre of the Enlightenment hangs heavily over this presumption. As Dahlgren (1992: 29) notes, Enlightenment rationality tends towards 'neat dualisms, and polarities such as rational/irrational, mind/matter and logical/mythical' with the result that a valorization of the former categories occurs at the expense of the latter. Lyotard's critique of Enlightenment philosophy rejects such dualism's, claiming that a rational, coherent, 'reality' does not exist and that totalising theories are nothing more than 'terroristic' attempts to impose a unitary meaning or Absolute Truth on a multiplicity of localized interpretations and experiences. From this perspective the documentary enterprise can be seen as just another 'modernist' attempt to impose an authoritative truth in an era when the mantle of 'objectivity' is simply unavailable.

The core of Lyotard's objection to the Enlightenment project, that in an era of post-modernity one cannot simply 'tell the truth', has implications for all manner of attempts to document the world. However, television's preoccupation with mimesis renders it particularly vulnerable to post-modern critique. The core argument is that television produces or constructs reality rather than simply 'captures' it. As such televisual 'reality' is a product of discourse and not a 'given' in which a 'true-image' of the world appears. Nonetheless, despite television's problematic relationship with the real there is still a widespread presumption within theories of representation that there is a 'reality' distinguishable from its photographic image. In stark contrast to this, a radical post-modern view argues that there is no longer any difference between image and reality and that television's claim on the real is spent. It is in relation to this
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most controversial of claims that we encounter the hyperreal world of Jean Baudrillard.

Baudrillard and the Fading Out of the ‘Real’

According to Baudrillard, the rapid growth in mass media forms - especially television - constitutes the central characteristic of the transition from modernity to post-modernity: ‘whereas modernity centered on the production of things, commodities and products, postmodernity is characterised by radical semiurgy, by a proliferation of signs’ (Kellner, 1989: 67). In Baudrillard’s view, the multiplication of signs creates the conditions for a new ‘semiurgic society’ in which all previously held boundaries become obliterated giving rise to new modes of thought as well as new cultural forms and practices. Baudrillard’s claim is that whereas the sign was once held to refer to something other than itself - an external ‘reality’ beyond - this has ceased to be the case. Signs no longer carry a smooth referential function but refer only to the ‘logic’ of other signs. Consequently, signs have become their own pure simulacrum, their own simulated effect absented completely from any relationship with reality. Moreover, Baudrillard insists, we no longer possess the means by which we can recognize the difference between the ‘reality’ and its simulated counterpart. Media are wholly implicated in this process of the fading out of the real, and with our constant saturation by simulacra comes an inability to distinguish the difference between truth and falsehood or fact and fiction.

Baudrillard’s theory of simulacra has been ambivalently received (Chen, 1991) since it simultaneously touches on the excess of signs pervading our image-saturated culture whilst immediately denying that these signs have any meaning. Indeed, it is precisely Baudrillard’s nihilistic abandonment of meaning, truth and value that infuriates many
of his critics. Norris, for example, describes Baudrillard’s acquiescence to the world of surface appearance as a damning example of post-modernism’s *trahison de clercs* since it ‘is used a pre-text for dismantling every last claim to validity and truth’ (Norris, 1990: 182). However, for Baudrillard this is precisely the point:

'It is no longer possible for us to see through the appearance of, for instance, a ‘free market’ to the structuring relations underneath (e.g. class conflict and the expropriation by capital of surplus value). Instead, signs begin increasingly to take on a life of their own referring not to a real world outside themselves but to their own ‘reality’ - the system that produces the signs' (Hebdige, 1989: 82-83).

This is a remarkable claim because if he is correct, that reality is nothing more than an abundance of signs, then we have no power to *change* them since we cannot step outside them.

For Baudrillard, concepts such as ‘truth’ and ‘reason’ are simply defunct in a mass mediated culture. They are no longer useful as resources through which knowledge of the world can be produced and circulated. Baudrillard’s analysis of media culture figures as part of a wider rejection of Marxism (Kellner, 1989). His view is that Marxist theory does not offer any scope for an analysis of signs within consumer culture. According to Baudrillard, this is because critical theory (initiated by Marx and Engels in *The German Ideology*) is built upon a classical Platonist doctrine which holds out for an (endlessly deferred) epistemic moment of Truth over ‘illusion’ and ‘falsity’. Baudrillard’s view is that we must abandon such concepts and recognize the (paradoxical) reality that in the post-modern era the real no longer exists. Instead of endlessly (and hopelessly) appealing to the ‘real’, Baudrillard’s advice is that we
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should embrace simulacra and the hyperreal, where images relate not to hidden truths but to other images which are neither real nor false, but made in the image and likeness of other images. In short, Baudrillard’s claim is that we have moved beyond the possibility of analysing truth and falsity (crucial to the preceding age of representation) since it relies upon a sense of difference - the prerequisite for meaning - which can no longer be found.

This is a somber diagnosis (though Baudrillard himself welcomes this state of affairs). In his view, representational and mimetic theories that attempt, from different vantage points, to show that the real exists and can be grounded are no longer valid. At the same time, his central concept of simulation emphasises that there is no difference between image and reality: ‘The simulacrum... is both the reproduction and the original, both the image and the referent imploded into a single concept’ (Fiske, 1991: 57). Representation becomes a ‘non-issue’ for Baudrillard because ‘whereas representation tries to absorb simulation by interpreting it as a false representation, simulation envelops the whole edifice of representation as itself a simulacrum’ (Baudrillard in Docherty, 1993: 196). The irony of Baudrillard’s analysis is readily apparent: we may now possess the technical ability to communicate to the most dispersed and isolated of individuals but the very form this ability takes renders meaningful communication redundant. Consequently, in Baudrillard’s post-modern universe public dialogue gives way to the transmission of spectacle and information and meaning implode into ‘noise’.

The evacuation of meaning caused by the implosion of the image and the referent has profound consequences for television’s public sphere role. Baudrillard’s insistence that there is no difference between image and reality suggests that TV viewers
experience a vertiginous collapse into a meaningless void as they pathetically struggle to hang on to some sense of the real. However, Baudrillard's view is that the 'masses' are happy to consume images without their meanings since in a world of non-meaning that is all one can expect to do. Consequently, attempts to produce 'thoughtful' television programmes in which complex social issues and practices are scrutinised within a framework of 'meaningful analysis' are futile. The radical revelatory potential of the documentary, like ideology-critique, becomes redundant since no revelation of the 'real' is possible - except the revelation, made by Baudrillard, that the real no longer exists (Billig, 1994). Lyotard's rejection of a final concept of 'reality' or 'truth' is taken to extreme in Baudrillard's writing. His interpretation of our post-modern condition dispenses with any notion of 'reality' at all and with it the possibility that television can generate communicative understanding and truthfulness.

Baudrillard's view that notions of truth can now be dispensed with stems from his claim that in the contemporary era the signifier and the signified have been riven apart: 'This means that there can be no relationship between concrete events and regimes of interpretation' (Stevenson, 1995: 169). Baudrillard's position is one in which the real world and the simulated world are unable to be separated since everything is now appearance and appearance is now everything. In this environment, social life is bleached of significance such that there is no point in engaging in rational social enquiry (indeed for Baudrillard the category of the 'social' is itself no longer viable in an era of simulation). As Eagleton (1991: 38) puts it, 'In this sphere, as in the realms of the media and everyday culture, form overwhelms content, signifiers lord it over signifieds, to deliver us the blank, affectless, two-dimensional surfaces of a post-modernist social order'. Baudrillard's view that media content implodes into a 'depthless' form has parallels with another influential observer of contemporary
media culture, Neil Postman. Like Baudrillard, Postman's (1985) view is that television culture displays not an external reality but show business. In the process, serious public discourse is paralysed by the sheer weight of visual images.

*Amusing Ourselves to Death: Television and the Erosion of Public Discourse*

Postman's thesis is a lament for the demise of a print-based culture. In his view, television's ascendancy has relegated the printed word to a position of secondary importance amongst the institutions of the public sphere. In the short time since its inception television has become the major medium through which and by which western culture converses with itself. Thus, whilst TV has vastly increased the range of issues we might talk about (sex, death, environmental degradation, racism and so on), it has significantly altered how we talk. The important issues of our time - politics, health, education, religion, science - have increasingly come to take the form of entertainment. Whereas the printed word was rooted in a deployment of discourse which encouraged the (reading) public towards reflection and rational critique, Postman's claim is that contemporary television culture offers only a 'peek-a-boo' world of non-stop trivia and entertainment. Consequently, 'the decline of a print-based epistemology and the accompanying rise of a television-based epistemology has had grave consequences for public life, ... we are getting sillier by the minute' (ibid: 24). In short, entertainment *automatically* overwhelms information and the cause of this is the technology of television itself.

Postman’s essentialising of television takes its basic trajectory from Marshall McLuhan (e.g. McLuhan, 1994). Postman hails McLuhan’s claim that the technical dimensions of television shape the content of the message carried as decisive for understanding the nature of the medium. Consequently, in Postman’s thesis public
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discourse - what can be said, by whom, to whom, about what and in what ways - is regulated by the variety of media forms in circulation at any given moment. Drawing on McLuhan’s aphorism that the medium is the message Postman argues that serious discussion of public issues is impossible on television because it is a medium that allows only some modes of discourse to the necessary exclusion of others:

‘It is an argument that fixes its attention on the forms of human conversation, and postulates that how we are obliged to conduct such conversations will have the strongest possible influences on what ideas we can conveniently express. And what ideas are convenient to express inevitably become the important content of a culture’. (ibid: 6)

His claim is that television influences the ideas that a culture can be said to ‘conveniently express’. He argues that just as the medium of the smoke signal cannot do philosophy - the form excludes the content - television cannot communicate serious information because ‘its form works against the content’ (ibid: 7). On this point Baudrillard and Postman are in agreement. Both see television content imploding into form so that whatever ‘information’ is transmitted by the medium immediately dissolves into spectacle (‘information devours its own content’ to use Baudrillard’s phrase).

What emerges from Postman’s account is above all a distrust of television as a medium of public discourse. For Postman, the crux of the problem is that television mediates its messages through visual images rather than speech. Thus, what we see on television becomes all that counts as truth since we cannot mistake the evidence of our eyes. Consequently, we do not require much in the way of speech to emphasise the ‘reality’ of what we have ‘witnessed’. What little there is, Postman says, is not
discourse proper but a simulation of discourse in which the necessity for serious and rational public conversation is upheld for appearances sake (which it still requires). Postman, like Baudrillard, thus believes that television is a banal, depthless medium. It is simply unable to do anything but entertain:

‘What I am claiming... is not that television is entertaining but that it has made entertainment itself the natural format for the representation of all experience. Our television set keeps us in constant communion with the world, but it does so with a face whose smiling countenance is unalterable. The problem is not that television presents us with entertaining subject matter but that all subject matter is presented as entertaining... Entertainment is the supra-ideology of all discourse on television (ibid: 87).

Postman’s broadside against television is predicated on a ‘typographical bias’ in which print offers the best hope for a rational democracy. This is also a view shared by Habermas. His original (1989) thesis on the print-based public sphere argues that contemporary media of mass communication, especially television, appear more concerned with the production of spectacle than with the production of rational discourse. For both Habermas and Postman, the rapid-fire environment of the ‘three minute TV culture’ means that the communication of serious issues is impossible as style is promoted over substance. In this image-saturated environment the ‘sight-bite’ becomes the conduit for measuring the (entertainment) value of a television programme rather than what it has to say. And what of Truth? In Postman’s view it becomes increasingly difficult to find given the myriad show-business forms within which it now (dis)appears.
Amusing Ourselves to Death is an account of the commercial imperative in US television and as such has considerable merit. However, Postman, like Baudrillard, is guilty of attributing television’s infantilising power to its technological characteristics and assuming that the effects of the medium are universal and irreversible in their consequences. In Postman’s hands, television becomes an omnipotent power in which audiences’ understanding of the world are blurred as the boundaries between informational programming and entertainment implode. Following Postman, the development of dramatized factual (‘infotainment’) programmes like America’s Most Wanted and 911 are a sign, not of increasing triviality in current affairs television per se, but of television recognizing that even in the sphere of current affairs what it does best is entertain. In contrast to Baudrillard, Postman’s argument is therefore not about an absence of meaning caused by a proliferation of televisual signs but, rather, an argument about the proliferation of the same signs all producing the same thing: endless entertainment.

The Limits of Technological Determinism: Raymond Williams and Television

The commercialization of the American broadcasting environment forms the backdrop to Postman’s critique of television. Commercial TV in the US has long been the target of educationalists and others, concerned that relentless competition for audiences has effectively paralysed any hope that the medium might instill the capacity to question, to criticize, and to protest (Boddy, 1995). Postman’s intention is to extend this critique and to argue that television’s educational potential is at best minimal. In pursuing this line he urges us to ‘read Marshall McLuhan’ (op. cit.: 145). The reason for this recommendation is McLuhan’s claim that its technical dimensions determine the communicative character of television. However, the question of the
medium's 'essential' qualities is begged: 'does television's performance as we know it have to do with some essential quality or with the way it has been used culturally' (Dahlgren, 1995: 58). On this issue Raymond Williams is instructive in detailing the error of attributing to technology specific *intentions* which place it outside society. In his book, *Television: Technology and Cultural Form* (1974), Williams claims thus:

> It is... [a] sophisticated technological determinism which has the significant effect of indicating a social and cultural determinism; a determinism, that is to say, which ratifies the society and culture we now have, and especially its most powerful internal directions. For if the medium - whether print or television - is the cause, all other causes, all that men (sic) ordinarily see as history, are at once reduced to effects (1974: 127).

Williams's comments are directed at McLuhan. However, they also apply to Baudrillard's view of media. In Baudrillard's theory, television becomes the most significant determinant of the nature of society. Reversing the familiar adage that television is a mirror of society, Baudrillard claims that society is now a mirror of television (Kellner, 1989). In his hands media technologies are in the driving seat of history. There is no sustained exploration of this claim by Baudrillard. He simply notes that in 'this world of surface appearances TV takes over from the real as the place where real things happen only if they're screened' (Hebdige, op. cit.: 82). Truth simply disappears beneath the simulacrum as the masses embrace the 'ecstasy of communication': the impossibility of finding meaning in a world where only images matter.

Whilst Postman's thesis is less extreme than Baudrillard's his strong adherence to McLuhan's technological determinism opens him to the accusation that he too
brackets off many critical issues. For example, his account of television ignores the long history of federal regulatory decisions, which have shaped the commercial structures and programme forms of the medium in America. Consequently, his critique says nothing about how the US television industry operates as an industry with traceable consequences for the range of discourses and representations in the public domain (Golding and Murdock, 1991). Williams's view that technology is shaped by existing social relations and not by some 'innate' qualities of the medium invites a consideration of television's communicative character from within a perspective that looks 'not for the components of a product but for the conditions of a practice' (Williams quoted in Golding and Murdock, ibid: 17). This approach allows recognition of television as a technological medium which shapes aesthetic forms of programmes but acknowledges the impact of non-technical influences (e.g. broadcasting policy decisions) on the 'look' and sounds of programmes.

Following Williams, we can avoid a technologically determinist approach and acknowledge instead that television is an 'applied technology' in a society where information and communication are centralized in their origin. Moreover, an important part of Williams' historical approach in Television is the contrast between British and US television. The differences he observed between the forms of programming in the US and Britain led him to see 'television' as more than just spectacle. His view is that TV is on the whole a positive cultural development since it broadens the basis of representation. This point has been developed in a British context by Scannell (e.g. 1989). His view is that public service broadcasting has immeasurably extended and enriched the contemporary public sphere by initiating a new democratic 'right of access' to a public voice: 'The fundamentally democratic thrust of broadcasting lay in the new kind of access to virtually the whole spectrum of
public life that radio first, and later television, made available to all’ (Scannell, 1992: 322). Thus, Scannell sees a direct relationship between the communicative character of broadcast output and the normative ideal of public broadcasting as a space inviting the participation of all citizens.

According to Scannell, the ideals embodied within the British broadcasting system have led to the recontextualization of private life into the public domain, and vice versa. Consequently, broadcasting has in Scannell’s (and Williams’s) view considerably broadened the range of what can be legitimately talked about in the public domain. Enacting the principle of a ‘right of access’ meant that broadcasters discovered not only the ‘pleasures of ordinariness’ but also the entitlement of ordinary people to speak and be heard in the public domain. Thus, the merging of public issues with private testimony has significantly expanded the scope of the broadcast public sphere by including private experiences as a legitimate part of broadcasting’s ‘universe of discourse’. The normative framework of public broadcasting advanced by Scannell (following Habermas) suggests that it has been pivotal in denying those in positions of authority their relative monopoly on public expression and representation. This is in fact an empirical issue and will be addressed later in this thesis in the context of public discourse on mental illness. Here, the crucial point is that television’s ‘communicativeness’ withstands any simplistic or dismissive analysis and demands instead a recognition that the medium is above all grounded in a diversity of ways of mobilising talk, seeing, information and entertainment. This diversity is perhaps nowhere more apparent than in the range of actuality programmes currently claiming purchase on ‘ordinary’ people’s lives.
Private Testimony in the Public Sphere

In recent years, television programmes documenting 'private life' and 'private experiences' have become a major feature of broadcasting output (Livingstone and Lunt, 1994). Across the television schedules the views, opinions and experiences of 'ordinary people' are central to many programme makers' concerns. Interest in ordinary people has always been part of British broadcasting's 'communicative ethos' and we trace the key developments (and limitations) of this impulse in Chapter Two. However, the explosion of so-called 'access' programming poses certain problems for Habermas's classic model of the public sphere. On one level, ubiquitous access formats and other 'reality' genres (Kilborn, 1994) have broadened and legitimized the diversity of popular voices in the public sphere. Indeed, they appear to go some way towards Habermas's requirement for inclusivity and recognition of the 'other' as a possible partner in discourse. On another level however, access programmes point towards the antithesis of a Habermasian ideal speech situation since the 'force of the better argument' appears redundant in many programmes. This raises the possibility that the mixture of voices and discourses within access-type formats appear to more accurately reflect Lyotard's post-modern position of celebrating difference and relativity.

Talk shows in particular have come to signify television journalism's estrangement from traditional current affairs and documentary programming (Blumler, 1991). We noted earlier how the classic documentary format functions as the quintessential mode of public-oriented 'truth-telling'. Dominated by experts and an official kind of talk, programmes such as Panorama and Horizon purport to give an overarching account of a problem or issue and to identify feasible solutions. In contrast, uncovering the
truth of things is not (usually) the motivating dynamic of talk shows. Rather, they are based on the sharing of intimacies on private life and family matters, or putting a personal point of view based on grounded experience. The dwindling number of documentary formats on television (and the concomitant rise of access initiatives across a broad range of television, from children’s programmes to ‘real’ holiday shows) suggest a greater sensitivity amongst broadcasters to the multiple, differently experienced realities within which people live their lives. This is not to suggest that official, public language and arguing is no longer a feature of public discourse. Rather, it is to acknowledge that private, everyday language and experience now play a much larger role in broadcast talk (Tolson, 1991; Fairclough, 1995).

The post-modern challenge inaugurated by Lyotard in principle claims this hybridization of private and public discourse as a reflection of a post-modern sensibility, which refuses to declare some discourses ‘true’, and others ‘false’. In other words, access formats recognize the “free play” of discursive processes - dissensus rather than consensus - as the inevitable ‘logic’ of a public broadcasting system no longer driven by a quest for truth and justice What matters in talk shows is not the force of a better argument but the unpredictability of the communicative performance itself: the public display of private emotions and feelings wrapped in a plethora of personal narratives. In the Habermas tradition, this is a sign of a simple decline in the public sphere, where rational reflection and debate are sacrificed on the alter of “entertaining television”. But the sheer number of ‘new’ voices being heard in broadcast talk points to another possibility. It may be that Habermas’s model of the public sphere requires re-shaping into a more sympathetic public space; one that respects the feelings and emotions of the people whose testimonies it routinely draws upon. In short, the hybridization of public and private discourses focuses attention on
the shortcomings of Habermas's classic public sphere model conceived as an arena of *rational* reflection and debate.

**Rationality, Madness and Discourse**

We have already referred to feminist critiques of Habermas's account of the bourgeois public sphere that argue that his masculine dissociation from the feminine reproduces a public world devoid of emotion and affect. This general criticism is well taken since it points to the way in which prevailing relations between reason and emotion structure rights of participation in the public sphere. According to his feminist critics, Habermas's gender blindness is not an oversight. It reflects the dominance of a masculine form of reasoning (Stevenson, 1995). Critics have also questioned the dominance of the so-called rationalist voice on the grounds that ‘[t]he Enlightenment, in promoting the hope of universal reason, silenced those whose voices were considered unreasonably emotional, superstitious or old-fashioned’ (Billig, 1996: 12). The post-modern celebration of ‘Otherness’ has gone some way towards reinstating these maligned voices as worthy of appreciation in their own right. It would be a mistake however, to think that every voice suppressed by the dominant voice of western rationalism has been rescued.

Despite the apparent multivocality of post-modernism, certain subjects (and subjectivities) remain susceptible to criticism and rejection by ‘rational’ society. One group for whom this is a particular and continuing problem is the mentally ill. For almost three centuries, madness has stood in opposition to reason. It is unreason and irrationality that are presumed when an individual is identified as mad. This view of reason and unreason as doubles is most closely associated with the French philosopher, Michel Foucault. In his view, the rational and the irrational have come to
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coexist, while remaining separate. As he (1987: x) states in the Preface to his classic
text on the ‘discourse on madness’ in the west, *Madness and Civilization*:

In the serene world of mental illness, modern man (sic) no longer
communicates with the madman: on the one hand, the man of reason delegates
the physician to madness, thereby authorizing a relation only through the
abstract universality of disease; on the other hand, the man of madness
communicates with society only by the intermediary of an equally abstract
reason which is order, physical and moral constraint, the anonymous pressure
of the group, the requirements of conformity.

According to Foucault, the constitution of madness as an illness at the end of the
Eighteenth century ‘broke the dialogue’ between reason and insanity. In other words,
reason came to speak for and on behalf of unreason allowing a vast silence to engulf
the mad. Concomitantly, the mad themselves were increasingly spoken about only
within the framework of medical, moral and scientific discourses on ‘mental illness’.
Whilst Foucault’s historiography in *Madness and Civilization* has been challenged
(see the helpful discussion in Merquior, 1991: pp. 21-34), his view that the history of
unreason is coterminous with the history of reason is compelling. It forces us to
acknowledge that the history of madness is also a history of power relationships.
Thus, generations of doctors and other experts doubted that there was any reason in
madness and discounted whatever their charges said or wrote. In so far as the
behaviour of the mad made any sense, ‘it was not in terms of their intentions, of the
here-and-now, of social relations and the loom of language, but in extraneous terms -
diabolical possession or an infantile neurosis’ (Porter, 1987: 5). A central task of the
present thesis therefore, is to explore contemporary residues of the severed dialogue
Television and Public Discourse between reason and madness focusing in particular on the *public testimonies* of 'experts' on mental illness on the one hand, and tales told by those labelled as 'mad' on the other.

From this point of view, the project of deinstitutionalization represented by the move to care in the community (see Chapter Three) might appear as a particularly helpful context in which to explore professional and lay testimonies about mental illness. Free of the asylum, both carers and users of mental health services can enter public discourse on *equal terms* in order to contribute to public understanding about mental health-related issues. But this ideal speech situation borrows heavily from a Habermas-inspired view of public discourse. It presupposes for example, that the mentally ill will encounter no difficulties in entering a discursive space predicated on *rational* reflection and debate. As later chapters will illustrate however, there is a continuing association between mental illness and the realm of the irrational - one that is often represented visually - which poses particular problems for mentally ill peoples' attempts to articulate a systematic and coherent (but also emotionally charged) account of their experiences. Here, the crucial point is that Habermas's emphasis upon the rational character of communication compounds mentally ill people's difficulties in taking up certain rights of participation in the public sphere. At the very least, we might expect those with a diagnosis of 'mental illness' to be wary of publicly drawing attention to their mental health status.

In contrast, post-modern narratives do not conform to the Habermasian ideal type of rational, seminar-style, discourse. This has important implications for television's attempts to understand and represent a broad panoply of contemporary experience. For example, rather than advancing a set of objective claims about the 'real world' (as
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in classic forms of documentary) perhaps more subjective forms of public discourse (e.g. camcorder-based ‘video diaries’) might make visible exactly those elements which have traditionally been absent in documentary programming: emotional intensity and one’s own “point of view”. Viewed in this light, access programmes, while broadening the number of discourses in the public sphere, are also representational forms that oppose the established discourse practices of ‘rational society’. They also throw into relief ‘why the concept of the public sphere must necessarily be wedded to the ideal type of communication oriented towards reaching consensus based upon the force of the best argument’ (Keane, 1995: 17). In short, public representations that engage with emotion and promote empathy (though not sympathy) with others, may provide the potential for a more congenial and supportive rehousing of personal testimonies of the mentally ill than that offered by Habermas’s ideal of a rational public sphere.

In later chapters we analyse in detail both classical forms of documentary and new types of access formats and demonstrate how they provide different opportunities for public expression and representation. In doing so they raise questions about the degree of freedom they allow to participants to speak either for themselves, or for others. These issues are taken up in more detail in later chapters. Here, we would simply say that the growth of access programme formats and other new modes of representing the ‘real’ offers an excellent opportunity to test the relationship between various forms of television and ideas about its social and communicative character. It may be that in giving greater access to storytelling and testimonial types of discourse they provide a platform to individuals and groups who previously lacked a public voice. At the same time however, they may compound the long-established view that access TV does not lead to any changes in power relations, but simply provides an illusion of participation.
in public life. While these programmes may be far removed from the Habermasian ideal of rational debate they also, paradoxically, encourage us to re-examine the grounds on which participation in the public sphere is currently being provided.

Conclusion

In this chapter the aim has been to outline and reject the notion that television is a banal technology and to argue instead for an approach which acknowledges the importance of television's 'communicative character'. In doing so, we noted how the medium's historical development as a discursive space has been shaped by a re-negotiation of the boundaries between the public and private spheres. Indeed, reorganising the relationship between public and private discourse may well prove to be British broadcasting's most important social achievement. At the very least, in bringing together the discourses of expertise and grounded experience within a universally accessible public space (albeit one marked by constant tensions between 'openness' and 'closure') broadcasting has created significant opportunities for ordinary people to contribute to the cultural and political life of the nation. To argue that taking part in television programmes is simply "ideological" is to miss the connection between people's involvement in the representativeness of public life, and their active participation in mass democracy. It was precisely the awareness of this linkage which encouraged the early programme makers to create the conditions for accessing lay voices in the emerging public sphere. The forms this enterprise has taken are traced in the next chapter. This history of 'access' provides an essential context for the detailed case studies of contemporary forms of public participation in television programmes about mental illness that make up the core of the present thesis.
Chapter 2

Creating a Public Voice:

Access Broadcasting in the UK
Creating A Public Voice

Introduction: The Public Sphere and Public Service Broadcasting

In recent years the Habermasian model of the public sphere has gained increasing currency amongst those defending the ideals of public service systems of communication against the swelling chorus of voices proposing commercial models (e.g. Curran, 1991, Keane, 1991). Its attractiveness lies in the link Habermas forges between the conceptual foundations of communication and the sociological concern with political institutions. The key to his formulation is his sustained exploration of the means by which the mass of citizens can participate in rational and critical discussion of public affairs and thus contribute to a democratic civil society (Dahlgren, 1995). In his early work on the rise of a mass-mediated public sphere he posits that the processes of late capitalism (chiefly the steering ‘media’ of money and power) progressively squeeze out the space available for an autonomous public sphere. In this starkly pessimistic view, democratic public life has been fatally compromised by the intrusion of large-scale commercial interests. Public opinion, in this context, is no longer the collective judgement of reasoning citizens but an orchestrated show of mass mediated spectacle.

Habermas characterizes the increasing ubiquity of the mass media (especially the rise of broadcast media) in terms of a ‘refeudalisation’ of the public sphere (see previous chapter). Implicit in this formulation is the idea that public opinion formation has undergone a transformation away from reasoned critical debate towards the ascendancy of public relations and marketing techniques. This shift results in a decline of public involvement in political life. Instead of providing a forum that facilitates participatory, democratic discussion the media manipulate mass opinion and become a ‘tranquillising substitute for action’. This characterization of a
commercially debased public sphere reveals a continuity with the accounts offered by some members of the Frankfurt School. Indeed, Habermas's emphasis on the commodification of the public sphere exhibits a similar ambivalence towards modern cultural forms as Adorno and Horkheimer's 'mass society' critique (see Stevenson, 1995). And yet, this story of the public sphere's compromise and decline appears to be contradicted by the non-state, non-market ideals Scannell (1989) sees embodied within the British public broadcasting system. In Scannell's view, public service media are a modern embodiment of the classical public sphere.

The core principles of public service broadcasting are by now familiar. The classical regulatory regime that directs broadcasting in Britain [via the BBC and the ITC (Independent Television Commission)] was widely seen as an essential means of implementing these ideals by guaranteeing equal and universal access to a diverse and mixed output that sought to represent the widest possible range of opinion and experience. Just how well the existing public service media have lived up to these principles is open to debate. More certain is that these principles are seen by defenders of public broadcasting as reliant upon two fundamental conditions: firstly, that public broadcasting institutions remain independent from the pressures of commercial market competition in order to avoid 'lowest common denominator' programming and ensure that 'minority' interests are catered for; and secondly, that state intervention in the planning and production of broadcast output (beyond allocating financial resources) should be minimized and editorial autonomy protected and defended. For Scannell (1989, 1992), public service broadcasting's insulation from the market ensures that people are addressed as citizens rather than consumers.
The establishment of a public broadcasting system in Britain coincided with the moment that the vote was finally conceded to all adult men and women. It is therefore no coincidence that radio was seen, from the outset, as necessarily involved in enhancing the process of mass democracy. Broadcasting was envisaged to be an independent 'public sphere', and a forum for public discussion of matters of general concern. To this end, John Reith, the BBC's first Director-General, declared the importance of establishing 'a genuine political independence for radio so that it might effectively realise its potential as an agent of a more informed and enlightened democracy' (Scannell and Cardiff, 1982: 163). Through its universal availability broadcasting would contribute to the formation of listeners as rational political beings.

It could, however, be objected that such an account substitutes an admirable prescriptive ideal for an accurate historical portrait. Ang (1991) for example argues that the entire history of British broadcasting can be better grasped as an ongoing project of resistance to the BBC's 'cultural mission'. This interpretation sees the BBC's contract with its audience as similar to a teacher/pupil relationship in which the latter is to be cultivated and educated by the former.

Nevertheless, as Goode (1996) argues there remains something attractive about Scannell's attempt to demonstrate that public service broadcasting is - ideally, at least - a dialogical arena in which the boundaries between the public and private spheres are continually renegotiated: 'Broadcasting... brings public life into private life, and private life into public life, for pleasure and enjoyment as much as for information and education' (Scannell, 1992: 325). At its best, public service broadcasting has been pivotal in denying - though never without difficulty - those in positions of authority their relative monopoly on public expression and representation and in bringing public figures and private citizens together in a shared discursive space. As Scannell puts it,
broadcasting is not simply the aggregate of the programmes which constitute its output but, rather, a 'universe of discourse' (ibid.: 325) which over 70 years has shifted from a distant, authoritative and paternal stance towards its audience to a more equal and accessible relationship. The history of British broadcasting is thus also a history of the progressive opening up of opportunities for access to a common discursive space.

That broadcasting can and often does play a fundamental role in the social processes of communication, self-expression, and holding those in power to account militates against those forms of reductionism within media studies that see only the ideological power of the mass media. The implication of the public sphere model, as Garnham (1992) rightly notes, is that it promises a fair and equal distribution of communicative entitlements among citizens. Whatever the shortcomings of this promise - and there are many - the ideal of an inclusive public communicative space remains an attractive proposition for those seeking to broaden the democratic practice of public life. The ideal of public service broadcasting is not simply reducible to the principle of public access. Its very nature as a mass medium entails a permanent disparity between the number of people involved in the production of symbolic goods and the numbers receiving them. However, granting access to a diversity of 'voices' and perspectives goes some way towards closing the gap. The remainder of this chapter is therefore devoted to tracing the pursuit of the ideal of inclusion.

Reith and Radio: The Suppression of Regional Voices

The struggle for public access broadcasting begins with radio. Towering over the early history of the medium in Britain is the figure of John Reith. He saw the BBC as a powerful vehicle for national cultural leadership. When he became the
Corporation's first Director General in 1927 (it had previously been a commercial company) the organization was a loose arrangement of regional and local stations offering distinctive services rooted in the community. In its early days, limited finances meant that local (often amateur) talent often constituted much of the output of the local stations. However, the foregrounding of ordinary people within local programmes also stemmed from a recognition by many local BBC producers that their output should reflect the lives of the people living in the areas they served. According to Scannell and Cardiff (1991: 14) this commitment ensured that the relationship between local programme makers and their audiences was 'interactive and participatory'. It also meant that for a brief period in the late 1920s people had an opportunity to express, to people like themselves, their own feelings and opinions about local and occasionally national issues.

However, the rise of this nascent participatory culture was short-lived. By 1930 local radio had virtually disappeared, displaced by a strongly centralized structure. The logic of the Reithian BBC was to subordinate difference and particularity, geographical or otherwise, to the unitary 'voice' of the nation. With the creation of a National Programme service based in London, Reith established the central control he believed was necessary to secure the BBC's role as a national broadcasting institution. Thereafter, he seized every opportunity to establish a programming strategy rooted in a conception of 'culture' as a hierarchy, a ladder which listeners must be encouraged to climb. As he explicitly stated, 'our responsibility is to carry into the greatest number of homes everything that is best in every department of human knowledge, endeavour or achievement' (Reith in Scannell and Cardiff, 1982: 163). The 'best' was identified with the tastes and judgements of the best people - the great and the good. This project involved riding roughshod over diversity and
differentiation. The country, including Scotland, Wales and Northern Ireland, were forced to accept centrality of control from London and were expected to succumb to the hegemony of English culture. This was to have a debilitating impact on audience participation in local and regional radio:

The regime of control would replace informality by a studied formality; to replace local variety and differences by a standardised conception of culture and manners; to replace audience participation by a more distanced, authoritative and prescriptive approach to broadcasting; to replace ordinary people and amateur performers... by authorities, experts and professionals (Scannell and Cardiff 1991: 16).

For Reith, the improvement of the audience was all that mattered. The extension of the franchise first to working men and then to women had confirmed his view that education was the real purpose of radio. As Reith famously stated: ‘It is occasionally indicated to us that we are apparently setting out to give the public what we think they need - and not what they want, but few know what they want, and very few what they need’ (quoted in Scannell and Cardiff, 1991: 28). The BBC saw its purpose as celebrating and proselytizing a particular set of cultural values, rather than representing the general audience’s interests. It did not aim to reflect the public’s tastes, but sought to educate and guide them towards ‘higher things’. The Corporation however rejected accusations of elitism arguing that there was no inherent connection between cultural values and social class. Given the opportunity, the BBC argued, everyone could appreciate the music of Bach or Beethoven and the drama of Shakespeare (Crisell, 1997). In short, Reith’s Arnoldian aspiration for public service broadcasting was that it should raise standards of public knowledge and taste through the active promotion of education and information. Nowhere was this paternalistic desire reflected more keenly than in BBC talks.
Matheson, talks required the inclusion of ordinary 'human' voices. To exclude them, she argued, was to ignore both the grounded experience underpinning the topic being discussed and the extent to which people were competent to speak for themselves. In 1934 a talks series called *Time To Spare* caused a sensation when unemployed people themselves came to the microphone to testify to what it was like living on the dole (see Scannell, 1980; Greene, 1935). Transcripts of the programme were used by Labour MP's to attack the government's treatment of the unemployed. In response, questions were asked in the right-wing press about the factual claims of the speakers and their right (as 'untypical' unemployed people) to speak. With the BBC Charter up for renewal in 1935 Reith considered controversy of this sort a liability, and the department was disbanded.

After 1935, although working people with radical opinions were given access to the microphone, they were more likely to be heard in discussion type programmes rather than talks. Such programmes had the advantage of being low key and the opinions expressed were clearly established as personal and could be balanced by other speakers. The function of reflecting 'typical' working class life was increasingly taken over by documentary features (Cardiff, 1980). These programmes, which date from 1928, were very different from the educative talks favoured by Reith. They were often regarded as experiments in sound broadcasting and employed a montage of narrative, dramatic dialogue, music, verse, sound effects and later, actuality sound (Crisell, 1997). Scannell (1986) points out that although many of these programmes were ambitious failures, in the context of the growing economic recession of the 1930s they gradually acquired social and political relevance. The strength of the BBC's documentary output in the 1930s thus 'grew... unexpectedly out of its organizational upheavals, in particular from Reith's desire for firm control at the centre and for
radical and dissident members of the Corporation to be dispersed to its fringes' (Crisell, ibid.: 36).

North Region: The Voices of People and Place

Reith's attempts to 'bring the regions into line' had in fact been only partially successful. Despite centralized policy control they had managed to maintain a degree of programming autonomy from London. Even as Reith was fashioning the BBC into a pre-eminently national and metropolitan cultural institution it was clear that the Corporation could not dispense with the need to have some kind of regional perspective (Harvey and Robins, 1994). Thus, when in 1936, the BBC commissioned its first comprehensive Report on the Regions from the newly appointed Director of Regional Relations, Charles Siepmann, he acknowledged that 'centralisation represents a short-sighted policy' bringing about a 'uniform pattern of thought' and 'standardising taste and values' (Siepmann in Harvey and Robins, ibid.: 39). What developed was a system in which regional expression and difference was accommodated but as a subsidiary element within the symbolic 'unity' of the nation. This meant that while there was no regional BBC policy as such, there was an acknowledgement that regional voices would be tolerated within the more 'universal' principles of a metropolitan and national broadcasting culture.

Meanwhile, Reith's abolition of the Talks Department had resulted in the dispersal of key members of the department's staff (Scannell and Cardiff, 1982). London's loss was to be the regions gain. This was especially so in the case of North Region. Under the direction of Archie Harding, a left-wing former talks producer, Manchester's North Region harboured some of the most talented writers and actors in the country. Harding devised a strategy for making programmes that evoked the spirit of the North
and its people. Harding's best known creation was *Harry Hopeful*, a series that began in 1935. The programme was based on the eponymous character's travels (an unemployed glass blowers assistant played by Frank Nicholls, in real life a clock mender from Manchester) through the North in search of work, meeting and talking to people he encountered. The series occupied a space between drama and current affairs and employed a blend of fact and fiction (see Scannell, 1986). Its pioneering use of actuality sound meant that Nicholls' interviews with ordinary people, among them the long-term unemployed, allowed them to relate their own experiences and feelings in their own words.

The BBC had launched actuality sound in 1934, using a recording van hired from a film company (Scannell, 1986). It was used in a documentary about cockneys hop-picking in Kent entitled 'Oppin 'Oliday (the dropped 'h's emphasising that the BBC knew how ordinary people talked). In 1937 the van was acquired by North Region and immediately pressed into service by Olive Shapley, one of Manchester's most dynamic producers. Shapley took the van all over the region recording people talking at home, at work and on the streets. Her influence on the development of the pre-war radio documentary was enormous: 'Single-handed, she brought to maturity the use of recorded actuality as the basis of the radio feature' (Scannell, 1986: 20). Shapley's colleague Geoffrey Bridson (a close collaborator with Harding on *Harry Hopeful*) also made use of the mobile recording unit. Many of Bridson's programmes incorporated actuality into his studies of the region's major industries (coal, steel, wool and cotton). His technique of letting ordinary people speak for themselves was predicated on the idea that everyone had something to say. Together, Shapley's and Bridson's programmes broke new ground in social documentation and established the practice of using actuality sound as a way for speakers to communicate with listeners.
By foregrounding the voices of ordinary people producers like Shapley and Bridson revealed themselves to be sensitive to the new possibilities for form and content in the medium. Their efforts did not go entirely without recognition in the years leading up to war. BBC listener research (begun in 1936) had identified the stratified nature of the audience and towards the end of the decade attempts were made to produce ‘popular’ as distinct from ‘serious’ talks for the National Programme (a development facilitated by Reith’s departure from the BBC in 1938). At the heart of the new communicative ethos was renewed consideration of the viewpoint of ‘the man in the street’ (Cardiff, 1980). Broadcasting had learnt that it could not work with the discourses of expertise alone. The testimonies of ordinary people were now seen as crucial to broadcasting’s social role as a medium of public communication. However, the balance between speakers remained highly uneven: ‘Experience might provide material for [public] debate but analysis was generally the province of expertise’ (Murdock, 1994: 113). This crucial difference in communicative entitlement also characterizes another significant moment in the development of pre-war social documentation - the film, *Housing Problems*.

*Housing Problems and Accessed Speech*

Alongside radio, the work of the British documentary film movement during the 1930’s provided a new space for re-presentations of ‘everyday life’. Under the direction of John Grierson, the movement’s mission was to reveal ‘the facts’ about working class lives. Within some of the movement’s films there was an attempt to let ordinary people speak for themselves (although some critics have questioned the degree to which Grierson’s method actually allowed this - see for example Aitken, 1990 and Winston, 1995). In the film *Housing Problems*, made in 1935 by Arthur
Elton and Edgar Anstey (and produced by Grierson) for the British Gas Association, working people were able for the first time in the history of documentary film to speak about their social conditions using their own words. Despite the non-naturalist 'look' of the film (all the working class subjects in the film are shown wearing their 'Sunday best' clothes and their testimony is delivered directly to the camera rather than slightly 'off' to a questioner) Housing Problems initiated a tradition of anthropological investigations of 'real life'. However, what the slum dwellers provide is not their own opinions about the conditions in which they live, but rather personal testimonies about the difficult experience of slum dwelling.

Even so, Housing Problems was a landmark. Its radicalism lies in its communicative intentionality: its purpose is to ground its truth claims in the testimony of ordinary people. The film's claim to represent 'reality' is anchored by shooting testimony in the slum dwellers' own houses and in their direct address to camera. These pioneering modes of exposition reveal an important feature of the access idea: namely, that of providing the viewing audience with access to issues and problems that would otherwise remain unseen or hidden (Corner 1994). When Ruby Grierson (John's sister and the person chiefly responsible for securing the testimonies of the slum dwellers) said to one participant during filming, 'The camera's yours, the microphone's yours, now tell the bastards what its like to live in the slums' (quoted in Alan Bennett's series, The Long Summer, C4, broadcast date: 5/4/94) she was expressing a desire both to access the audience to a hidden social problem, and to give a public voice to the previously silenced. This double aspect of accessing - of bringing lay testimony to a wider audience and opening the audience to lay testimony - is the source of Housing Problems importance as a key moment in the early history of the visual documentation of the 'ordinary' in Britain.
Despite *Housing Problems*’ achievement in giving slum dwellers a voice however, throughout the film an invisible middle class voice-over provides an evaluative commentary on what is shown while a ‘specialist’ narrator - a councillor on a London housing committee - provides expert analysis of participants’ testimonies. Although *Housing Problems* acknowledged the importance of giving a voice to slum dwellers the film makers signalled the very clear limits within which they could speak. The slum dwellers, as ‘victims’ of inadequate housing policy, are entitled to speak about their experiences but analysis and explanation of their plight is the prerogative of an ‘expert’ in housing solutions (i.e. the councillor). Thus Anstey’s claim that in accessing slum dwellers *Housing Problems* was not his and Elton’s film (but theirs) is grossly overstated (Winston, 1995). Despite the priority given to ‘official’ voices in *Housing Problems* however, the presence of the ‘ordinary’ consistently breaks through in the form of uninterrupted testimony. And it is this *registering of everyday experience* that connects it with television documentary’s attempts to voice social issues in the post-war era.

*The Emergence of Popular Television*

When the BBC resumed a limited television service in 1946 (transmission had begun in 1936) radio was still the dominant medium. Its role during the war had secured its place as a national institution. However, the coronation of Elizabeth II in 1953 provided the stimulus for the building of a mass audience for television (a point underlined by the fact that more people watched the ceremony on television than listened to it on the radio). The arrival of ITV in 1954 broke the BBC’s monopoly on television. ITV was less deferential to authority and more willing to cater to populist pleasures. Its supporters trumpeted the new commercial system as ‘people’s
television' and claimed that ITV spelled the end of a patronizing and paternal broadcasting system. However, such claims belie the fact that the ITV system was itself modelled on the public service traditions of the BBC. Even so, its populist ethos meant that 'a stronger sense different voices, of previously unaccessed experience, came through the filter of their programmes formats than had hitherto managed to penetrate through the sieve of metropolitan-centredness which habitually, if unconsciously, was used by the BBC in fashioning its images of the nation' (Corner, 1991a: 9).

The introduction of competition and decentralisation also provided a motor for the de-metropolitanisation of broadcasting, as 'regional' cities such as Manchester, Birmingham, Glasgow and Cardiff became more important as production centres. Thus alongside imported American comedies such as I Love Lucy, the regionally based companies of the ITV system promoted provincial culture by providing indigenous, locally made programmes for the network. Although there is disagreement over the extent of ITV's commitment to local programming (see Curran and Seaton, op. cit.: pp.181-82) there is no doubt that by the late 1950s the BBC's metropolitan bias was seen exactly for what it was - bias. It is therefore no coincidence that the two most popular television programmes in the 1960s, Granada's Coronation Street and the BBC's Z Cars (a police drama series) were set in cities in the north west of England (see Laing, 1991). These dramatized images of 'northern reality' presented in both programmes reflected British television's broader interest in representing ordinary working class people and their experiences. But it was to be the television documentary which would offer the most sustained attempt to get closer to the 'real lives' of ordinary working class people during the 1950s and 1960s.
By the early fifties the documentary had emerged as a staple feature of television. The essentially live nature of the medium during this period meant that most television documentaries were studio-based ‘live’ productions (Scannell, 1979). They were scripted, rehearsed and used actors to play the parts of working class characters. These ‘drama documentaries’ (as they became known) were a practical solution to the limited options available within a television service lacking any full-scale facilities for documentary film work. They were displaced from the schedules when the technical limitations of obtaining relevant kinds of actuality material were reduced.

The BBC’s approach to documenting social issues during its brief monopoly of television was, in the main, both distant and non-committal. Its ‘distance’ was evident both in its reliance on experts and in its technical inability to get close to ‘real life’. But with Special Enquiry it made a ground-breaking attempt to create a television documentary series with a populist agenda at the heart of its approach to voicing the social.

Under the influence of Norman Swallow Special Enquiry (1952-57) set new standards for documentary on television. Swallow, a former North Region producer, had been enormously influenced by Anstey and Elton’s Housing Problems and he sought to use recorded interviews with ordinary people as the basis of his films. Swallow’s desire to access ordinary people derived from his view that early television documentaries were depopulated: ‘What was missing from television documentaries before the mid-fifties was, quite simply, people’ (Swallow quoted in Scannell, 1979: 104). He recognized that in order to communicate with audiences documentary makers had to work with non-professional voices. Inspired by the American CBS programme See It Now,
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Special Inquiry avoided using experts or eminent speakers to introduce chosen topics and turned instead to a less pompous style of television presentation - the 'enquiring reporter' working on 'our' behalf against 'them'. In other words, the modus operandi of Special Enquiry was to position itself on the side of the 'man in the street'. By doing so, and placing the concerns of ordinary people centre-stage, the series forged a new style of television journalism in which the principle 'point of view' was that of the audience.

In 1955 Denis Mitchell joined Swallow on Special Enquiry. A former BBC features producer, Mitchell believed that the voices of subjects should form the core of actuality broadcasts. His pioneering use of the portable tape-recorder enabled Swallow to gain much closer access to people's 'inner' thoughts and feelings by allowing subjects to speak unhurriedly and unprompted (Swallow had previously used 35mm film stock which ran out after four minutes seriously disrupting location interviews). Later, the development of 16mm recording equipment and cheaper film stock meant that Mitchell's location interviews could be obtained easily and cheaply. Swallow's use of ordinary speech helped ground each episode of Special Enquiry in 'subject' rather than 'observer' consciousness (Corner, 1991b). Mitchell's own documentary work for Granada during the 1960s made extensive use of popular speech as the route to a richer and deeper portrayal of popular experience and attitudes.¹ It is for this reason that Corner (1991b: 56) has described his work as 'an

¹ Mitchell was not alone in this endeavour. The BBC radio producer Charles Parker and the folk singer and political activist Ewan MacColl (along with MacColl's wife Peggy Seeger) pioneered the use of tape-recorded actuality for the BBC series Radio Ballads (1958-1964). During the recording of the first Ballad entitled 'John Axon' (the story of a railwayman whose actions in tackling a runaway train saved the life of an entire trainload of schoolchildren but cost him his life), Parker and MacColl realised that the recorded speech of those who knew and worked with Axon was immensely powerful and deserved to be heard without the use of an actor's voice (the standard technique of the radio feature at the time). The programme received both critical and popular acclaim. The use of ordinary speech to drive the story was an extraordinary achievement ('Axon' was subsequently nominated by the BBC for the prestigious international radio prize, the Prix d'Italia) and helped cement the importance of allowing
early version of 'access' television'. By providing an extensive and symbolically rich entry into vernacular experiences Mitchell's techniques of recording paved the way for more personalised presentations of ordinary peoples' testimony.

In the 1960s the documentary tradition, which had developed in the 1950s, continued to flourish. *Special Enquiry*'s shift of focus from the powerful to the ordinary evolved into the highly successful *Tonight* programme. Although *Tonight*'s magazine format was substantially more informal than *Special Enquiry*, it continued and enhanced television's interest in the 'real world'. *Tonight*'s philosophy was summed up by the distinguished broadcasting commentator Grace Wyndham Goldie: 'It was not always necessary to be respectful; experts were not always right; the opinions of those in high places did not have to be accepted (quoted in Crisell, op. cit.: 94). Its conversational approach to topics chimed well with an informal, even irreverent, mood that was beginning to emerge during the 1960s. However, the break with Reithian paternalism following the arrival of commercial television had done little to alter the new balance of power within which the duopoly operated. Professional programme makers continued to control public broadcasting's system of representation.

By the end of the 1960s television had taken over the cinema's mass working class audience and was rapidly developing its own distinctive forms - in its treatment of politics, drama, comedy and satire, sport, interviews - different from anything previously seen or heard in the cinema or on radio (Curran and Seaton, 1997). In its non-fiction output the 'fly on the wall' technique of documentary production extended the aesthetic limitations of the TV documentary-as-journalism approach (exemplified by *Special Enquiry*) by developing a style of observationalism (or verite) that has ordinary people to speak for themselves in radio programmes dealing with the realities of their
remained popular with audiences and schedulers. The availability of lightweight 16 mm cameras enabled a strong 'evidentiary' level of visualisation to take precedence over commentary: 'The observational mode, variously combined with expositional forms (interview, voice-over, to-camera presentation), becomes the central principle of verite-style programmes, to the point that in many such programmes all discourses external to the plane of observed action... are excluded' (Corner, 1995: 88). In practice, the 'following' of ongoing action by programme makers gives viewers the sense of unmediated access to actuality uncompromised by the presence of the camera.

One of the best-known examples of the fly-on-the-wall technique was Paul Watson's series, *The Family* (BBC, 1974). The Wilkinses of Reading were the subjects of Watson's film. The cameraman, Philip Bonham-Carter, spent most of the recording period in the Wilkins' sitting-room selectively filming the comings and goings of family members as well as recording their testimonies (see Corner, 1996: pp. 46-8). Indeed, recorded actuality formed the core of the series and created space for the Wilkinses to articulate about intimate domestic topics. But despite Watson's avowedly back-seat approach to determining subject matter the fly-on-the-wall aesthetic remained the 'property' of the documentary maker. In other words, while spawning a long-running strand of documentary television, *The Family* 'belonged' to Watson and the BBC. For some critics, professional control of the documentary form jarred with the democratic impulse of the documentary enterprise (to reveal, to make known, to expose etc.). Thus, while British television became increasingly interested in the 'realities' of everyday life, dissatisfaction with television's established everyday lives (see MacColl's own discussion of the Radio Ballad form in MacColl, 1990, pp. 311-36).
representational practices was beginning to be voiced by those concerned about the undemocratic nature of public broadcasting systems.

The 1970s: Discontent and Criticism

The late sixties proved to be a decisive moment in the development of 'alternative' forms of media. Across all major fields of culture - in music, film, theatre, art, publishing, etc. - recognition of social divisions and a growing irreverence towards 'established authority' was finding expression in new and challenging modes of representation. In this radical climate concern about the centralized control of broadcasting gathered pace. By the early 1970s the mood was typified by the emergence of a number of campaigning groups - the Free Communications Group, the 76 Group (made up of disaffected BBC and ITV producers), and the Standing Conference on Broadcasting - each of which sought to widen public access to the production side of broadcasting (Crisell, op. cit.). For these organizations, enabling citizens or groups to participate in the mass communication process was a way of democratizing the media.

Against this backdrop of political objections to the media the edifice of professionalised mediations of the televised 'ordinary' began to be questioned. Reithian paternalism had entailed the exclusion of a multitude of voices and views, experiences and values. The call for more open and democratic broadcasting practices emerged out of criticisms that the BBC and ITV duopoly was not representing the full spectrum of opinion and experience within British society. The limits to the autonomy of the duopoly, coupled with a working reliance on an assumed social and political consensus, led to the accusation that national broadcasting systems per se were flawed. Critics argued for alternative methods of distribution centered on small units
which they believed could be more democratically controlled and equipped with less complicated, less expensive equipment for use by ordinary people in local programme making. A combination of technological developments in video and the emergence of an embryonic cable television system gave these hopes a degree of currency.

Democratsizing Television: From Community Television to Community Programmes

Cable television has existed in Britain since the early 1950s. Cable systems originally came into being as a method of enhancing signal reception in areas where local topography made the latter difficult. For a rental fee cable companies such as Rediffusion supplied good quality signals to homes via piped cable. As advances in UHF transmission quality improved however subscribers left these services. In response to their crumbling subscriber base the cable operators tried to exploit one of the main advantages of cable systems - their relative abundance of channels. With some notable exceptions the cable companies were legally prohibited from originating material of their own since it broke with the public service tenet that broadcast channels should be universally available (Hollins, 1984). The exceptions were temporary licenses granted by the then controlling body, the Ministry of Post and Telecommunications, to five cable companies to allow them to experiment with local television services (see Lewis, 1978). All five experiments were owned and operated by commercial companies who were required to bear the full financial cost of the three-year experiment. Thus Bristol Channel was operated by Rediffusion while money from EMI helped finance the Swindon Viewpoint station.

They were interested in the idea of local television because they felt it might help open doors to more profitable forms of cable-delivered programming like pay-TV. Initially hopes were high that the Conservative government (who had issued the
licences) might sanction the move into pay-TV by allowing the cable companies to show films and major sporting events. But these hopes were dashed by the return to power of a Labour government in 1974. The licensees quickly abandoned interest in these stations when it became clear that the new administration would not support their broader commercial interests. Nonetheless, the local stations continued to produce television programmes thanks to volunteer groups enamoured with the communicative potential of community access television. The emergence of community media - local TV, radio, video, photography, print, film - in the 1970s signalled a growing conviction that the means of communication and forms of public expression should be 'small scale' with no intention of becoming mass media. For community media groups public broadcasting institutions had failed in their basic duty to provide space for a plurality of expression and opinion.

The call for local television based upon the principles of access and participation must be understood as one of several efforts to reverse the societal trend towards still larger units and greater concentration of power (Prehn, 1992). The 'new left' in the early 1970's felt that electronic media could be powerful tools for generating social change. Hostility and mistrust of the BBC/ITV duopoly centred on the inability of 'mass communication' to involve ordinary people as political citizens in policy and decision making activities (Groombridge, 1972). The hope was that engaging non-professionals in media production would increase their social and political awareness. Small-scale forms of public communication were not necessarily aimed at confrontation with the establishment, but at trying to create a local forum for articulation and discussion. The established national and regional broadcasters, due to their institutionalized character, were considered incapable of catering to specific audiences or of addressing local topics or interests.
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For community media groups, small scale broadcasting in specific localities were both a means of changing the broadcasting system and a potential basis for social renewal. The small scale of operation also meant that local people could be encouraged to take part in all stages of programme making and in running the stations (Nigg and Wade, 1980). However, differing attitudes on the part of the licensees meant that there were significant variations in the stations' aims. Thus one saw its task as providing a local television service of high technical quality based on national standards. It included information about community life as well as programmes made by local residents in which they expressed their own views and opinions. Another sought to fill gaps identified in major network output and therefore provide a local alternative to national television. Others again, intended to provide community television in which members of the local community could act as initiators, participants and programme makers. All the stations experienced difficulties in attracting and sustaining community participation over a period of time.

Although the five original community cable experiments survived the initial severing of interest by the parent companies, most did not survive for long. Despite donated equipment and enthusiastic volunteers their shoestring budgets meant they could only continue to produce community television programmes for about two years. By the end of the experimental period four of the five stations had folded. However, by the end of that year a new experiment in local television appeared - Channel 40. Its uniqueness lay in its mode of finance. It was launched entirely with public money (from the Post Office and the development corporation charged with promoting its home base of Milton Keynes as a 'new town'). Channel 40 was set up as a local service providing information for people new to the area and as a community facility for anyone who wanted to participate in making TV programmes. Although a few
full-time technicians and producers were employed to give editorial advice about producing broadcast quality programmes, Channel 40 was perceived first and foremost as a public communicative resource 'enabling individuals and... interest groups to achieve their communication aims irrespective of... audience appeal' (Barrett, quoted in Lewis 1978: 67).

In his report on community television for the British Film Institute in 1978, Peter Lewis noted that those working in the sector saw their job as providing something different from mainstream broadcasting professionals. They put the local community first, rather than the dictates of a mass institution or the demands of 'professional excellence'. They shared a strong conviction that certain communities (including 'communities of interest') were either ignored by mainstream media or were being exploited as the 'subjects' of a professional documentarians' 'gaze' (Bibby et al., 1979). In contrast, advocates of community television argued that local TV was a form of social advocacy in which the people being 'documented' were not simply the objects of a film-makers interpretative vision, but the subjects of their own vision. Thus the central hope underpinning the Channel 40 experiment (at least for those working for the project) was that community television could provide an alternative forum for the self-representation that was being denied elsewhere. What gave this hope the possibility of realisation was the medium of video.

The existence, and survival, of community television stations like Channel 40 depended on both the active involvement of local people in programme making, and people's practical relationship to the video-based technology which made community television possible. To this extent, community television was technology-led. The availability of relatively inexpensive, broadcast-standard video equipment simple
enough to be operated by amateurs was a vital factor underpinning the hope that community television might actually work. The idea of letting citizens take the new video cameras (known as portapaks) out beyond the 'institutional space' of the TV studio in order to record aspects of their daily lives was for some 'alternative' media enthusiasts inherently democratic and challenging (though the practice was not without its critics - see Bibby et al. op. cit.).

At Channel 40, the residents of Milton Keynes were trained in the use of portapak video and then encouraged to make their own programmes about the experience of living in a new town. The technology allowed a unique mode of address to emerge; which for the lack of any better phrase can be called 'point of view' programming. Thus many Channel 40 programmes expressed a 'this is what it's like..' attitude towards a broad range of 'local' issues. As Michael Barrett, Channel 40's station manager put it: 'Channel 40... is not, like entertainment television, obliged to feature the sensational, the special, the noteworthy; Channel 40 is about the real, the ordinary, and the every-day in the life of the new city' (Barrett, quoted in Bibby et al op. cit.: 29 original emphasis). The channel's concern with the 'real', the 'ordinary', and the 'everyday' marked the culmination of attempts by Barrett and his colleagues to create a democratic public forum based on the concerns of everyday life. For them, it was in the ante rooms of social activity that community television could truly develop its character as a two-way form of communication.

The community cable stations were not the only British experiments in access television however. In the early 1970s dissatisfaction with public broadcasting's representational practices was also becoming increasingly evident amongst professional broadcasters. They felt that the social changes of the 1970s were being
ignored by the major broadcasting institutions and that a considerable gap had opened up between their routine practices and the complexities of contemporary social life (Murdock, 1994). Established programme formats were seen as ignoring or marginalizing substantial areas of social and cultural activity. Thus around the same time that the first community cable channel began broadcasting at Greenwich (July 1972), BBC2’s national access programme *Open Door* also began transmission. It came about as a result of a recognition by established programme makers that their industry ‘was... out of touch with ‘views, life-styles and community backgrounds’ different from those of the broadcasting professionals themselves’ (Corner, 1994: 21). *Open Door* was produced by the BBC’s newly created Community Programmes Unit (CPU) and was inspired by the broader public debate about control of broadcasting in the UK as well as by developments in community access television in the USA and Canada (Dovey, 1991).

The CPU’s remit was to establish a regularly scheduled access opportunity within the framework of a national television network. According to Jeremy Gibson, the current head of the CPU, the original maxim which brought the CPU into existence remains the same: ‘We exist to represent the under-represented, the mis-represented or the non-represented’ (Dovey, ibid.: 164). However, while Gibson’s sentiments are laudable it is important to remember that the CPU has, for almost 25 years, made programmes in which minority groups have been almost totally reliant upon broadcasting professionals to represent their point of view for them. While the CPU gave formal editorial control to its accessees, its open access model was accompanied by substantial aesthetic involvement from the Unit’s professionals. Thus according to Dovey (ibid.: 166) *Open Door’s* successor, *Open Space*, ‘started to look... like any other high-quality BBC documentary feature’ (ibid.: 166). Although there is nothing
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inherently 'inauthentic' about high quality access television it is arguable that the CPU's attempts to let accessees represent themselves has to some extent been overshadowed by professional notions of what access television should look like.

The issue of professional involvement/interference in programme production has dogged access television since its inception. Both the editorially 'guided' programmes of Channel 40, and the professionally produced programmes of the CPU, give rise to the accusation that neither initiative substantially developed the scope for 'true' self-representation on television. For example, Channel 40's critics accused it of aping the conventions established by mainstream television - in particular, of transforming the documenting potential of video into a more conscious 'documentary' format (Bibby et al., 1979: 30). While the CPU's professionally-assisted forays into public access can easily be assimilated into existing notions of 'good television'. Neither venture can be said to have wrested representational authority away from mainstream broadcasters. Despite their best efforts, opportunities for public participation and involvement in the mainstream television system remained limited. So much so in fact that calls for the establishment of a 'third force' in British broadcasting were increasingly being voiced both by programme-makers within the BBC/ITV duopoly and by lobby groups. What they had in mind was the creation of a fourth television service to break the duopoly's stranglehold on public broadcasting.

Channel 4: Extending Voices

While Channel 4 has multiple origins (see Lambert, 1982), the channel as finally set up aimed to extend the diversity of broadcast output by serving special interests and in particular the needs of ethnic and other minority groups. To this end it was required to experiment with programme forms and to commission its programmes from
independent producers. The centralized conditions under which BBC/ITV programmes were produced made it practically impossible for independent programme-makers to get their work broadcast on the BBC and ITV networks. In the 1960s and 1970s this was brought home to a number of distinguished television programme-makers (including figures like Alistair Milne, Robert Kee and Jeremy Isaacs) who had attempted to set up independent production companies, and had discovered how hard and financially unrewarding it was to work outside of the duopoly (Harvey, 1994). Their dissatisfaction with the 'closure' of the duopoly was shared by Anthony Smith, a former BBC producer and during this period a research fellow at Oxford University.

Ever since the BBC had been awarded a second channel in 1962 (BBC 2 eventually began transmission in April 1964), there had been a general understanding that the government would allocate the vacant fourth channel. The argument, made most consistently by Conservative MP's, was that ITV should run the channel to restore 'balance' to the duopoly. However, that convenient assumption was comprehensively challenged by the wider debate on the nature and purpose of the fourth channel. During the early stages of this Smith outlined an influential plan for a 'National Television Foundation' which would commission programmes from 'authors' (Lambert, op cit.: pp. 46-49). These, Smith argued, would form a new production base outside the impregnable walls of the duopoly. His idea was that the fourth channel would act a 'publishing house' for independent programme-makers that could tap into and give expression to the cultural needs of minority groups neglected by mainstream television. That some of these producers could also tap into the new ethnic communities of Britain was seen as important for creating an alternative televisual space for public discourse and representation.
Smith’s publishing analogy, though not entirely without critics (mainly over its
financial viability - see Docherty et al., 1988), struck a cord with many involved in the
debate about the purpose of the fourth channel. More importantly, members of Lord
Annan’s committee of enquiry into the future of broadcasting (set up by the 1974-79
Labour government) were sympathetic to his proposals and in particular his
suggestion for creating a new television channel for minority audiences. As a
consequence, much of his thinking (including his frustration with the duopoly) found
articulation in the Committee’s final report in 1977. Following Smith, it
recommended an Open Broadcasting Authority (OBA) which would operate as an
electronic publisher of material provided by independent programme-makers.
Although the OBA plan was rejected by the then Home Secretary, William Whitelaw,
in favour of control by the IBA the idea of developing an independent production base
outside of the duopoly found favour amongst those in government charged with
bringing the channel to life. The IBA version of Annan (and Smith) was broadly the
model that the incoming Thatcher government adopted in its parliamentary bill of
February 1980.

As an institution that operated as a publisher of programmes rather than a producer,
Channel 4 gave expression to a newly identified set of cultural needs, while adding to
the commercial armoury of the independent television sector. A flourishing
independent sector has been crucial to Channel 4’s interpretation of its statutory duty
to give expression to new themes and otherwise unheard minority views and values.
As such, it is the latest (and probably the last) extension of the public service
broadcasting principle. By showing independently produced programmes, often made
in close relationship to particular locales and intended primarily (though not
exclusively) for particular groups and communities, the hope was that television could
be opened up to the challenge of hearing new voices and experiences. Indeed, the channel’s first Chief Executive, Jeremy Isaacs, made it clear after taking the job that he saw Channel 4’s great promise as being ‘one in which all kinds of people would be able to put their point of view’ (Docherty et al., op cit.: 18-19). This commitment to diversity is a defining feature of Channel 4’s core project of correcting inequalities in mainstream broadcasting’s (mis)representation of the disadvantaged and marginalized.

Whether Channel 4 has been successful in this is a moot point. That the channel has tried to do this however is contestable. Its relative success in giving expression to the ‘new pluralism’ of the eighties has affected the whole ecology of British broadcasting, extending the range of subjects dealt with by television (Harvey, 1994). One particularly notable aspect of the channel’s attempts to voice the tensions of the 1980s (tensions involving a broad range of social and cultural changes) has been its accessing of strong opinion. Through programmes such as Comment, Opinions and Right to Reply, Channel 4 established the notion that TV programmes can express ‘directly’ stated views without upset to the body politic. Indeed, the representation of ‘strong opinion’ was interpreted by Isaacs as a key element of Channel 4’s remit (Harvey, ibid.). This approach was firmly within Smith’s original aim for the fourth channel; that it should function according to a doctrine of openness to expression rather than the bland and neutral ‘balance’ characteristic of the established channels.

By challenging the received notion that ‘argumentative’ programming should revolve around two contrasted points of view Channel 4 has markedly broadened the forms of public argument and discussion on British television. In response, the mainstream networks have adopted some of the channel’s ideas about ‘polemical’ television
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(Docherty et al., op cit.). Despite its achievements in ‘publishing’ alternative points of view however, accessing ‘ordinary’ people and ‘ordinary’ views is not the channel’s main priority (nor has it ever been). Moreover as Corner (1994: 31) points out, ‘In recent British broadcasting, the tendency has been for access to be increasingly ‘professionalised’ as it has been partly subsumed within the movement towards minority programming, supplied to the networks by small independents’. Instead, a new form of access television is being championed. The arrival of the domestic camcorder has been hailed as the latest and perhaps last hope for securing unmediated access within the competitive and highly pressured television environment of the 1990s.

The Camcorder Revolution: Access as ‘Do-it-Yourself’ Documentary

Although the domestic camcorder was available as long ago as 1980 its poor picture quality ensured that its use as a tool of public communication was not taken seriously. It was only with developments in its technical quality coupled with its mass production and relative cheapness that its aesthetic possibilities (see below) have been realised. The first VHS combined camera and recorder emerged in the mid 1980s. In contrast to the portapaks used by the local cable television stations earlier in the 1970s these cameras were smaller, easier to use, cheaper and of better quality. They also had additional features such as ‘steady shot’, instant playback and swift autofocus, all of which contributed to their popularity amongst the public. The camcorders relative ease of use has seen it rapidly establish itself as an essential recorder of family histories, documenting and authenticating domestic lives. The pleasures of home video viewing have not been lost on television producers. The popularity in the late 1980s of programmes such as ITV’s You’ve Been Framed and the BBC’s Caught on
Camera (based on happenstance ‘accidents’ captured on camcorders and sent in by viewers) was the first indication that a ‘camcorder culture’ was emerging and with it the possibilities for access might be transformed.

The most important development in this context has been the innovatory Video Diaries series, developed by the BBC’s Community Programmes Unit. In Video Diaries individuals with a story to tell are first selected and then issued with a VHS camcorder to record events in their own or their family’s lives. Diarists then edit the tapes in consultation with professionals in the CPU. The resulting programmes are then broadcast on the national network and are the joint property of the diarist and the BBC. What Video Diaries aims to do (in theory at least) is to empower the individual diarist by mobilising their experientially-based vision of the world.

This home-produced camcorder material is the latest attempt to wrest representational power away from broadcasting professionals by letting ordinary people express their own special concerns and present their own particular arguments in their own language and in their own way. This possibility rests not on the replacement of the professional film maker by the amateur but on a changed relationship between them:

In Video Diaries the diarist is at different times, and often at the same time, researcher, director, producer, camera operator, sound person and editor (not to mention subject) and the role of the professional producer in the process is not so much removed as renegotiated (Keighron 1993: 24).

However, this ‘renegotiated’ relationship between professional and amateur film makers raises wider questions concerning the degree to which diarists have final editorial/aesthetic control over their productions. According to Video Diaries’ executive producer Bob Long, the ultimate editorial control of the diarist is the only
thing about the series which is ‘set in stone’ (Keighron, 1994: 24). However, this claim belies the fact that potential diarists still have to go through the most arduous editing process of all - being selected to make a diary. The fact that only 1 in 50 applications are given serious consideration, suggests that the CPU’s celebration of the authorship rights of individual diarists continually bumps up against strong professional criteria. This is further highlighted by the accusation that, editorially, Video Diaries’ selection strategy has drifted towards the sensational and voyeuristic (see Corner, 1994 op. cit.; Dovey, 1991 op cit.). At the same time, the claim that editorial control of the projects finally selected lies with diarists suggests that the original political aspirations of the CPU - to promote access and participation in the television process - remain relatively intact within the BBC, despite the organization’s increasingly populist agenda.

Despite concerns about the CPU’s editorial drift, subjectivity remains the core of the Video Diaries form: ‘The diarist becomes the subject, story, of the film whatever other issues may be under discussion’ (Dovey, 1996: 129). For some, such as American TV producer Ilan Ziv, this poses an exciting challenge: ‘My task is to destroy television’. What he in fact wants to destroy is the ideology of objectivity and replace it with a new emphasis on the subjective: ‘Lets go ‘subjective’ all the way’ (Fraser, 1992). Such a celebratory insistence upon the individual point of view is what for Ziv marks out the camcorder as a technology capable of creating a new form of ‘personal testimony’ journalism. Whereas traditional forms of documentary place great emphasis on a neat packaging of ‘the issues’ within an impartial “here-is-the-problem-this-is-the-answer” structure, camcorder culture rejects the ‘dominant ideology’ of TV naturalism (Goodwin, 1993). No longer do we have to trust in mediated representations of a world ‘out there’, nor do we have to abdicate
responsibility for truth-telling to TV professionals. Using the camcorder we can now have raw, authentic, self-representations of an 'inner' - somehow more 'truthful' - personal world that even the most revealing of verite documentaries could not hope to achieve.

The claim that the camcorder is moving television towards a new aesthetic of documentary truth resides in the medium's 'techno-reflexivity'. Whereas the 'fly-on-the-wall' approach to documentary tried to efface the intervention of the camera crew and offer a kind of ideology of the 'neutral' camera (Channel 40's project director Michael Barrett also believed - perhaps somewhat naively - that community access television could effect a 'neutral' stance in its facilitating role), camcorder culture (at least in its Video Diaries manifestation) does the opposite. It celebrates the actual presence of the film-maker as part and parcel of its truth-telling function. The wobbly, awkward, grainy shots (especially of the diarist picking up or switching off the camcorder) operate as a visual guarantee of the veracity of what the camera is recording/showing. Transmitted images of diarists switching off their camcorder within the flow of a diary can be seen as signifying that they are choosing to break with the 'professionalised', constructed, conventions of the mediated documentary form preferring instead to represent their lives in ways that they themselves have chosen.

Following Corner (1994), the question remains as to whether camcorder technology has succeeded in developing 'access' as a communicative enterprise in the nineties. There is no doubt that the Video Diaries series has been a major advance in broadcasting personal testimony. These are the accounts of people traditionally under-represented, misrepresented or simply ignored by mainstream television. In the
process all kinds of subject matter have been dealt with (see Dowmunt, 1991). Video Diaries (along with its sister programme Teenage Diaries) has allowed viewers a privileged and unique mode of access to a degree of subjectivity unimaginable in traditional documentary modes of expression. However, even though Video Diaries has concentrated on 'seeking out voices that are, for whatever reason, genuinely unheard' (Dovey, 1991: 167) there remains the possibility that the series offers nothing more than an entertaining (sometimes embarrassing) form of navel-gazing. In other words, the private, individual concerns of diarists are an end in themselves - a subjective discourse of emotion and self-reflection/self-scrutiny which in contrast to other factual television forms contributes little either to the public sphere or to the access idea per se.

However, this criticism can be challenged on the grounds that it privileges precisely those types of factual programmes in which 'public' (masculine) issues are seen as more important than 'domestic' (feminized) concerns. The Video Diary format may well allow a voice to be heard but it is a lone voice that begins and ends in the sphere of domesticity. At its best it encourages an intimacy between diarist and viewer. At its worst it is 'purely' personal communication taking up precious public broadcasting space. This approach sees developments in access and other 'reality' formats (see Kilborn, 1994) as symptoms of a decline in public television's role as the pivot of the public sphere. But as Dinsmore (1996: 55) points out, the inclusion of private discourses in the public domain could also be seen as the result of a growing recognition that television is a broadcast medium enhanced by domestic tones of voice:
In the context of other factual television programmes in the schedules, the Video Diaries’ use of a private language which is recognized as domestic and familiar claims a place in the public airwaves not simply for voices that would otherwise be unheard, but also for a tone of voice that is rarely privileged as part of the public discourse of television.

Private, domestic, voices have been consistently marginalized by a public service discourse dominated by experts and an official kind of talk (Bondebjerg, 1996). Video Diaries reacts against this top-down tradition by privileging the private, the intimate and the domestic within a context of intimate engagement with the otherness being portrayed. In doing so, the series creates the possibility for ‘subtly self-reflective programmes in which the personal, subjective discourse of emotion and self-reflection, which is frequently denigrated by other factual television forms, is privileged as an intensely sophisticated strategy for self-scrutiny’ (Dinsmore, op. cit.: 54).

This broadening of television’s style of address facilitates a whole new repertoire of topics and styles of performance, a point emphasised in Scannell’s (1992: 334) account of the role of broadcasting in the democratisation of everyday life: ‘The world, in broadcasting, appears as ordinary, mundane, accessible, knowable, familiar, recognizable, shareable and communicable for whole populations. It is talkable about by everyone’. This is not the independent realm of discourse imagined by Habermas. It is rather that new forms of public discourse are being generated, forms which like Video Diaries are indigenous to their setting. It is therefore inappropriate, Scannell argues, to draw upon Habermas’s model of rational discourse, based as that is on a literary rather than electronic culture: ‘I prefer to characterize the impact of broadcasting as enhancing the reasonable, as distinct from rational character of daily life in public and private contexts’ (ibid.: 342). This perspective makes it less
paradoxical that a public national network should be the means for communication in private and domestic tones of voice. It also gives rise to the possibility that public debate on television could be a more inclusive rather than exclusive experience than it has hitherto been. This issue has been brought to the fore most recently with the rise of audience participation programmes.

**Audience Participation Programmes: Rarely Heard Voices**

Participatory talk shows are not a new phenomenon on television. They have a history stretching back over twenty five years in the United States (Rose, 1985). However, they are a relatively novel phenomenon in British television. The move from elite to participatory and access programming has been a slow and difficult rearrangement despite the greater pluralism of public broadcasting in the 1960s and 1970s (Murdock, 1992). The spectre of Reith has loomed large ensuring that attempts to broaden media participation have been consistently met with questions about qualifications to speak. Talk shows challenge established access regulations by inviting ordinary people to participate in a television debate on a (usually) topical issue. They are presided over by a host who controls the discussion by moving around the studio and nominating speakers. The studio audience is made up of two key constituencies: lay people, some of whom have grounded experience of the issue in question, and ‘experts’ with specialist knowledge and/or professional understanding of the issue. A crucial feature of presentation is that experts and lay participants are seated in a ‘democratic’ manner such that neither is recognized as having priority access to the host (see Livingstone and Lunt, 1994 for a detailed description of the talk show setting).

The talk show is built upon the experiences, opinions and lives of ordinary people. Across the television schedule there are a variety of both British talk shows (e.g.
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Kilroy (BBC), The Time The Place (ITV)) and their American equivalents (e.g. Ophrah (BBC2) and Ricki Lake (C4)). In all these programmes ordinary people are invited to give opinions and speak authoritatively on social and personal issues, as well as to recount their experiences. By providing a public forum in which lay participation is highly valued, expert contributions are often marginalized (sometimes even completely absent). Lay knowledge is valorized on the basis of the authenticity of lived-experience. What the lay person knows is elevated over and above what experts know precisely because the former possesses grounded experience of the issue whilst the latter does not. Experts lack 'authority-born-of-experience' and as such are generally considered inferior witnesses in talk shows. Consequently, their erudition can work against them, particularly when the host draws attention to the abstract or ungrounded character of their specialist knowledge (such as when data or theories are introduced into discussion) and invites lay participants to directly challenge them.

Talks shows therefore involve a significant challenge to established hierarchies of knowledge by providing a forum in which experts are held directly accountable to lay epistemologies. Both are presented as interested parties but are held to know different things in different ways. However the argumentative strategies of lay participants are more readily accepted. In the discursive space provided by these programmes expertise is contrasted with and set in opposition to the experiences of everyday life (indeed experts are often invited to learn from lay experience). Livingstone and Lunt (1994: 97) make clear the implications of prioritizing the lay over the expert and the use of private individuals to illustrate public issues: 'As experts belong, in Habermas's terms, to the system, while the laity belong to the private domain of the life-world, these forums break with cultural traditions, and attempt a reconstruction of both expertise and lay knowledge'. By placing ordinary people on an equal footing
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with experts common knowledge and everyday experience is rescued from its subordinate status as ‘vox-pop’.

In the talk show the voice of the expert has to respond to the testimony of ordinary people by joining them in constructing mini-narratives of everyday life. This requirement is established at the beginning of each programme by the hosts’ use of a personal narrative to open up the broader issues at stake (at least the issues as dictated by the host). Underpinning the talk show’s conversational discursive mode is a valorization of ‘common sense’. Common sense prevails over expertise precisely because it is assumed to give privileged access to ‘the truth’. However, truth in the talk show is conveyed through an interpretative frame that privileges the personal and individualistic over the social and structural (Dahlgren, 1995). What counts as evidence and a ‘good’ argument is therefore less structured and more spontaneous than in a documentary deploying a narrated argument or ‘dominant account’. Because the paternalism of established public service discourse is absent from many (though not all) of these talk shows they have been welcomed as a sign that a pluralist public sphere is beginning to emerge.

*From the Bourgeois to the Plural Public Sphere*

The description of the public sphere offered by Habermas can also be read as an account of the emergence of an intolerant public culture. It will be recalled that the bourgeois public sphere is held by Habermas to be an ideal space in which people come together as a ‘public’ to pursue rational debate in the interests of all. However, this space, and the conditions for communications within it, favours the participation of some citizens over others. Feminists in particular have criticized Habermas’s failure to engage with the exclusion of women from the public sphere arguing that his
gender (and class) blindness privileges an overly rationalistic view of human communication (Stevenson, 1996) which reinforces masculine forms of reasoning and argumentation as the most appropriate model for communication. It is notable how well this criticism applies to formal broadcasting practice. As we have seen, attempts to win space for ‘different’ publics and construct a more inclusive model of public communication have consistently battled against a powerful paternal ethos.

It is in light of feminist critiques of Habermas that Livingstone and Lunt welcome the emergence of the talk show. Their approach is one that sees talk shows as expanding the public sphere. The Habermasian model places a heavy emphasis on rational dialogue to the detriment of narrative, conversational and emotional modes of talk. The latter have been ‘feminized’ and downgraded ensuring that domestic issues have less of a stake in public discourse. In their view the talk show is evidence of a new, more pluralistic, public sphere in which marginalized and excluded voices regulate the discourse of the more powerful through the mixing of public and private discourses. Instead of aiming at social consensus forged through rational debate among ‘the public’ (dominated by experts and professionals) the talk show format celebrates the essential diversity of multiple, overlapping publics engaging with particular (rather than universal) concerns. Livingstone writes:

> If we move away from Habermas’s idealised hope for (and disillusion concerning) the public sphere, towards a model based on plural and diverse publics in negotiation with each other, then the audience discussion programme may be reasonably understood as one of the media genres which provides... a real public space for such negotiation (Livingstone, 1994: 439).

However, some critics claim that talk shows, far from leading to changes in power relations, provide only an *illusion* of participation (see for example the criticism of
talk shows in Berman, 1991). Supporters counter by arguing that this reading is too narrow. In their view the social occasion of the talk show should be analyzed in the context of the general proliferation of access and public participation genres. Carpignano and his colleagues for example claim that talk shows not only signal a shift away from formal political agendas but also reveals the underlying crisis of the bourgeois public sphere:

The crisis of the bourgeois public sphere is fully visible and displayed in front of our eyes. The crisis of representational democracy is the crisis of the traditional institutions of the public sphere - the party, the union, and so forth - and, most importantly, the present mass refusal of politics. If we think about the reconstitution of the public sphere in terms of revitalization of old political organizations... then the embryonic discursive practices of a talk show might appear interesting, but ultimately insignificant... But if we conceive of politics today as... consolidated in the circulation of discursive practices rather than in formal organizations, then a common place that formulates and propagates common senses and metaphors that govern our lives might be at the crossroads of a reconceptualization of collective practices (Carpignano et al., 1990: 119).

The importance of the talk show for these commentators lies in its contribution to the 'circulation of discursive practices'. Its conversational style displaces a structure of debate, conceived as a rational or civil exchange of conflicting viewpoints and privileges modes of discourse which are unable (or unwilling) to arrive at a conclusion. According to Livingstone and Lunt this generates a new type of public sphere in which everyday life and established power are mediated according to mixed and shifting discursive conventions. Crucial here is the blending of private and public discourses as part of a more democratic conception of 'the public interest'. In their view the talk show promises to be a more tolerant site of public discourse in which
voices that were historically excluded from participation in the major medium of public communication can now be heard.

*Post-modern Babel or Game Show?*

Livingstone and Lunt’s positive interpretation of talk shows advances an important claim: that in giving a platform to a multiplicity of voices and discourses they represent a ‘post-modern’ condition. The talk show is for them evidence that in the post-modern world ‘the media play a central role, facilitating a plurality of previously repressed voices and subject positions’ (Livingstone and Lunt, 1994: 175.). The interplay of multiple discourses and forms of argumentation are confirmation that those voices that were previously drowned out by a paternalistic public broadcasting system, have been rescued. The traditional valorization of professional authority over lay experience is abandoned in favour of a ‘contested space’ in which new discursive practices are developed, and within which participants are relatively free to make diverse interpretations, depending on their particular circumstances. The talk show thus becomes a dialogic community where multiple meanings flourish and diverse perspectives and viewpoints interrelate. However, while talk shows are clearly antithetical to the Habermasian ideal of rational debate and opinion formation the claim that they are the vanguard of a Babel-like explosion of repressed voices is one that merits caution.

There is for example the possibility that the diverse voices of the talk show are evidence not of a post-modern babel, but of something more brutal: ‘The media today testify to the existence of an expanding market-driven heteroglossia’ (Billig, 1997: 225). From this perspective, talk shows are part of an instrumental appropriation of conflicting voices in keeping with the media’s constant pursuit of ratings and new
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formulas. Instead of being reflections of a post-modern celebration of repressed voices the talk show’s revaluation of lay opinion entails a more cynical manipulation of personal experience. There is, then, another re-valuation of ‘everyday voices’ at work here, one in which ‘the accessed ordinary will be made productive within the terms of market competition’ (Corner, 1994: 33 original emphasis). As television becomes increasingly open to market-driven channel choice in Britain, the loyalty of audiences can never be guaranteed. The ‘economic ordering’ of discursive variety such as that found in the talk show helps cement that illusive loyalty.

While television is the dominant medium of the public sphere, ‘public sphering’ as Peter Dahlgren (1995: 148) notes, is clearly not television’s dominant institutional purpose: ‘As an industry, television has to follow the precepts of audience maximization and profits’. Recognizing that television operates as an industry points to the institutional logic underpinning the explosion of talk shows and other access formats. It is a commercial logic that drives the television industry’s continual search for new programming possibilities. This market-driven desire to produce popularity lies behind the talk show’s melange of entertainment, information and opinion. In this context, the talk show’s blurred borderlines appear less as a post-modern collapse of established genre boundaries (whereby popular culture is undermining and overwhelming reasoned political dialogue and criticism), and more as testaments to the fluidity and hybridity demanded by the industry (Fiske, 1987). This is why the talk show contains characteristics of both game shows and ‘classical’ debate programmes (Livingstone and Lunt, 1994) which helps explain both its populist disregard for intellectual debate and factual precision and its selection of topics and voices from outside the traditionally defined arenas of public interest. In the final analysis,
however, the question remains as to whether in the talk show’s din of voices anyone gets heard.

Conclusion

In sketching a brief history of public access within broadcasting this chapter has focused attention on the system’s relative ‘openness’ (and closure) to the opinions and experiences of ordinary people. We have seen a continual struggle over two contrasted conceptions of ‘public service’. On the one hand, broadcasting is conceived as a public sphere in which representatives of cultural groupings, civil associations, pressure groups and so forth articulate particular interests. On the other hand it appears as a discursive space which can ‘soak up’ the diverse opinions and experiences of individual citizens speaking. However, as this chapter has shown the principle of access runs up against its limits as soon as we acknowledge that professionalism and expertise will continue to have an important role in the public communicational enterprise. In the provision of specialist information, the filtering and framing of experience and the production of ‘high quality’ programmes public service media have no choice but to violate their own principle of equality of access for all citizens:

public service media... distribute entitlements to speak and to be heard and seen unevenly. They... develop a cast of regulars - reporters, presenters, commentators, academic experts, businessmen, politicians, trade unionists, cultural authorities - who appear as accredited representatives of public experience and taste by virtue of their regular appearance (Keane. 1991: 123).

Nevertheless, access to and participation in the public broadcasting system has long been recognized as a matter of democratic importance by both broadcasters and
public. The question of representation - of having a voice, of being taken seriously, of being treated with sympathy and understanding by programme makers - points to the necessity of an open public space in which external influence is limited and which accesses the widest possible range of viewpoints, perspectives and experiences across a variety of forms and genres. However, as we shall see in the context of our case study of schizophrenic people's entitlement to a public voice, 'access' and 'participation' in the public sphere of broadcasting is no easy matter.
Chapter 3

Debates and Issues in Mental Health
Introduction: Asylum and Community Care in Context

The history of the care and treatment of the mentally ill is characterised by a series of cycles of reform and neglect. Each moment of reform has been marked by a belief that a new institution or form of treatment would solve the problems of the past. Thus the prominent nineteenth century lunacy campaigner, Sir George Paget, could claim that the public asylum was the "the most blessed manifestation of true civilization the world can present" (Quoted in Scull, 1996: 69). With the benefit of hindsight this appears a curious, even perverse, statement but at the time it perfectly expressed the Victorians' conviction that a kindly, more humane approach to treating the mad had been found. Later, the resurgence of community-based mental health care was again the occasion for optimism. Here, for example, is a visiting New York psychiatrist to mid 1950s Britain commenting on hospital-community relations:

My trip to England... changed my attitude towards the function of the mental hospital, and the needs of the mentally ill. The progress we so admired in England, which is culminating in... community-oriented psychiatry, arose from the attitude that mentally ill patients were still responsible people who were competent to control their own behaviour except for brief periods... We discovered that the mental hospital was not the exclusive site for psychiatric treatment, but served as a centre for community-based mental health programmes which included consultation with family doctors, clinic treatments, and day care (quoted in Jones, 1993: 153).

In the mid 1990s however, enthusiasm for community-based mental health treatment is at a low ebb. The social costs of community care have been increasingly questioned and there is even talk of it being a 'failed' policy and that perhaps the mental hospital was, after all, the best place in which to care for the seriously mentally disturbed.
To understand current concerns and debates however, we need to retrieve something of the complex history of oscillation between the ascendancy of the asylum and the counter claims of community-based care. As a recent historiography of nineteenth century psychiatry has shown (Scull, 1996) the choice of asylum or community is not mutually exclusive. Victorian faith in the capacity of large, well run asylums to deal with the problem of ‘madness’ did not mean that existing community-based interventions were abandoned. To the contrary, private forms of ‘community care’ remained in situ long after the provision of public asylums. Similarly, the ascendancy of community-based mental health services in our present era does not mean that the hospital has no role to plays in the delivery of psychiatric treatment. The need for asylum for the most disturbed mentally ill continues to be at the forefront of community care policies (Though agreement over the number of beds needed for this group is surprisingly elusive). The challenge for mental health policy is in striking a balance between the practice of confinement and the principle of restoring mental patients to mainstream society. This chapter shows how difficult this balance has been to achieve.

*The Emergence of Modern Psychiatry*

Before the nineteenth century the treatment of the mad was not a specialized branch of the medical profession. When for example George III suffered attacks of mania he was treated by Francis Willis, who was both a clergyman of the Church of England and a doctor of medicine\(^1\). Willis had a reputation for successfully treating madness which had been earned by running a private madhouse in Lincolnshire (Porter, 1987).

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\(^1\) Clergymen keen to supplement their church income operated many early eighteenth madhouses by taking in fee-paying lunatics. This was how Willis initially came to be a private madhouse keeper (see Jones, 1972: pp. 34-8).
Private madhouses in eighteenth century England were run for profit and were thus for the exclusive use of wealthy families. They began, like the Bethlem hospital (or Bedlam in popular parlance) in London, as municipal or religious charities (Scull, 1979). They might have an honorary physician who would visit and prescribe treatment - usually a combination of purging, emetics and bleeding with detention and restraint for the most violent. In contrast, pauper lunatics in the eighteenth century were dealt with under the existing poor laws and were subject to the harsh conditions of the workhouse (along with poor, old, disabled, and orphans). The absence of formal provision for the majority of lunatics in this period reflects the fact that lunacy was more a social than a medical category and therefore not seen as a condition which warranted specialist attention by medical practitioners.

By the early nineteenth century private madhouses in England were a flourishing and lucrative business. They were set up by individuals who saw a potential market in the residential care of the insane. They had also begun to take in large numbers of pauper lunatics under a system of contracting out developed by the poor law authorities. For many of these unfortunate people the madhouses were a coercive and brutal experience. Since they were not subject to any form of inspection, profit-hungry madhouse keepers were able to chain their pauper charges more or less permanently. Private patients fared little better. Without a formal admission or discharge system 'troublesome' men and women were illegally placed in private madhouses for the benefit of unscrupulous relatives whose motive was (usually) financial. Indeed, madhouses became an issue of increasing public concern throughout the nineteenth century2. The gradual emergence of voluntary asylums funded out of charitable

2 Lurid and frightening tales of people detained against their will were common. Women appear to have been especially vulnerable to illegal detention by their husbands (see Jones, 1972, pp. 111-14).
donations however, pointed to a more therapeutic attitude towards lunacy bound up with the idea that lunacy was a medical matter requiring a *curative* rather than entrepreneurial approach.

Porter (1990) argues that medical practitioners increasingly took over from the lay entrepreneurs who had previously controlled the lucrative trade in lunacy. There were two reasons for this: the value of specialisation necessary in a congested occupation (medicine); and the professional and financial benefits to medical career prospects (cf. Scull, 1996). The establishment of voluntary lunatic asylums grew out of the provision of specialist lunatic wards attached to general hospitals. The first separate institution for lunatics was St. Luke's Hospital in London opened in 1751 and by the early nineteenth century lunatic asylums were a common feature of the urban industrial landscape. Medical men were often involved in the initial establishment of voluntary asylums because of the possibilities these institutions offered for enhancing their position (see for example Scull's (1996) discussion of the early nineteenth century mad-doctor, John Conolly). The new asylums helped cement the professionalization of a group of 'mad-doctors specialising in insanity. However in the turbulent arena of early Victorian psycho-politics the medical profession met with resistance not only from private madhouse keepers (understandably worried about their livelihoods) but also from protagonists of William Tuke's moral treatment.

The medical profession had for some time been concerned with developing a model of insanity in which madness was identified as a medical category with a biological basis. The beginning of the nineteenth century thus saw a proliferation of diagnoses with specified symptoms and aetiology. The causes of insanity were seen to be inside the person; a result of physical imbalances and an eruption of nature (Porter, 1987). In
contrast, Tuke's lay theory of moral insanity viewed madness as intrinsically bound up with the social environment. It rejected established medical treatments (bleeding, blisters, evacuations, beatings) and in principle eschewed mechanical restraints\(^3\) preferring instead to offer patients an orderly physical environment in which they could regain their 'normality' (Rogers and Pilgrim, 1996). That the medical model prevailed (and eventually assimilated moral treatment into its armoury of therapeutic techniques) underlines the ascendancy of the scientific world-view during the Victorian era. For lunacy reformers madness was one of the natural ills that human flesh was heir to and its cure lay in the hands of 'scientific psychiatry'.

In the first half of the nineteenth century lunacy reform was led by an influential lobby of aristocratic philanthropists, entrepreneurs and Quakers (Busfield, 1986). Their effort in bringing lunacy to the forefront of government thinking and action was crucial to the eventual implementation of a public asylum system\(^4\). Between 1801 and 1844 there were 71 Bills relating to lunacy (Rogers and Pilgrim, 1996). Recurring scandals involving the treatment of lunatics in private madhouses\(^5\) and the few existing 'county' lunatic asylums (legalised in 1808) forced parliament and the medical profession into agreement with lunacy reformers that a comprehensive public asylum system should be established. Scull (1989) also argues that the allure of economies of scale encouraged government support for lunacy legislation. Segregated

\(^3\) Though in practice Tuke and his colleagues retained the use of certain 'material bonds' (i.e. chains) for the control of particularly violent or dangerous inmates (Jones, 1993).

\(^4\) For an account of the long-campaign by lunacy reformers to establish a public asylum system see Jones, 1993: pp. 41-77.

\(^5\) The English parliamentary inquiries of 1807 and 1815-1816 had alerted a larger public to the issue of the treatment of the insane. Many of the most serious abuses exposed by the 1815-1816 Committee implicated medical men in the beatings and maltreatment (including deaths) of lunatics. Thus, parliamentary revelations of inhumanity and neglect in the madhouses simply confirmed to many people that madhouses and mad-doctors were dangerous places and to be avoided by all who had the means to do so.
control for the mad provided an economic solution to the increase in the cost of poverty that arose from the burgeoning market economy system. Lunacy reformers also argued that asylums would provide a site of scientific cure and recovery for mental disorder, which would restore people to an economically active status. The culmination of the lunacy reform campaign was the passing of the 1845 Lunacy Act.

The 1845 Act was the crucial legislative moment in the birth of the public asylum system. It ensured that the provision of asylums became mandatory in England and Wales. All public asylums were required to have a medical practitioner specializing in mental disorder living within the physical boundary of the institution and acting as its ‘superintendent’. Thus, while asylum reform involved certain bureaucratic obligations for superintendents they were now legally recognized as the primary experts in the care and treatment of the insane. The public asylums provided an institutional basis for the development of expertise and claims to expertise, so crucial to the successful professionalization of asylum superintendency (The medical profession had struggled hard to persuade government that the superintendent post was only suitable for a medically qualified person). They also offered increased opportunities for the psychological analyses of madness and other mental deficiencies necessary for the development of a coherent conceptual framework of mental

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6 According to Scull (1989) the promise of recovery was crucial to the constitution of the public asylum system. The lunacy reform movement championed the mental asylum as the best possible hope for the recovery of lunatics. Crucial to their argument was the construction of the asylum as an ‘ideal therapeutic space’ in which people could once again be made economically productive and self-reliant. Ideologically, this vision of the asylum was extraordinarily attractive and helped secure the Victorian governing classes’ consent to the lunacy reformer’s schemes.

7 Scotland’s legislative separation from the rest of Great Britain meant that it did not develop a formal public asylum system until 1856 (see Scull, 1996: pp. 90-5 for an account of the evolution of lunacy reform in Scotland).

8 The Lunacy Act thus spelt the end of private madhouses. The Act specified that the medical profession had exclusive jurisdiction over the treatment and management of insanity.
disorder. The term 'psychiatry', which was introduced into British medicine for the first time in 1846, is further evidence of the link between the 1845 Act and the emergence of a sub-speciality of medicine.

The confinement of large numbers of pauper lunatics in purpose-built mental asylum's created opportunities for an intellectual empire which in the late nineteenth and early twentieth century was colonised by new concepts, theories\(^9\) and treatments for mental disorder. Asylum doctors (known as alienists) decided not only the boundaries of mental disorder in the broadest sense, but also the type of problems and procedures that were best dealt with in an institutional context. Typically the asylum would cater for those labelled insane, while the less severe emotional disturbances (commonly called 'neurosis') were largely the prerogative of private doctors and general practitioners. It was on the terrain of the less severe mental disorders that psychoanalytic ideas and treatments (the so-called 'talking cure') established and maintained a therapeutic foothold outside the framework of institutional psychiatry (Busfield, 1996). Thus, by the close of the nineteenth century madness and insanity was identified as the distinct intellectual and physical property of the psychiatric profession with their own claims to specialist expertise.

*The Asylum Years*

Most public county asylums were situated in the countryside and pursued a policy of segregating the mentally disturbed from the general population so as to avoid the

\(^9\) Throughout the nineteenth century a variety of medical journals appeared devoted to the idea that insanity was a disease of the brain. These publications (the most influential was the *Journal of Mental Science* first published in 1854 and the forerunner of the *British Journal of Psychiatry*) were extremely important in identifying lunacy as the professional domain of medical experts. They also helped ground
threat of ‘moral contagion’ posed by mental illness. After the 1845 legislation, both the numbers of asylums and their inmates grew rapidly. By the time of the First World War some county asylums housed upwards of 2000 inmates ensuring that they performed a major custodial function (Jones, 1972). At its peak in the mid 1950s, Britain’s asylum population reached approximately 150,000. At the same time, it became increasingly clear that these institutions were ‘anti-therapeutic’, not least because they were morally stifling as well as custodial. That the Victorians produced a morality as severe and uncompromising as their architecture is evidenced by the harsh moral regime experienced by inmates (based largely on Tuke’s moral treatment). Despite (or perhaps because of) this, the asylums provided a practical ‘solution’ to the social problem of lunacy. And because asylum superintendents were charged with defining madness and admitting patients, they could effectively create the demand for their own professional services.

The asylum doctor was adorned with the full panoply of professional power. Their charges were often restrained in immobilising chairs, spun to the point of collapse in revolving chairs, purged, starved and beaten (Scull, 1979). Eventually other less immediately punishing treatment regimes were introduced. The late nineteenth century saw the introduction of drugs. Potassium bromide, chloral hydrate and paraldehyde were widely used as hypnotics and anticonvulsants (In fact most inmates regardless of symptomatology were given some form of medication). It will be noted that the drugs mentioned also have a powerful sedative effect and excessive reliance on preparations like these was as much a managerial response to the growing number of patients being admitted to the asylum as it was a search for medical benefits.

medical claims that insanity was essentially a scientific phenomenon amenable to rational discussion and empirical investigation.
Despite Victorian distaste for mechanical restraints (e.g. strait-waistcoats and leg-locks) such devices remained in common use within all asylums. One reason for this was the relatively small number of attendants per asylum inmate, many of whom were left to manage their vulnerable (but no doubt difficult) charges in whatever practical way they thought fit.

The public asylums were for many years dependent on the labour of untrained nurses and attendants (the first training programme for asylum attendants did not take place until 1889). Their work was often arduous and exhausting (some wards accommodated up to sixty or seventy patients). They were responsible for all aspects of care: exercise, amusements, dressings and poultices, employment, and the treatment of the incontinent. Attendants could expect to work up to seventy hours per week often in split shifts (they might only have four hours sleep in twenty). Their rates of pay were low and theft of hospital property rife. 'Between 1860 and 1880, 91 out of 567 attendants were dismissed for reasons varying from 'dishonesty' and 'cruelty' to being drunk on duty' (Jones, 1993: 119). Asylum doctors were not generally keen on training for attendants for the simple reason that they would have to do (and pay for) it themselves out of the asylum budget. Some attendants worked for many years on the same hospital back wards (wards which were deemed unpopular or which housed chronic and demanding patients). It is not therefore surprising that most asylums fell prey to a culture of bullying and petty tyranny by bored and unsupervised attendants.

By the close of the nineteenth century public asylums had become mammoth, custodial institutions. In the half century following the introduction of the compulsory
asylum system while the general population grew by 80 per cent the number of lunatics quadrupled (Scull, 1979). The reasons for this growth are varied. Nineteenth century doctors were convinced that mental disorder was on the increase (as a consequence of industrialisation and a rapid growth in population and geographical mobility). Another view simply sees the growth of the asylum in terms of medical progress and greater benevolence towards the 'mentally ill'. Yet another posits that asylums were a disciplinary response to the poverty caused by an expanding market economy system (Scull, 1979). In response to these explanations Jones (1972) has noted that many of those admitted to asylums had problems which were well-advanced by the time of admission. In part, this was the result of the institutional bias of the poor-law system which meant that families in need of help for disordered relatives could only obtain poor-law relief in institutions. In part, it was because of the custodial, last resort character of the institutions themselves (Those admitted were held on a compulsory basis). Asylums thus became clogged up with chronic cases many of whom were unnameable to therapeutic intervention.

Within this closed and forgotten world, the nineteenth century asylum patient’s life was harsh and unremitting. Their lot was essentially one of work, plain food and conformity. Physical, psychological and social restraint was freely employed and asylum staff always had the comfort of knowing that the 'unimproved' or difficult patient was safely segregated in a setting where the social mores of society would not be offended. The inmates were largely poor and were expected to display suitable gratitude for the care and shelter provided. There was considerable social distance between staff and inmates and an aroma of moral censure permeated the attitudes of many who worked there. New patients quickly learnt their place in the asylum’s pecking order and it was unlikely that once they had been 'put away' they would be
able to re-emerge and assume their former place in society. This loss of liberty was compounded by a loss of individuality once immersed in the system. Inmate’s lives became moulded to the needs of the institution until finally, they became institutionalized and dependent on the regime that was supposed to effect their cure.

However, as the present century unfolded experimental (cynics might say desperate) attempts to do something for the masses of forgotten asylum patients began to appear. Within psychiatry the suspicion that insanity was the result of an organic disease found legitimacy in new modes of biological thinking. Developments in German psychiatry had a particular impact on European psychiatric thought. The work of Griesinger and Wernicke emphasised the congruence of psychiatry and neurology and helped establish academic psychiatry as a university discipline (Porter, 1997). Influenced by German models, physical treatments focusing on the brain were seized upon by many European psychiatrists. In 1933 Sakel introduced insulin therapy in the (mistaken) belief that hypoglycaemia associated with a carefully induced insulin coma would somehow interrupt abnormal neural connections in the brain. In 1935 the Portuguese neurologist Egas Moniz introduced psychosurgery (prefrontal leucotomy) for the management of obsessions and anxiety. The procedure, for which Moniz was awarded the Nobel Prize, spread rapidly throughout the world and formed an important component of the psychiatric arsenal (It continues to be used today on a small scale).

These latter modes of psychiatric treatment are well known. However, less well known are other bizarre treatment approaches that reflected psychiatry’s strong desire

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10 A highlight was the discovery around 1900 that syphilis was the cause of a condition called General Paralysis of the Insane, which affected a large group of patients, and seemed to give hope that a physical basis would soon be found for all types of mental disorder.
to be taken seriously within the scientific world. These include: malaria therapy (the rationale was to induce a fever so that the resulting heat would fry the disease); transplantation of endocrine organs; surgical removal of large parts of the small intestine; renal dialysis; and metrazol-convulsion therapy (see Clare, 1980). Although these haphazard attempts at treatment assumed drastic physical forms they nevertheless helped ground psychiatry’s claims to scientific legitimacy. In 1938 Cerletti introduced electroconvulsive therapy (ECT). It immediately assumed ‘heroic’ status within the therapeutic armoury of the asylum and was freely applied to most inmates regardless of symptoms. The idea of ECT was to induce an epileptic type seizure in individuals in the hope of alleviating distressing mental symptoms (ranging from mania to depression). It was partly because of the hostility that shock treatments later attracted both within the institution and in society at large, that when the new range of psychotropic (mood-influencing) drugs becoming available after the war they were greeted with great enthusiasm by psychiatric professionals (Porter, 1991).

De-institutionalization and Community Mental Health

As early as mid-Victorian times, when the asylum-building programme was at its height, many of those involved in the drive to establish the new system expressed concern that a gigantic asylum was a gigantic evil (Porter, 1991). However, a full century would pass before the modern anti-psychiatric movement began to systematically catalogue the negative effects of institutionalization. During the Second World War the British psychiatrist Maxwell Jones began to generate interest in an alternative approach to caring for the mentally ill. His supervision of armed forces personnel traumatised by the experience of war led him to the view that large
Debates and Issues in Mental Health

Institutions were not suitable to caring for many types of mental disorder. He argued for a more democratic restructuring of the care setting in ways which led to the establishment of more open and patient-centered facilities. The concept of the 'therapeutic community' was born. With it came the hope that community-based mental health care might prove a more therapeutic site of treatment for those with mental problems.

The years 1954-59 has been described as ones of 'therapeutic flux' in British psychiatry (Jones, 1993: 150). During this critical period the barriers between the mental hospitals and the outside world began to erode. A combination of new and highly effective psychotropic drugs (see below), the rise of the anti-psychiatry movement, and mounting fiscal pressures together triggered an 'open door' movement in psychiatry. For the first time Britain's mental hospitals began to unlock their doors and give patients some freedom of movement. The notion of psychiatric day hospitals attached to District General Hospitals was suggested as a possible new setting for community-based mental health care. Many politicians favoured this approach since it offered the prospect of reducing the large numbers of very expensive psychiatric beds. It was a Conservative Health Minister, Enoch Powell, who delivered the clearest possible signal that the large mental hospitals had had their day. In an address to the annual conference of MIND (the National Association for Mental Health) in 1961, he spoke in characteristically uncompromising terms of the elimination of most of the country's mental hospitals within fifteen years. He described them thus:

There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity. Do not for a moment underestimate their power of resistance to our assault (Jones 1993: 160).
Powell's assumption that an asylum closure programme would be strongly resisted was correct. Many superintendents opposed his policy arguing that the mental hospital was, amongst other things, a great success in caring for many vulnerable and friendless people and therefore should not be allowed to decline and disintegrate. But the superintendents had a vested interest in maintaining the traditional system. Their position carried great prestige and authority within the hospital power structure (which placed them at the apex of the hospital hierarchy and patients very firmly at the bottom) and many viewed their patients as little more than vulnerable children who needed constant care and attention. Such *infantilization* (a direct consequence of the moral treatment regime borrowed from Tuke) meant that patients could not develop fully adult roles within the hospital setting and certainly could not challenge their medical treatment. Indeed, such was the authority of the superintendent that even junior members of the medical and nursing staff were unable (or unwilling) to challenge them about any aspect of their regime. The entire asylum was under the powerful punitive influence of the superintendent.

Despite the superintendents' hostility to asylum closures however, support for a community based mental health system quickly began to gain support from a number of sources. For the DHSS (the Department of Health and Social Security), it made sound financial sense to treat psychiatric patients on the site of existing general hospitals rather than to duplicate hospitals and ancillary staff. It was also anticipated that a vigorous community care system could further reduce the need for hospital treatment and thereby reduce costs (Clare, 1980; Scull, 1977). But amongst those most supportive of the plan to close the mental hospitals were a growing number of newly trained psychiatrists keen to have their expertise recognized as on a par with that of their medical and surgical colleagues:
The majority of psychiatrists desired to be recognized as clinicians within the mainstream of medicine and saw the promised transfer of their work from the isolated mental hospitals to new units situated alongside their medical and surgical colleagues as tangible evidence of such recognition (Clare, 1980: 415).

The asylum had provided the context in which psychiatry had successfully medicalized madness. In this respect the work of the asylum was complete. What was now imperative was to bring psychiatry in from the margins of scientific medicine and establish its rightful place as a speciality on a par with, say, obstetrics or neurology.

Meanwhile, the effects of protracted institutional living - collectively described as institutionalization - was beginning to attract public attention. The hospital environment was the subject of a number of powerful critiques on both sides of the Atlantic. Long-term institutional care was identified as the cause of apathy, dehumanization and passive dependence which, in combination, render the patient helpless and may be more damaging than the disorder leading to their hospitalization in the first place. In 1959 a British psychiatrist, Russell Barton, produced the important book Institutional Neurosis in which he used the term announced in the title to describe (and thus medicalize) the constellation of adverse effects of institutionalization upon patients. The ‘mental bed sores’ described by Barton gave way to an even more damning account of institutional life. The American sociologist Erving Goffman’s analytical dissection of a public asylum in Washington D.C. (published in 1961) revealed the degree to which the rigid confines of the mental hospital ‘stripped’ people of their individuality and led inevitably to social atrophy. Goffman’s book helped to reinforce a picture of the mental hospital as an outdated, custodial institution unsuitable to the promotion of good mental health.
His work acquired widespread currency amongst those who saw the mental asylum as the crucial factor in forming mental patients. Its efficacy as a therapeutic environment was placed in serious question in many western countries. The legitimacy of community care for the mentally ill therefore emerged, not through a careful demonstration of its merits, but by rendering the alternative unthinkable: 'who in the circumstances would attempt to dispute the claim that “the worst home is better than the best mental hospital”' (Scull, 1989: 310). Community-based mental health care was presented as superior to institutional care primarily on the grounds of its difference from what had previously been the dominant therapeutic strategy. The psychiatric profession, stung by a succession of internal and external criticisms of its institutional practices, pushed hard for reform of mental health policy and saw a move to the community as an opportunity for greater professional prestige. This negative re-evaluation of the asylum eventually led to two important developments, deinstitutionalization policies, through which thousands of mental patients were released from long stay hospitals, and the allied psychiatric orientation towards social and community care (Samson, 1995).

The movement for the abolition of the mental asylum gathered pace throughout the 1960s. The Ministry of Health issued the Hospital Plan for England and Wales a year after Powell's speech. The Plan stated that mentally ill and other similar patient groups (such as the mentally handicapped) would no longer occupy hospital beds for long periods (Jones, 1993). Mental illness was recast as acute illness rather than as a chronic problem requiring long-term institutional facilities. Psychiatric treatment

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11 Sir Keith Joseph encapsulated the new approach towards the treatment of acute mental illness during his tenure as Conservative Secretary of State for the Social Services. In the year of his appointment (1971) he announced with some enthusiasm: 'Psychiatry is to join the rest of medicine... the treatment of psychosis, neurosis and schizophrenia have been entirely changed by the drug revolution. People go into hospital with mental disorders and they are cured, and that is why we want to bring this branch of
would in future be concentrated in the new District General Hospital that would provide acute treatment in all medical specialisms. Although admissions to asylums began to drop from the mid 1960s, the reduction in the overall numbers in long-stay psychiatric beds was slow. The full impact of community care policies only began to be felt in the following decade with the introduction of small psychiatric units situated in the new District General Hospitals. The new model of care aimed to provide services for every stage of the illness, and to emphasize prevention as well as cure: through primary care facilities, hospital beds for chronic patients, day hospitals, residential care, hostels, out-patient clinics and so forth. This diverse range of services called for greater involvement from a wide range of specialists in mental health not just the psychiatric profession.

Since the early 1980s the delivery of ‘individual patient care’ has been the responsibility of the multidisciplinary (MDT) psychiatric team. The MDT is made up of a range of professionals (including community psychiatric nurses, occupational therapists, psychologists, and social workers) working alongside (rather than subordinate to) psychiatrists in supporting the mentally ill. MDT’s therefore contain a broad spread of views and experience. Although, typically, the MDT works together each profession has developed specialists in their own individual area of practice. The proliferation of specializations within the mental health system has compounded the erosion of medical dominance within psychiatry begun by the dismantling of the asylum system. Community psychiatric nurses and social workers have emerged as important figures in the community care enterprise acting as a mediating link between the MDT, the patient/client and their family. It is in this context of the non-medical
mental health practitioner assuming a primary care role that British psychiatry has arguably been transformed into a more egalitarian system of health care than was possible during the asylum era.

_Mental Health Services in the 1990s_

Although the idea of community-based mental health care has been promoted by successive national government’s the rhetoric has not matched the reality. Despite Powell’s reference to asylums as ‘doomed institutions’ (Jones, 1972: 322), mental health services remained highly dependent on institutional and hospital-based resources until the 1980s. Margaret Thatcher’s third Conservative administration finally brought to fruition Powell’s vision of asylum closures. The 1990 National Health Service and Community Care Act can be considered a ‘defining moment’ in the acceptance of care within communities as the preferred way of meeting the needs of older people, disabled people and those with mental health problems or learning difficulties. The Act committed local authorities to provide both acute and long-term care in a community-based context (though its implementation was delayed until April 1st 1993). The Act immediately accelerated the previously slow decline in mental hospital/residential beds. Many thousands of long-stay and chronic patients found themselves discharged from hospital and under the care of local social service departments rather than a specialist mental health service.

One the major criticisms of deinstitutionalization centered on the political support given to care in the community by the Conservative government. For many, the community care policy was driven primarily by fiscal rather than social concerns. The
evidence for this claim lies in the fact that expensive and costly long-term psychiatric beds have been cut in favour of less expensive community services for acute, less serious mental disorders (Busfield, 1986). The disappearance of long-stay psychiatric beds and the lack of a co-ordinated discharge policy have also created a vacuum at the heart of care policy for mentally ill people. This has led to an explosion of private, residential care for this vulnerable group of people. Places in private residential homes are funded through social security benefits and a new breed of ‘mental entrepreneurs’ has emerged to exploit the profits to be made from housing the chronically mentally ill. Between 1978 and 1989 for example, total spending on supplementary benefit leapt from £80 million to £1.5 billion (Muijen, 1995). In short, a new trade in lunacy has emerged that dwarfs the profits made in the private provision of residential care for the mentally ill in the nineteenth century.

Models of Mental Illness

The decline in the pre-eminent position of the mental asylum has also been matched by a decline in adherence to medical models of mental illness amongst mental health professionals. The values and assumptions of bio-medical psychiatry have traditionally been most secure in the context of the mental asylum in which doctors held the balance of power (Samson, 1995). The movement away from the asylum has meant that orthodox bio-medical concepts of mental health and illness have become much more insecure. Likewise, particular professional approaches to ‘curing’ are increasingly open to question. The long-standing philosophical and sociological

12 Private residential homes catering exclusively for the mentally ill are usually described as ‘hostels’ or even ‘hotels’ in order to avoid the employment of expensive psychiatric nursing staff. The fact that residents are discharged from hospital and thus no longer formally recognised as ‘patients’ means that the more unscrupulous proprietors need only employ a bare minimum of untrained staff.
critique of psychiatry has found renewed enthusiasm amongst those concerned about the ‘socially relative’ nature of both psychiatric knowledge and general concepts of illness (Sedgewick, 1982). This critique has been especially influential amongst psychiatric professionals working on the fringes of medicine (such as social workers or psychotherapists). The social model of mental illness has therefore been one of the main beneficiaries of de-institutionalization.

The work and approach of western psychiatry, like most branches of the medical profession, is based on a scientific method which, according to its practitioners’ own professional self-conception, justifies its institutional separation from lay knowledge of the ‘human mind’. Thus, while psychiatrists acknowledge their power as an occupational group with specialist knowledge, they do so in the belief that they exercise their power and knowledge in the best interests of both individual patients and society. However, an alternative view of psychiatry sees it as a dominating profession which has historically monopolised the provision of mental health care within the institutional context of the hospital/asylum and has consistently made covert value judgements about a person’s ‘mental illness type behaviour’. This division between the ‘pro’ and ‘anti’-psychiatric lobby underpins a crucial point: that psychiatry operates not with a straightforward consensus about its clinical and diagnostic practices but in a force-field of conflicting ideologies and competing models of mental illness.

The ‘medical model’ of psychiatry has long faced opposition from other, ‘social models’ of mental health care (Tuke’s theory of moral insanity being perhaps the first instance of lay opposition to a medical model of mental disorder). Medical models are based upon the assumption that mental disorders are illnesses like any other. There is
assumed to be a pathological lesion within the brain that leads to disturbed function, the lesion being assumed to be genetic or biochemical. Medical models do not exclude the effect of social and/or psychological forces, but place them in a subordinate relationship to physical changes in the organism. They see the mentally disordered as suffering from illnesses that are, as yet, incurable and only amenable to palliative treatment (aimed at relieving the symptoms rather than an unidentified cause). Such approaches display a marked preference for physical treatments (drugs, electric shock treatment and, occasionally, psychosurgery) which are distrusted by many critics of psychiatry who tend to view them as essentially punitive measures. However, many psychiatrists point to the amelioration of symptoms as evidence of their treatments’ success (see Roth and Kroll, 1988).

Social models on the other hand, tend to emphasise the presence of social and psychological factors in the aetiology of mental disorder. Whereas medical models situate ‘the problem’ firmly inside the patient, social models locate the roots of mental disorder in social and family structures. ‘Mental illness’ is seen as a label applied by psychiatrists to certain forms of ‘deviant’ behaviour with the result that ‘patients’ are stigmatised in much the same way as criminals (Schell, 1966). Much of the momentum behind the concept of labelling is derived from an appreciation of the arbitrary nature of psychiatry’s diagnostic process (that practitioners usually first decide what to do about a person, and then ‘discover’ the appropriate diagnostic label with which to justify their decision). Labelling theory also posits that persons begin to act as mentally ill only after and as a result of having been labelled as such by psychiatrists acting as agents of the dominant social order (see Rosenhan, 1973). A rider to this view holds that the full clinical picture and deteriorating course of
illnesses such as schizophrenia are caused not by the unfolding of the disease process itself, but by the effects of hospitalization upon the patient.\textsuperscript{13}

Labelling theory was mostly an external critique. However one of the most influential counters to orthodox psychiatry came from within psychiatry itself. R.D. Laing’s critiques of his own profession has attracted both veneration and vituperation. It has been enshrined by the broad left as encapsulating a scathing indictment of the tyrannical bourgeois family and capitalist society. But it has also been roundly condemned by many social scientists as mystical, confused and unscientific. Laing’s work on the meaning of madness is imbued with a deeply humanistic concern for the plight of those labelled as ‘mentally disordered’. His first book, \textit{The Divided Self} (1959), presented what would become a lasting contribution to the philosophical analyses of bio-medical psychiatry and the rendition of schizophrenia as an ‘intelligible’ phenomenon. His principle claim was that seemingly irrational and schizophrenic responses are in fact ‘normal responses to an abnormal situation’. Laing’s thesis is that the behaviour called schizophrenia is a strategy by means of which sensitive people can live in an unliveable situation, a creative form of escape from the madness of the ordinary world.\textsuperscript{14}

\textsuperscript{13} The premise here is that the person was only a ‘little deviant’ prior to hospitalization but became fully so once an illness label had been attached. However, social labelling theorists have been accused of ignoring evidence which suggests that seriously mentally disturbed behaviour has been recognised by family members for considerably long periods of time before medical help is sought. Only then, months to years after the onset and full development of an illness is a diagnosis offered (see Roth and Kroll, 1986).

\textsuperscript{14} In a passage in the preface to the second edition of \textit{The Divided Self} (1965: 11) Laing describes our ‘present pervasive madness’ thus: ‘A man (sic) who prefers to be dead than Red is normal. A man who says he has lost is soul is mad. A man who says that men are machines may be a great scientist. A man who says he is a machine is ‘depersonalized’ in psychiatric jargon. A man who says that Negroes are an inferior race may be widely respected. A man who says his whiteness is a form of cancer is certifiable’.
Laing's name is often coupled with that of Thomas Szasz. Szasz (1974: 8) suggests that, strictly speaking, illness can only affect the body, not the mind: 'Mental illness is not something a person has, but is something he does or is'. His argument (similar to Laing's) is that mental hospitals are prisons and that those who work in them are jailers. However, Szasz does not deny the concept of mental disorder but vigorously attacks the concept of 'mental illness'. He suggests that people who have 'life problems' such as being victims of racism) are thrust into the 'sick role'. While the 'neurotic' embraces the role in order to receive help with problems of living, the 'psychotic' may have the sick role involuntarily applied. It thus acts as a convenient way of labelling objectionable behaviour and helps to justify 'treatment' by incarceration. In other words Szasz considers traditional psychiatry to be a form of social oppression which suppresses and controls deviant minorities under the cloak of medicine. However, it is important to note that his opposition to institutional psychiatry is delivered from the point of view of a psychiatrist in private practice. His main target was a publicly funded mental health service, which in the United States posed a considerable threat to private psychiatric practice.

*The Contested Terrain of 'Mental Illness'*

Mental illness, like its nineteenth century counterpart madness, is an evaluative concept which categorizes some aspects of thought, action, or behaviour as abnormal, defective or disordered. According to Foucault (1987) this involves first and foremost, a judgement of mind rather than of behaviour. His argument is that 'madness' is constructed in opposition to reason, and that it is therefore unreason and irrationality.

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15 Both Szasz and Laing's claim that the mental hospital was essentially a prison found 'empirical' support Goffman's influential critique of asylums as 'total institutions' not dissimilar from jails and borstals.
that are presumed when an individual is identified as mad/mentally ill. But it is not the content of ideas and beliefs per se that underpin claims as to irrationality. Rather they are typically grounded in judgements of the way in which beliefs, ideas and actions are grounded and accounted for (see Smith, 1978). Disputes over what does or does not constitute mental illness cannot therefore be easily settled by resort to ‘the facts’. They necessarily involve judgements, values and ethics. Establishing the boundaries between different types of mental disorder is often the result of lobbying and competition between medical practitioners working in the field. and outcomes vary across time and place. As a consequence, the demarcation lines separating mental illness and mental health are continually contested.

We cannot, with any confidence, draw a simple dividing line and insist that those characteristics falling on one side are invariably to be found only in the mentally ill and those on the other are only to be found in the mentally healthy. Between the stark confusion and despair of mental illness and the lived peace and contentment of mental health, there lies an extensive gulf of unhappiness and maladjustment within which we can be far less sure of our categories. Within this intermediate zone there are many people whose behaviour may well be disturbing to established norms (for example, glue sniffers) but who cannot be easily subsumed under a simple definition of ‘mental illness’. However, despite these difficulties of attribution the psychiatric profession has over the years advanced strong claims for its ability to classify and diagnose mental illness in its various manifestations. This has always been a disputed and

16 The now classic example is homosexuality, which had been included as a mental illness in the American Psychiatric Association’s Diagnostic and Statistical Manual. However in 1972 the Association decided (by postal vote) that it was not in itself an illness and removed it.
controversial exercise and nowhere has psychiatry’s taxonomical endeavour been more troublesome than with the concept of ‘schizophrenia’.

The Disputed Concept of Schizophrenia

The severe abnormalities of experience and behaviour associated with schizophrenia have been described by clinicians for more than a century. According to most accounts, it is a major mental illness characterized by various symptoms including; visual and auditory hallucinations, delusions, bizarre beliefs, thought disorder (manifest in incoherent speech), social withdrawal and lack of insight. However, despite the apparent certainty of such definitions schizophrenia continues to provoke fierce disagreements. According to one researcher, ‘[s]erious questions remain about whether schizophrenia can be considered an illness; about whether it is one condition or several, about whether clear dividing lines exist between schizophrenia and normal functioning or even between schizophrenia and other kinds of mental disorder’ (Bentall, 1990: xiii). Despite one hundred years of research and clinical interrogation then, there is no consensus about what schizophrenia is, what causes it, and whether or not there is (or should be) a ‘cure’. Furthermore, doubts about the validity of ‘schizophrenia’ as a medical label surface constantly in relation to claims concerning the problematic status of the concept of mental illness more generally.

Doubts about the medical concept of ‘mental illness’ are played out against a backdrop of continual dispute over schizophrenia and the arguments surrounding its present position as the cornerstone of modern psychiatric theory. This has led some critics to suppose that one can bring the whole edifice of psychiatry crashing down simply by demolishing ‘schizophrenia’ as a scientifically valid category (The work of...
Szasz is often cited as an example of this approach. No other type of mental disorder has such a reputation. The antipsychiatric movement of the 1960s and 1970s reserved its fulmination almost exclusively for schizophrenia. In contrast, ‘manic-depression’, schizophrenia’s main bedfellow in psychiatry’s classificatory system of major mental illnesses, has been relatively ignored by the fierce ideological battle being waged over the existence/non-existence of ‘mental disease’. This is in part a consequence of a more clear-cut aetiology and relatively successful treatment approach (such as lithium, which helps stabilize mood). But it is also due to the persistence of strong competing views of schizophrenia as both a scientific concept and a political issue.

At the centre of controversy has been the lack of empirical evidence to justify schizophrenia’s status as a scientific concept. Boyle (1990), for example, has argued that the concept was full of contradictions at birth and remains so now. Her view is that early evidence for the existence of schizophrenia is unreliable but that its survival as a concept is crucial to psychiatry’s continued credibility as a medical profession: ‘Given the central role attributed to ‘schizophrenia’, the vast literature surrounding it, and the research effort to validate claims made about it, it seems reasonable to suggest that psychiatrists are dependent upon its retention as the prototypical psychiatric disease’ (Boyle ibid: 179). The problematic status of schizophrenia as a classification is further compounded by social scientific objections to the label ‘schizophrenic’ and the value judgements it incurs. Many sociologists of illness have denied that

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17 The objection appears to stem from the task of trying to place physical and mental illnesses on the same (positivist) footing, in order to reduce the controversial nature of the distance between the two (see Sedgwick, 1972). Many social scientists argue that by working in the reverse direction (relativism rather than positivism), the character of both physical and mental illness can be revealed as ‘social constructions’. Intrinsic to this view is the point that there are no ‘illnesses or diseases in nature’ outside of the significance that humanity attaches to them in a given culture. This is not to deny that diseases would exist as phenomena in the world if we did not recognise them. Indeed, it is precisely their existence that necessitates trying to make sense of them if we are to diminish human suffering.
mental 'diseases' are meaningful scientific realities, regarding them as 'labels' pinned on patients for reasons of social and professional convenience: that which is disturbing gets called 'disturbed'. In other words, the disorder may not be 'real', but an artefact of the encounter between psychiatrist and patient in which the former exercises power over the latter.

Even from this brief sketch it is clear that the concept of schizophrenia does not command consensus. It lies on the cusp of competing interpretations of mental disorder; scientific, historical and sociological discourses each making sense of the subject according to its own particular agendas. However, scientific discourse has clearly had most direct impact upon individuals. It is from the formulations of scientific psychiatry that we have inherited a highly deterministic view of the unfolding of schizophrenic lives. A crucial issue here is the degree to which an exclusively scientific account of schizophrenia precludes and obscures other possible interpretations. The 'discovery' of schizophrenia is rooted in the nineteenth century asylums of Europe. It is from within these places that psychiatry derives its power to define and classify certain types of behaviour and experience as 'schizophrenic'. But it is also in these places that the 'disease entity' of schizophrenia is implicated in a social history that has had, and continues to have, a bearing on how we view schizophrenics. In order to understand the relation of medical ideas about schizophrenia to moral judgements about schizophrenics we will briefly trace the origins of the condition.

However, the concepts we invent to account for the disease come to shape not only the observations we make and the remedies we prescribe, but also the very manifestations of the disease itself.
The Making of Schizophrenia

In 1896 the great German psychiatrist Emil Kraeplin (1856-1926) introduced his important differentiation between manic-depressive psychosis and ‘dementia praecox’. His pioneering work on a classificatory system for mental disorder led him to a study of specific clusters of symptoms, showing particular patterns of onset, development and outcome. Bringing together existing concepts of ‘hebephrenia’ (an incoherence in the train of thought as well as marked emotional disturbance), catatonia and paranoia into a single disease entity his formulation outlined a degenerative psychotic condition with typical autistic features. Kraeplin described the characteristic symptoms of the dementia praecox patient as including: hallucinations (usually of an auditory nature), a decrease in attention towards the outside world, an interruption of the thinking process, an impairment of understanding and judgement, delusional beliefs, emotional blunting and stereotyped behaviour (Clare, 1980). The term was to prove short-lived however. Firstly, many dementia praecox patients did not show a permanent dementia. Secondly, the term encouraged a rather hopeless prognosis and therapeutic nihilism. Within a decade Kraeplin’s identification of dementia praecox had been superseded by another formulation which would prove far more durable.

It was the Swiss psychiatrist Eugen Bleuler (1857-1939) who in 1908 first used the term ‘schizophrenia’. He chose the term because, as he put it, ‘...the rending (disconnection) or splitting of the psychic functions is an outstanding symptom of the

18 Current diagnostic practice, reflecting the influence of Kraeplin, postulates the existence of two major functional psychoses - schizophrenia and manic-depressive psychosis - which are regarded as separate and discrete mental disorders.
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whole group"¹⁹ (Clare, ibid.: 122). Bleuler’s conception was wider than Kraeplin’s. He retained the concept of a disturbance in the coherent integration of ideas and emotions as an essential feature of schizophrenia, but did not speak of a discrete disease per se. He used the term in the singular, but was in no doubt that he was dealing with a group of diseases: the schizophrenias²⁰. Kurt Schneider, a German psychiatrist, further consolidated the definition. In 1959 Schneider identified a number of symptoms which he regarded as of first rank importance in differentiating schizophrenia from other psychotic conditions. First-rank symptoms comprise thought disorder (such as believing that thoughts or actions are under the control of an external, alien force), auditory hallucinations in the third person (e.g. disembodied ‘voices’ maintaining a running commentary on one’s actions, or discussing thoughts or behaviour as they occur), and primary delusions (e.g. delusional ideas arising from perceptions which are in themselves normal). In Britain these symptoms have been adopted as the operational benchmark for diagnosing schizophrenia (Clare, ibid.).

¹⁹ The term ‘schizophrenia’, although literally meaning ‘splitting of the mind’, refers to a fragmentation of thought processes in which a sufferer’s personality is said to ‘deteriorate’. Bleuler’s original formulation emphasised possible psychodynamic factors in the onset of the disorder. In contrast, Kraeplin’s dementia praecox emphasised the probability of a biological causation. British psychiatry has favoured the Kraepelinian approach whilst the greater influence of psychoanalytical theory in the United States has meant that Bleuler’s concept has found more fertile ground (see Boyle, 1990: pp. 16-41).

²⁰ Subsequent classifications of schizophrenic disorders identify four main types: Simple schizophrenia (Onset is usually adolescence with insidious and slowly progressive deterioration of personality. Hallucinations and delusions are usually absent The primary symptoms are emotional blunting and loss of volition.); Hebephrenic schizophrenia (Onset is usually in late teens. The underlying state is one of dullness and apathy though behaviour may be erratic and unpredictable. Auditory hallucinations are common.); Paranoid schizophrenia (This form has a later onset (30-50 years) and the major symptom is the presence of delusions of persecution with auditory hallucinations.); Catatonic schizophrenia (This form is commoner in females. It has become increasingly rare in the last 30 years and many catatonic symptoms may have been a response to institutionalization. The essential feature of this form is psychomotor disturbance, often alternating between the extremes of hyperkinetic excitement and catatonic stupor). For a detailed medical overview of schizophrenia see Clare, 1980: pp. 120-68.
Schizophrenia as Other

The ‘discovery’ of schizophrenia as an all-encompassing illness finds clear expression in the creation of the asylum system. However, arguably the figure of the schizophrenic was not produced so much by the asylum as by their exclusion from a wider field of social forces. Nevertheless, the asylum came to play a crucial role in making the schizophrenic more nearly resemble what others took them to be (demented, feeble-minded, unpredictable, etc.). It also provided the conditions of observation in which social judgements could be made about their broken and biologically flawed individuality. In this context asylum doctors became distrustful of what their charges actually said. They heard not the person, but the ‘typical’ illness, the psychosis at the heart of every schizophrenic’s improper engagement with the world. The patient, we were told, showed little meaningful interest in the outside world, neither engaging nor communicating with it. Their condition rendered them incommunicado, alien from humanity. This designation of schizophrenia as flawed individuality ‘brought into focus one of the inchoate tendencies of psychiatry, the notion that insanity was essentially alien, different, other’ (Porter, 1987: 34).

Critics of orthodox psychiatry such as R.D. Laing have observed that it is a short step from claiming madness to be alien and meaningless to the notion that it is incomprehensible and inaccessible. The suffering of the schizophrenic (if we allow that schizophrenia is an illness in which suffering occurs) further compounds the

21 This is not to deny that many of the ‘chronic symptoms’ displayed by patients hospitalized in large, impersonal and faceless asylums resulted from the institutional environment in which they were contained. Rather it is to suggest that the identification of the chronic schizophrenic was the inevitable consequence of their inability to take part in the productive process. They were perceived as valueless in relation to the requirements of the labour market (see Barham, 1992: pp. 85-7).
obstacles to communicating with them. Their psychotic symptoms - 'voices', delusions, thought disorder - are the very stuff of incomprehension. Following Kraeplin, generations of doctors and other experts have been taught that this failure to communicate, to interact properly, is the fault of the schizophrenic (or more precisely is the fault of the disease process as manifest in individual patients) rather than the inability of the professional to deal with 'disturbed' patients. This has led 'to an extraordinary deafness towards the communications of the disturbed, and in particular a discounting of the reactions to, and complaints against, the psychiatric treatment meted out to them. The protests of the mad have been interpreted as symptoms of their madness' (Porter, 1987: 5). We have thus inherited a deep disposition to see schizophrenia as an abyss of difference, a 'constellation of pathology' which sets the patient apart from other human beings.

The destination of those labelled 'schizophrenic' has for the most part been as long-term inmates of asylums. Their fate has largely been in the hands of psychiatrists but the psychiatrists' diagnoses push the person further and further into the role of the Other. They become dangerous 'outsiders' existing beyond the moral community. For many thousands of schizophrenics discharge from the asylum was not something to be expected. Theirs was an all encompassing condition to which loss of liberty was the only appropriate response. In crucial respects the custodial history of the asylum is recapitulated in the traditional account of schizophrenia 'as a narrative of loss in

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22 The notion of 'moral community' is used here in the sense that moral considerations appear to inform judgements and decisions about what constitutes mental illness. Thus, where the intelligibility of an action cannot be adequately perceived as deviance of an 'accepted' kind (i.e. breaking a rule knowingly or intentionally) the ascription of mental illness is likely from a lay person and, consequently, has a very high probability of being confirmed by psychiatrists, albeit with the gloss of a medically defined diagnosis.
which the pre-illness person goes missing, seemingly abandoned by the force of the disorder' (Barham and Hayward, 1991: 2). They are cast out from the role of ordinary citizen and lose all rights and obligations normally attached to that status. The schizophrenic is someone in whom a drastic rupture has taken place in the continuity of their biography: 'Suppose we ask, 'Who and what existed before the illness, and who and what endure during and after?' Some schools of thought... 'do not accept that there is an “after” with schizophrenia, only before' (Barham and Hayward, 1991: 2, my emphasis).

*New Problems, New Controversies*

The closure of asylums does not mean that the difficulties of schizophrenic people are over, however. On the contrary, there are presently a number of contentious issues surrounding Britain's mental health system which affect, to a greater or lesser extent, both people with a diagnosis of schizophrenia and their carers alike. Firstly, there is the issue of what constitutes proper *provision of care* for schizophrenics discharged from mental hospitals under care in the community arrangements. Secondly, the concept of ‘labelling’ people as ‘schizophrenic’ continues to focus attention on the medical conception of the meaning of hearing ‘voices’. Thirdly, there is concern over the *treatment practices* of orthodox psychiatrists and in particular their apparent over-reliance on drugs to treat schizophrenia. Fourthly, there is the issue of *equity of treatment* for black schizophrenic patients detained within the mental health system. It is to these four areas of controversy that we now turn.
The transfer of Community Care responsibilities to local authorities, although welcomed by many mental health professionals, has brought new problems and controversies. With Community Care reform has come criticism that the mentally ill are no longer in receipt of appropriate (i.e. medical) treatment and allied support both because of a lack of properly trained staff (especially community psychiatric nurses) and the absence of adequate local authority day-care facilities. Moreover, housing shortages mean that thousands of former mental hospital patients are now homeless and are unable (or unwilling) to be monitored by mental health professionals and general practitioners. Consequently, Community Care policies have resulted in potentially dangerous individuals being left to roam the streets becoming at the very least a public nuisance and, at worst, a threat to themselves and/or others. Notwithstanding the accuracy of such claims (and the significant, though little reported fact, that the risk of serious violent attack from mentally ill individuals is very small24) two heavily publicised violent incidents involving mentally ill people discharged from psychiatric hospitals have become synonymous with the supposed failure of Community Care.

Firstly, the murder in December 1992 of Jonathan Zito, a passenger on a London Underground train attracted considerable media attention after it became clear that Zito was the random victim of a mentally ill man who had recently been released from a psychiatric hospital in order to receive care in the community. It was widely

23 G.P.'s are extremely reluctant to take homeless mentally ill people on to their books, a problem exacerbated by fund holding arrangements that make chronic mental illnesses (e.g. schizophrenia) a financially unattractive condition to treat.
reported that Zito's killer, Christopher Clunis, was a paranoid schizophrenic with an apparently long and unpredictable history of violence. Clunis had become increasingly paranoid in the days and weeks before his attack on Zito yet had failed to be given the appropriate treatment which might have prevented his mental condition from worsening. Following his arrest it was established that Clunis believed fellow passengers on the Underground were about to harm him and this prompted him to launch an attack on Zito, stabbing him to death. Zito's murder and Clunis's subsequent incarceration in Broadmoor special hospital were widely reported on by the British media and mobilised to illustrate the problems apparent in the care in the community approach. The crucial question asked by the media was whether Zito would still be alive if Clunis had received proper medical (i.e. drug) intervention in the days building up to the attack.

The second incident involved another schizophrenic, Ben Silcock, who was badly mauled after climbing into the lions den at London Zoo on New Years Eve 1992. The incident had occurred only days after Silcock tried, but failed, to gain admission to his local psychiatric hospital. He had recognized that his schizophrenic symptoms were worsening and had sought treatment. However, rather like the character Yossarian in Joseph Heller's *Catch 22*, it was felt by medical staff at the hospital that his action was itself evidence that he was not suitable for in-patient treatment and he was refused admission. The incident was significant (and especially newsworthy) because

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24 In fact MIND point out that Community Care has led to increased harassment and a number of extremely violent attacks upon former mental patients by members of the public (see Sayce, 1995).  

25 Following Clunis's conviction the Zito case continued to attract public interest because Zito's widow and Clunis pursued a joint legal challenge against Camden Mental Health Trust for failing to provide Clunis with the psychiatric treatment necessary to stop him from becoming seriously mentally ill. Their claim for damages against the Health Trust was subsequently rejected by the High Court but succeeded in keeping the issue of Community Care provision high on the political and policy agenda.
Silcock was filmed by an amateur camcorder enthusiast being mauled in the lions' den. Surgery to repair the damage reportedly took eight hours (Jones, 1993). The footage of Silcock in the lion's den received considerable media attention and quickly became a *cause celebre* symbolising for many, the failure of Community Care. Though different in their consequences, both the Clunis and Silcock cases generated sustained criticism of the government's asylum closure programme and prompted debate on the specific motives underpinning Community Care policies.

*Hearing Voices: Labelling Madness*

One issue that has plagued psychiatry continually in the post-war years has been the meaning of hearing 'voices'. In a famous study, Rosenhan (1973) reported how he and seven colleagues from Stanford University, managed to pass themselves off as schizophrenics, and get committed to twelve mental hospitals in the United States simply by declaring that they heard sounds or voices saying the single words 'empty', 'hollow' or 'thud'. Beyond complaining of this one 'symptom' and falsifying details of their names and occupations no further alterations of their personal histories were made. Despite ceasing to complain of their symptoms immediately after hospitalization all, but one, were diagnosed as paranoid schizophrenics whose symptoms had temporarily 'remitted'. The only people said to have been suspicious of their true identity were some of their 'fellow' patients. The Rosenhan study points not only to the unreliability of psychiatry's diagnostic categories but also to the power of psychiatrists to label some individuals as mentally ill and others as 'normal'.

26 However, critics of Rosenhan argue that, far from decisively attacking the validity of diagnosis, his study merely demonstrates that a psychiatrist can be fooled when assuming that persons seeking help are being truthful in their descriptions about themselves.
Traditionally, psychiatrists have maintained a widespread and close control over the meaning of hearing voices with only a few radical 'anti-psychiatrists' such as Laing (1965), speaking up on behalf of those whom society labels 'mad'. Notwithstanding his fall from prominence, Laing’s great contribution to the post-war understanding of madness was his insistence that psychotics could (indeed should) be listened to in order that we might arrive at a more fundamental understanding of the ('normal' and 'abnormal') individual. At the heart of Laing’s critique of Western psychiatry is the argument that there exists a tendency 'to translate our personal experience of the other as a person into an account of him (sic) that is depersonalised' (ibid: 22). In other words, practitioners of orthodox psychiatry tend, according to Laing, to ignore the actual lived-experiences of the mad, and to treat them as always inferior to the process of being mad. For their part, psychiatrists would counter that socio-psychological theories of voice-hearing are insupportable in the face of convincing experimental evidence that psychosis has a biochemical/genetic aetiology.

Despite Laing’s speculative views on the phenomenological nature of madness he remains a powerful source of inspiration for those who believe that psychiatry tends to approach the voice hearing experience as a symptom of psychosis and to disregard its meaning for individuals. Hearing 'voices' is conventionally understood to be a symptom of 'mental illness' and is therefore seen as an undesirable experience (whether the voice hearer thinks so or not). Inevitably, though, the concept of mental illness has accumulated a good deal of interpretative baggage. Hence, the label 'schizophrenia' not only governs the interpretation of hearing 'voices' (that it is part of a disease process requiring a medical response) it also functions to anticipate the behaviour of 'voice hearers' who are judged as having an 'illness'. Indeed, it is the social expectations surrounding the behaviour of schizophrenics that has resulted in a
dominant lay (and arguably medical) perception of them as 'irrational' beings who are, at best mentally incompetent and at worst, violent and aggressive.

This separation between a medicalized view of a psychotic’s experience and the world as experienced by the mad themselves invites us to recognise that there is more than one way of knowing the phenomena of madness. At present the medical view that voice hearing is evidence of psychosis (a symptom of ‘illness’) remains the dominant interpretation of the voice hearing experience. Nonetheless, there is increasing interest in the idea that ‘voice hearing’ affects a considerable number of people who have never been diagnosed as psychotic, and that their ‘voices’ are triggered not by biochemical or genetic ‘malfunctions’, but by stress and other environmental factors. The national network of Hearing Voices self-help groups for example, reject the medical interpretation of voice hearing as evidence of ‘illness’, preferring, instead, to interpret their own experiences from within their own life-world contexts. They reject objective psychiatric classifications in favour of a much more subjective approach to the voice hearing experience.

*Drug Treatment in Psychiatry*

The fact that drugs are the most widely used treatment for the control of psychiatric ‘symptoms’ underlines the pre-eminence of the medical model and the medical profession within mental health services. Drugs have been used in psychiatry since the nineteenth century, but in the 1950s and 1960s the use of tranquillisors, sedatives and euphorians became the basic tools of modern psychiatry. The emergence of Chlorpromazine (Largactyl) was hailed as a revolutionary breakthrough in the treatment of schizophrenia and has since been credited for helping bring about a
decline in the population of the mental hospitals. The first anti-depressants appeared in the 1950s and became widely prescribed by both hospital-based psychiatrists and general practitioners. The new drugs had a significant impact on psychiatry and gave added impetus to the closure of asylums. Yet four decades later the enthusiasm of those who talked of a therapeutic revolution now looks misplaced. The widespread use of drugs has been deemed inappropriate for a community-based mental health system. For many, the use of drugs is seen as continuing psychiatry's incarcerative social function.

Psychiatry's reliance on drug treatment has also led critics to claim that medication reinforces a narrow medicalized conception of 'cure' as the only really desirable outcome of clinical practice and, by implication, denigrates all other (non-medical) attempts at 'rehabilitation'. They argue that although the efficacy of many psychiatric drugs (e.g. minor tranquillisers such as Valium) is unclear beyond their short-term value in ameliorating the symptoms of acute mental distress, many patients remain on medication often for many years and only ever see their psychiatrist for 'reviews' of their drug treatment. Such criticisms are echoed by patients, many of whom complain of being treated like objects by their doctors who instead of allowing them to talk about their experiences and feelings, simply prescribe powerful combinations of drugs to reduce the troublesome symptoms of their 'illness' (Rogers et al. 1993). Moreover, frustration and anger at not being given time to talk is often interpreted as a symptom

27 However the 'chlorpromazine thesis' has been challenged most forcefully by Scull (1977). He argues that the Open Door Movement in Britain had already begun in the late 1940s before the introduction of chlorpromazine. Moreover, Scull also notes that there is little evidence that psychoactive drugs have been very effective in curing mental disorders. In short, the liberal-scientific claim that a range of 'miraculous' drugs emerged to further the cause of de-institutionalization is defective on the grounds of timing. Whatever the merits or demerits of Scull's argument chlorpromazine remains the drug of choice in the treatment of schizophrenia.
of illness and sometimes results in patients being given a cocktail of more powerful drugs.

The toxic effects of psychiatric drugs - in particular, the 'antipsychotics' (known as neuroleptics) used to treat the symptoms of schizophrenia - are a particular source of controversy. On average about one death per week is attributed to neuroleptic drugs (Sayce, 1995) and their use on patients has become a key concern for those convinced that drug regimes are part and parcel of a psychiatric system which routinely fails to understand why patients do not like taking them. Amongst the most severe side-effects (associated with long term use) are: motor restlessness (or akathisia) which compels the patient to pace the floor or shift their legs when sitting; severe involuntary 'jerk-like' movements of the limbs; and repetitive oral-facial movements affecting the mouth, lips and tongue (known as 'tardive dyskinesia'). Other common side-effects associated with neuroleptics include restlessness, sedation, hand tremor, dribbling, muscular rigidity (which together mimic the main symptoms of Parkinson's disease) and an increased sensitivity to sunlight. However, most psychiatrists argue that while neuroleptic medication does result in these side-effects the benefits of these drugs for many psychotic patients far outweigh the negative consequences of treatment (e.g. by reducing and often eliminating distressing hallucinations and tormenting delusions).

Although drugs are the dominant mode of psychiatric treatment their legitimacy use is no settled matter. For example, the use of long-acting neuroleptics is widespread across the mental health service and in Britain they are even given to a small but significant number of patients detained in hospital against their will under certain 'sections' of the 1983 Mental Health Act (relating to forcible treatment). However,
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many patients regard forced administration of drugs as punitive and symptomatic of a system, which fails to meet their individual needs. It is not therefore surprising that post-discharge compliance with drug treatment is perceived by psychiatrists to be a problem. Consequently, the Royal College of Psychiatrists has actively supported the recent (1995) implementation of ‘community treatment orders’, which enable psychiatrists to enforce treatment of ‘difficult’ patients who come off their drugs after being discharged. Nevertheless, the emergence of campaigning organizations like Survivors Speak Out indicates that challenges to the legitimacy of medical intervention will continue.

Racism and Psychiatry

The public face of psychiatry, like other medical disciplines, is that of an objective, applied science. Indeed, the practice of medicine is often seen as the neutral application of knowledge by doctors within a clinical environment that is value-free. But because it has its origins in late eighteenth and nineteenth century Europe and the US psychiatry has, according to some, evolved as an ethnocentric body of knowledge and thus is a vehicle of implicit and overt racial bias. The tendency to deny the importance of race and culture in psychiatry has been termed the ‘colour-blind, culture-blind’ approach (Fernando, 1991). Psychiatry’s biologism regards social factors as ‘things’ separable from a person’s experience of illness. Consequently, they are rarely taken account of in clinician’s ‘therapeutic’ responses. The method employed by orthodox psychiatrists therefore excludes the possibility that the social and psychological experience of racism can be a factor both in the onset and subsequent treatment of mental illness. We noted above the (false) assumption that violence and mental health problems are intertwined and that this perception seeps
into professional attitudes and practice. But when the 'service user' is black this assumption is at its most pervasive. The death in 1993 of Orville Blackwood, an inmate of Broadmoor Hospital, provides us with a case in point.

Blackwood's death was caused by heart failure after receiving huge dosages of neuroleptic medication. The report into his death describes a context in which hospital staff were afraid of a large black patient and had inadequate awareness of issues of race and culture: 'We have described previously a culture within the hospital that is based on white European norms and expectations. As such, there exists a subtle, unconscious on the whole, but nevertheless effective form of organizational racism' (Prins quoted in Sayce op. cit.: 136). Blackwood's management by staff at Broadmoor led the inquiry team to conclude that his anger at being incarcerated (unjustly in his view) and having medication forcibly administered to him led to increased anger and in turn increased levels of medication. In other words, his violence was seen as a symptom of his illness with the result that he died after being given a powerful cocktail of 'anti-psychotic' drugs following a violent incident.

Blackwood's size, colour and history of violent frustration at his treatment in Broadmoor fed into medical and nursing assumptions that his violence was part of a psychotic illness. More particularly, it fed into preconceived notions of the 'dangerous Black'. This image is not new (assumptions that black men are more likely to rape, for instance, have been prevalent for centuries: Hoch 1979). But it has recently been powerfully reshaped into the image of the man who is 'big, black, dangerous and mad', an image that has become part of a strong racist undercurrent in public debates on mental health. Thus, the generalised image of the 'dangerous black' collided with professional psychiatric assumptions that black people are particularly 'dangerous'
when suffering mental illness (Fernando 1991). However, the stereotype of the
dangerous Black has begun to be challenged in recent years not only by Black
organisations but also by psychiatric professionals from ethnic minority backgrounds
and charities like MIND, all of whom express concern at the negative impact of such
stereotyped perceptions on professional psychiatric practice. The focal point of their
concern is the treatment of black patients whilst being compulsory detained in
hospital.

_The Failure of Community Care: Back to the Future?_

This brief review of the mental health field in the 1990s reveals a contested and
fragmented psychiatric system. The absence of consensus on how best to implement
community care policies (let alone what the terms ‘community’ and ‘care’ actually
mean28) has left ‘mentally ill people... at risk of being caught up in the middle of an
ideological shoot-out’ (Muijen, 1995: viii). Mental health professionals in their turn
have been left feeling confused about whether their priority is to develop community
care services for the mentally ill or to lock them up on behalf of society. This
confusion over Community Care also reaches the highest level of government. Frank
Dobson, the Secretary of State for Health, interviewed in the _Daily Telegraph_
(17.1.98) recently gave a glimpse of the present Labour governments' position on
Community Care. His view was that care in the community had failed because it had

28 One of the basic difficulties of formulating policy in this area is the disputed character of what is
meant by ‘Community Care’. ‘Community’ itself is a term that is pervaded with ambiguity, and this
renders discussion of policy particularly difficult. In sociological parlance ‘community’ has some
connotations of locality. However, current policy flies in the face of the fact that location is
decreasingly the centre for the main social activities of many people in British society. Only a minority
of people still have activities which are primarily constrained by the locality. Therefore to promulgate
policies that are based on activities which are _supposed_ to take place in the locality may be well be at
odds with the social arrangement which in fact exist in society. One aspect of this is that in practice,
‘community care’ for people with mental health problems usually means informal care by kith and kin
(see Bulmer, 1987).
led to the deaths of innocent people. He also raised the possibility of the government creating more 'secure' places for those mentally ill people who are unamenable to receiving mental health care in out-patient settings. There was, he stated a larger number of people still needing some form of 24-hour care than the system presently recognises.

Yet in a later interview the Health Secretary repudiated his earlier statement. It was, he said, not true that Community Care had failed, what he meant to say was that some mentally ill people were not getting the level of supervision required. He then muddied the waters again by talking about the use of powers of treatment in the Community raising the spectre of compulsory powers for those who did not take their medication. This raised the expected protests. MIND for example pointed out that measures that concentrate on easing public fear about the mentally ill might breach the European Convention on Human Rights. In an attempt to sort things out Paul Boateng, a junior Minister of Health, stressed that there was no change in Community Care policy:

There will be no return to the grim Victorian asylums. The old mantra 'community good, hospital bad' is dead. We have to build a new basis of confidence in our mental health services. The public is entitled to nothing less. This means that every existing mental health closure is backed by a tough and credible alternative package that includes a mix of new style hospital care and community provision. We have got to secure the welfare of the mentally ill, while safeguarding the public (quoted in Bean and Keil, in press).

Whether the Government is prepared to put more money into mental health services remains to be seen. But even if they do matters are from clear. Mental health care is difficult to deliver perfectly, and seems to produce scandals and moral panics
whichever way services are organised. Society needs to choose between safety and freedom, between custody and community support. The pattern over centuries has shown that these forms of care tend to lead to either abuse in institutions or neglect in the community. The quality of care and the extent of such abuse will depend to a degree on resources invested, including training of staff. However, the choice is political, and is influenced by society’s values and beliefs at the time. Thus while the Daily Telegraph congratulated the Government on ‘taking the difficult decision that a whole generation of liberal social engineers was mistaken’ (Editorial 17/1/98, p. 25) the paper conveniently forgot that asylum closures were a result of fiscal considerations which used the ideology of Community Care to provide its humanitarian face (Scull, 1989).

Conclusion

We appear to be at a crossroads in the 1990s, developing community-based services for mentally ill people when society’s values are becoming more custodial. There is low tolerance of problems caused in the community that theoretically can be prevented with institutional care. Unfortunately, the complexity of mental health care, involving so many contradictory social policy areas and groups with opposing interests means that consensus is an unrealistic objective. Most parties will reject any compromise, since it can never go far enough in all opposite directions to satisfy anyone fully. One solution however, might be to base future mental health provision not on a compromise between professional and policy interests, but on a user-led perspective in which those with grounded experience of mental illness can shape their service. However, the user’s view of the mental health system can easily be
‘pathologised’ in a power dynamic which obscures the user’s perspective\textsuperscript{29} - a fact wryly noted by the Restoration playwright Nathaniel Lee, following his committal to Bethlam Hospital in the sixteenth century: ‘They called me mad, I called them mad, and damn them they outvoted me’ (Quoted in Porter, 1991: 1). As we shall see however, conceptualizations of madness as pathology are far from a purely medical concern. They also involve the overlap of historical and cultural representations, and are the focus of interest in the next chapter.

\textsuperscript{29} To this can be added the difficulties of including the long-term mentally ill in discussion about their future. No amount of wishful thinking that a user-led perspective could include representatives of the persistent mentally ill will result in their voices being heard in their own behalf. However, wider use of mental health advocacy schemes might be one solution to this problem.
Chapter 4

Madness and Representation
Introduction: The Iconography of Madness

From Hieronymus Bosch through Francisco Goya to Edvard Munch, the idea that the mad look different has found expression in the artistic imagination. Never the less, representing visually what is an unobservable mental phenomenon presented a considerable challenge. Sander Gilman (1988) has argued persuasively that the iconography of illness is an indication of the way in which society deals with and conceptualises disease: ‘The portrait of the sufferer, the portrait of the patient is... the image of the disease anthropormorphized’ (1988: 2). One key icon is dishevelment. Wild, unkempt, hair and tattered clothing has long provided an influential sign of madness. As Gilman observes, these representations are not necessarily accurate. Rather, they enable the intended audience to recognize that it is madness that is being portrayed.

That we are able to recognise the ‘mad’ as different from “us” reveals a deep rooted concern - perhaps anxiety - with knowing who the mad are. This applies as much to the psychiatric profession as to society at large. The lay assumption that you “know a lunatic when you see one” became a professional concern for those formally charged with managing and treating the mad. Mass incarceration in asylums (see Chapter Three) provided psychiatrists with an unprecedented opportunity for recording and documenting the physiognomy of madness (see Gilman, 1982). As psychiatry strove to shed connotations of quackery and turn itself into a legitimate science, the notion that clinicians could describe, define and even diagnose the insane according to their portraiture became increasingly important. Indeed, the ability to catalogue psychopathologies from outward appearances underpins psychiatry’s ‘discovery’ of madness as a phenomenon amenable to a ‘clinical gaze’. The blossoming of
psychiatric photography in the second half of the Nineteenth century (Showalter, 1987) also bears witness to the embedded definition of madness as exhibiting distinct differences in physical appearance and behaviour which doctors could learn to recognise and label.

Representations of madness as 'difference' have continued virtually unchanged into our own century. Gilman (1988: 13) interprets this relatively stable mode of representation as conveying a reassuring message to the public, that the devastation of mental illness is not likely to happen to them or people like them:

The banality of real mental illness comes in conflict with our need to have the mad identifiable, different from ourselves. Our shock is always that they are really just like us. This moment, when we say, 'they are just like us', is most upsetting. Then we no longer know where lies the line that divides our normal, reliable world, a world that minimizes our fears, from that world in which lurks the fearful, the terrifying, the aggressive. We want - no, we need - the 'mad' to be different, so we create out of the stuff of their reality the myths that make them different.

He argues that by marking mentally ill people as different, images of madness operate at two levels: first, at the level of the social construction of categories of disease; and second, the internalization of such images by individuals or groups who are labelled 'mad'. Thus, in his study he includes images of madness produced by artists labelled insane (e.g. Richard Dadd and Vincent Van Gogh), as well as by those claiming to represent the condition more 'objectively'. This internalized mode of representation 'is not merely a mimetic reflection of the daily world of the insane, but is also tied to the long Western tradition of representing psychopathological states' (ibid: 99). According to Gilman, the idea (fostered in particular by the Laingian antipsychiatric movement) that patients alone possesses true insight into their illness and treatment
and which is then rendered visible through their art, is naive. Rather, he suggests that a *continuity of representation* occurs in which visual representations of insanity by mentally ill artists reveal a borrowed 'structure of expression' in which dominant icons of madness as difference, shape their own perception of their 'difference'.

Gilman's analysis points to the importance of 'difference' as the long-standing core of representations of madness. Certainly, images in our own era continually draw upon conceptualizations and representations from past times. As Wahl (1996: 114) puts it, 'The creative professionals of today's media are, in some ways, just carrying on traditional depiction's of the past. Many of today's images are repetitions or residuals of long-standing popular beliefs'. In his discussion of US films involving the mentally ill for example, he notes how the portrayal of the "mad murderer" as looking distinctively different, activates artistic conventions that have evolved over centuries (see also Fleming and Manvell, 1985). Taking his cue from Gilman, he sees American cinema's representation of mental illness as a form of psychological reassurance: 'Presenting mentally ill characters as different and dangerous may serve a psychologically self-protective function' (Wahl, 1996: 124). So, while the single paintings of Bosch have evolved into the multiple images and mass reproductions of cinema and television, the basic public image of madness as difference have remained remarkably constant.

Over the course of the twentieth century, a number of films have dealt with psychiatrists and their patients. Gabbard and Gabbard (1987) identify over 250 US films. However, British films have generally avoided mental health topics. One reason for this neglect, we suggest, relates to the development of mental health services in Britain. We argued in Chapter Three, that access to asylum patients was severely
restricted and that an understandable uncertainty about what went on behind the institution's locked doors prevailed. Grounded testimony from those on the inside was therefore hard to come by which perhaps explains why Milos Forman's US-based film, *One Flew Over the Cuckoo's Nest* (1975), became synonymous with the British asylum experience. Based on the novel by Ken Kesey (1962), the film's account of authority and rebellion in a US State mental hospital is still often seen as a key moment in the discrediting of an *ancien régime*. However, its appeal to both British and US audience's belies larger national differences, firstly in relation to mental health systems and secondly, in relation to media systems.

*Mental Health and Broadcasting Systems in the UK and USA*

Public attitudes toward mental illness differ considerably between the UK and the US. Freudian theory for example, has deep historical roots in the US and for those who can afford to pay, psychoanalysis offers a popular alternative to medical models. The history of psychiatry in the UK on the other hand, has for the most part, been one in which patients are compelled to have treatment¹. Analysands have opted to be treated and to enjoy personal, intimate, encounters with therapists in (usually) office settings. By contrast, British psychiatry has traditionally revolved around centralized structures (the asylum) and an authoritarian system of management, presided over by a superintendent. The psychoanalyst's interest in 'neurotic' behaviour however, provided an alternative source of help for those whose mental (including sexual) problems put them beyond the province of the asylum doctor. As Porter (1991: 429)

¹ Before the 1983 Mental Health Act the rationality of the person with mental illness received little or no support in legislation, and mental patients were considered unable to give their informed consent. The 1983 Act gave consent a legitimate place in British law and allowed patients to legally withdraw their consent to treatment (see Barham, 1992: pp. 127-130).
puts it, 'Amongst the lay public - far more than within the wider psychiatric profession itself - psychoanalysis was to acquire an extraordinary aura. In countless novels and films from the inter-war years onwards, the 'shrink' was standardly depicted as the sage of the psyche, a wise man, magician, miracle worker, yet also a doctor: in short, the new priest of the twentieth century'. The British figure of the psychiatrist as a benign paternal authority vis-à-vis the US emphasises the commercial relationship between analyst and patient, and mirrors similar differences between the two countries' broadcasting systems.

Britain's broadcasting system has traditionally operated as a public service model, at arms length from government. The BBC, and later the ITV system, were cultural institutions whose management committee's (the BBC Board of Governors and the Independent Television (later Broadcasting) Authority, respectively) were drawn from the ranks of the Great and the Good. The system evolved into a centralized structure based on one-way communication, flowing from centre to periphery. The dominant US system by contrast, has operated according to a commercial model since its inception. Media policy is framed within a political culture that sees commercial activity as the cornerstone of individual freedom. Market theorists argue that because individual consumers express their preferences to suppliers (in this case, of broadcasting services) through the ratings system, commercially based stations are more responsive to audience wants and desires. This system was not installed without conflict and opposition however (Mosco, 1998). From 1928 to 1935, representatives from labour movements, intellectuals, the press, religious organizations and other civil society groups, opposed the commercial model. Although corporate interests eventually commandeered the key parts of the system, modest public service
requirements were instituted until weakened by broadcasting deregulation in the 1980s.

The importance of prime time (usually 7 pm to 11 pm) for broadcasters cannot be over-estimated. It represents the pivot of their daily schedule. Publicly funded broadcasting organizations, such as the BBC, are not directly subject to the same commercial imperative to deliver blocks of audiences to advertisers (though in practice, commercial and market criteria often influence programme making). Prime time television is made up, for the most part, of a stable and repetitive diet of drama, game shows, talk shows and commercials, designed to attract (and sell to) the largest possible public at the least possible cost. Its entertainment programmes often feature medical themes and medically-related shows have been a long-standing staple of commercial television (Turow, 1989; Karpf, 1991) It is therefore not surprising that mental illness has frequently featured in drama programming. Signorelli (1989) reports that since 1969, about twenty per cent of prime time drama has involved some depiction or theme around mental illness. This relative prominence has led a number of American academics to analyse television images of mental illness.

In an early study, Gerbner (1959) noted that mass media depictions of mental illness tended to be inaccurate and that television in particular played a key role in perpetuating harmful misconceptions (see also Gerbner, 1980). Similarly, Nunally (1961) concluded that the image of mental illness in the US media was farther removed from the characteristics established by mental health professionals than the image held by the general public (c.f. Winick, 1978). Instead of mediating between experts and the public, media images recycled traditional popular stereotypes and prejudices. In a later study, Wahl and Roth (1982) organised a ‘Media Watch’ of
prime time television broadcasts in the Washington DC area in February 1981. The findings highlighted the generally negative stereotyping of mentally ill people. Similarly, Signorelli (1989) reported that while mental illness features strongly in dramatic programming, negative stereotypes dominated storylines. Taken together, these studies reveal that portrayals of mental illness on American mainstream television are often inaccurate, unfavourable and biased. Associations between mental illness with violence for example, are routinely featured in action-adventure programmes and US soap opera. Whilst I do not want to take issue with this conclusion, I would argue that US television’s negative presentation of mental illness is largely explained by the restricted genres on prime time programming.

The saliency of negative mental illness stereotypes has recently been discussed by a leading mental health advocate, Otto Wahl, in his book *Media Madness: Public Images of Mental Illness* (1995) which focuses on representation of mental illness in the US media as a whole. From children’s cartoons through prime time drama to ‘slasher’ movies, he illustrates how different forms of popular mass media ridicule the mentally ill and are inaccurate in their portrayal of common conditions, such as schizophrenia (repeatedly implying that it leads inexorably to violence). Whilst Wahl’s book is a useful contribution to a generally sparse literature on the topic, we should not assume that his analysis is easily transferable to a British media context.

The UK’s shift from asylum care to a community-based mental health system requires that we view representations of mental illness historically. Recent changes in the organization of mental health care may have long-term implications for ways in which the mentally ill are publicly represented in the British media. In order to track past, present and future representations of mental illness, we need an approach that
acknowledges the different rules of representation governing media in different national and historical contexts.

*Mental Illness and Cultural Forms*

Deinstitutionalization involves more than just the administrative substitution of one locus of care for another. It invites a radical reshaping of the ways in which we think about, describe and, in particular, relate to people with a history of mental illness (Barham, 1992). The Glasgow Media Group’s *Media and Mental Distress* (1996) examines contemporary British media images of mental illness and explores their impact on public beliefs about the mentally ill through an audience reception study. Like Wahl, they establish a general profile of media portrayals in which the mentally ill are represented in overwhelmingly negative terms. Their analysis of media content in April 1993 found that two-thirds of items dealing with mental health issues forged a link between mental illness and violence. This category of content outweighed the second most common category (‘prescriptions for treatment/advice/recovery’) by a ratio of almost four to one. Despite methodological differences between this study and Wahl’s, it appears that on both sides of the Atlantic, a limited repertoire of mental illness representations is endemic across a range of media forms.

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2 The audience study consisted of six groups of approximately ten people. The intention was to explore the process by which media accounts of mental illness are interpreted and contribute to the formation of beliefs amongst the general population. Group exercises were conducted, prompted by still photographs taken from Coronation Street (a popular British soap opera). Participants were asked to provide dialogue to the photographs in which a mentally ill character attempts to snatch a child. Participants were also asked to reproduce ‘headline’ newspaper stories about the mentally ill. These exercises revealed how easily participants were able to reproduce the style and language of television drama and the popular press (which according to the Glasgow group points to the possible formation of social attitudes towards the mentally ill).

3 Wahl’s ‘methodology’ establishes the US media’s portrayal of mental illness on the basis of one-off examples of misrepresentation. By contrast, the Glasgow group adopt a more systematic approach
However, assumptions of uniformity are misleading. We cannot assume for example, that journalists working on broadsheet newspapers in the UK represent mental illness in the same way as tabloid journalists in the US. Another important difference is that the US newspaper industry operates primarily on a city/regional basis and so, unlike the UK, has almost no recognisably ‘national’ daily titles. As a consequence, US journalists’ perceptions of mental illness may well be contingent on local circumstances and differ from region to region, state to state. Both Wahl and the Glasgow group fail to acknowledge the structural differences governing newspaper production in their respective countries, nor do they make any aesthetic distinction between tabloids and broadsheets. Indeed, the Glasgow research explicitly excludes broadsheets and focuses solely on tabloid representations of mental illness on the grounds that ‘they are a potential source of common-sense understandings and popular myths about social issues and have a very large audience’ (Philo, 1996: 45). By concentrating on the ‘dominant messages’ given about mental illness across tabloids, their method glides over differences in meaning-making within other types of newspapers. Thus, questions about the operation of textual or discursive forms are not addressed. This neglect is particularly problematic in relation to different representational rules governing broadcast television and film.

While television and film share formal aesthetic properties (notably, image and sound combinations), they are distinct cultural forms (see Ellis, 1982). Consequently, they offer different possibilities for representing social issues, including mental illness. Differences in cultural form however, are acknowledged in neither Wahl’s nor the Glasgow group’s research. Both ignore the aesthetic differences between film and TV drawing on both quantitative and (to a lesser extent) qualitative research techniques. The Glasgow group’s approach thus renders it more suitable for control and replication at a future point.
whilst noting that negative stereotypes of mental illness are dominant across a range of visual media. The Glasgow group for example, collapse all distinctions between factual and fictional representations and ignore the differences between children's cartoons, teenage drama, soap opera and films shown on TV. These elisions conveniently avoid the question of whether similarities in representations of mental illness are more significant than the differences arising from the particular genres and forms being employed. The present work is primarily concerned with the extent and nature of these differences and the ways they mediate representations of mental health.

In their discussion of British television's presentation of discourses around "terrorism" Schlesinger et al (1983) note that 'closed' formats do not constitute the sum of its output, and they point to more 'open' programming in which various 'alternative' and 'oppositional' discourses are included. Even in the US, despite the prime-time imperatives that dominate mainstream TV's portrayal of mental illness, alternative voices sometimes do manage to obtain airtime and visibility, though the odds are very much against them.

Frederick Wiseman's 1967 documentary, Titicut Follies is a notable case in point. Its fly-on-the-wall account of conditions inside Bridgewater, a Massachusetts prison for the criminally insane, presents a very different portrayal of the mentally ill and their 'carers' to the one conventionally portrayed in prime time drama. Indeed, so challenging was the film, that the Commonwealth of Massachusetts upheld the prison authorities' call for it to banned from public display even though they had previously granted Wiseman permission to film in the prison. For over thirty years, it has had only limited distribution in the US (and has been shown only once on British
television, in 1993). Ironically, one of the central charges against the film is that it misrepresented prison life, by focusing on its more sensational aspects. Thus, while sensationalism is the stock-in-trade of drama, it is not supposed to be the motivation behind actuality-based programming. Amongst other things then, *Titicut Follies* fell foul of the regulating impact of genre. Its failure to avoid censure reminds us that cultural forms are important mechanisms for structuring public discourse (Golding and Murdock, 1991). It is for this reason, that the diversity of television programming, or lack of it, plays such an important place in the orchestration of national public debate.

*British Television Current Affairs and Mental Illness*

At this juncture we can pose a simple question: To what extent does the Glasgow group’s blanket pessimism about the British media’s representation of mental illness apply to the more uncertain and open genres of broadcast TV? In order to answer this question, the second half of the thesis will offer a number of case-studies of public talk about mental health issues on British television. Particular emphasis is placed on the manner in which different perspectives on mental health/illness have found representation within a range of current affairs programming. In approaching this issue, it is our belief that content analysis alone cannot adequately grapple with the complexities of unpredictable media forms. Whilst it usefully allows us to answer such questions as who spoke? and for how long?, such data only scratches the surface of television’s operation as a communicative medium. To account more adequately for the communicative character of televisual representations we need a more interpretative approach to the dynamics of meaning-making. This, in turn, requires qualitative analyses capable of capturing the subtleties of the interaction between the
particular form of TV programmes and the general discursive space in which it operates. As we will see, understanding representation as a cultural practice demonstrates time and again, that achieving 'visibility' and a voice is no guarantee of either sympathetic treatment or legitimacy.

Television is not a mechanism for relaying discourses but for reorganising them. As they move from their original arenas into viewers' homes they are subject to the procedural and aesthetic rules governing particular forms of programming (Murdock, 1991). At the heart of arguments over the application of these rules is the question of representation - in both its social and cultural sense. Socially, representation is a system of *social delegation*. The issues here include:

- who speaks in their own voice and who is spoken about?

- how are speakers accessed?

- how are they treated - with sympathy and respect or hostility

Culturally, representation is a system of *signification*. To understand the way television works in this regard it is necessary to keep firmly in mind that it organises *both* discourse and visual images. In exploring the organisation of discourse we need to pay attention to the relative openness of programmes, and in particular to how different voices are played against one another. The orchestration of images within programmes can reinforce the organisation of discourse (by confirming the authority of speakers and underlining what is being said) or it can cut across or undermine it.
In order to explore representation as a system of both social delegation and cultural forms, this thesis draws on insights from discourse analysts and semiotics in order to produce a detailed account of the ways that public discourse about mental illness is televisually constructed. This approach departs markedly from both Wahl's and the Glasgow group's analyses. However, despite differences in approach and methodology, this thesis accepts their challenge to researchers to engage more closely with professional and mental health service users. Focusing on current affairs TV enables us to test empirically Schlesinger et al.'s contention that negative images (in this case of mental illness) can be challenged in an arena commonly assumed to be 'open' and 'accessible' to different points of view and perspectives. By attending to the voices of those speaking on mental health issues we also move away from an assumption implicit in Wahl's and the Glasgow group's analyses, that media are nothing more than discrete texts or messages. Instead, we view television as a domain of everyday social life in which the opinions and experiences of all citizens are entitled to expression within a variety of contrasting programme forms and genres.

However, as we noted in Chapter Two, although the public broadcasting system may give people communicative entitlements, this is not the same as providing equality of access to a public voice. With this in mind we ask: "what is the condition of public discourse as played out in television current affairs' coverage of mental health issues?" In constructing an answer we have looked in detail at nine current affairs programmes chosen to illustrate the full range of programme formats currently available on British television. They differ significantly in terms of form, style and communicative intent. Comparative textual analysis allows us to demonstrate in detail how a particular issue or event is differentially mediated by the dynamics of
programme forms. Before turning to our case studies of televised talk about mental illness however, we need to briefly consider questions of method.

An Outline of Methods

The selection of current affairs programmes presented in the following chapters has been arrived at using a quota-sample. The aim of the present study is not to conduct a content analysis of everything on mental illness broadcast over a particular monitoring period. Rather, we have selected ideal-typical instances that illustrate the major forms of current affairs and documentary programming within the current British television system.

The programmes selected for analysis have been chosen primarily on the basis of their position within a matrix defined by two dimensions, which plot the degree of discursive space accorded to lay speakers. They are:

1. the degree of access given to programme participants

2. the control over that access exercised by the programme makers

Figure 4.1 provides a diagrammatic summary of where the nine selected programmes are located in relation to these cross-cutting dimensions.

Although our first concern is with the ways the discursive spaces within the selected programmes is organised we would stress again that in analysing televisual texts it is also necessary to look in detail at the organisation of visual representations and their complex interplay with participants’ talk. Consequently, the analytical questions we ask cannot be answered by counting the frequency with which particular
Madness and Representation

Fig. 4.1 Degree of Lay Access and Editorial Control Exercised by Programme Makers
representations occur or the amount of time given to speakers. As the Glasgow group’s research on images of mental illness show, these are indisputably important research questions. Our approach thus complements their work by pursuing other kinds of questions about the communicative form of programmes. Our approach aims to open up issues around the organisation of discourse and representation concerning mental illness in order to contribute to a general understanding of television’s ‘distinctive mediating devices’ (Corner, 1998: 240). Nevertheless, the content of individual programmes provides an important context for the analysis, and with this in mind we now turn to a synopses of the nine programmes we have selected for detailed analysis.

Individual Programme Synopsis

Kilroy, BBC1, 24 January 1993

Kilroy is a discussion programme in which lay people and experts debate issues related to topical news events. The edition examined here was broadcast following the Ben Silcock incident (see Chapter Three) and asks how schizophrenics are cared for in the community. It begins with footage of Silcock in the lion’s den. A number of schizophrenics are then questioned about their experience of hearing voices. Following this, the host probes a psychiatrist about the causes of schizophrenia. The psychiatrist’s’ views on medication are then challenged by lay members of the audience who offer their own assessment of the problems of caring for mentally ill relatives. The host also seeks contributions from representatives of charitable organisations. Their testimony is critical of Community Care policies. At this point, a Conservative MP, Jerry Hayes, is targeted by Kilroy-Silk as someone partly
responsible for the failure of care in the community. Relatives are encouraged to oppose Hayes’ views on this policy. Kilroy-Silk also raises the issue of compulsory treatment for schizophrenics living in the community and representatives of mental health charities and civil liberty organisations provide testimony on this issue. Finally, Kilroy-Silk ends the discussion by stating that if you are schizophrenic and need help you can always help yourself.

Disguises: ‘A Place of Safety’, ITV, 25 February and 4 March 1993

In ‘A Place of Safety’ Adam Holloway, the series reporter, impersonates a schizophrenic in order to investigate Community Care policies. In the first of two programmes he dons his ‘schizophrenic’ disguise and practices his voice-hearing performance. His investigation begins at a derelict mental asylum. He poses questions about the quality of community care for the mentally ill now those asylums are closing. In Birmingham, he assumes his disguise and using a concealed video-camera records his unsuccessful attempts to get psychiatric help at various GP’s surgeries. He then successfully convinces a duty psychiatrist in a local hospital that he is psychotic and needs ‘a place of safety’. Following a weekend in hospital he is discharged and given an accommodation list. He then recounts his failure to find temporary hostel accommodation. He then ‘experiences’ success with the Salvation Army who offers him accommodation and long-term help. Finally, Holloway informs us that he will now investigate private sector care in Mayfield Court, a ‘hotel’ described as being the ‘rock bottom’ of community care.

In part two of the programme, clandestine footage of Holloway’s two-week experience of Mayfield Court is mobilised to illustrate how the private sector does not
meet the needs of its 'customers'. We are shown extensive footage of a dilapidated building and its 'guests' whom, we are told, receive virtually no care at all (a claim validated by testimony from a psychiatrist posing as a relative). After presenting 'evidence' of bullying by hotel staff, Holloway (in-role) confronts the manager and leaves Mayfield Court for London. There, he maintains his disguise and attempts to find 'a place of safety' in hospital. He fails to find a bed for the night and is advised to go to a hostel or contact the police. He is refused admission to a hostel and tries to attract the attention of the police by taking his clothes off in the street. Police officers fail to help him, though a sympathetic policeman does advise him to go to Hackney police station for help. After doing so he is advised to contact Hackney's emergency housing service. This is unsuccessful and the programme closes with Holloway joining other homeless people on the streets.

Panorama: 'Whose Mind Is It Anyway?', BBC1, 1 March 1993

This programme focuses on the civil liberties issue surrounding Community Supervision Orders (CSO's) for ex-mental patients who refuse to take prescribed medication after discharge from hospital. The CSO plan is explored via three case studies of people discharged into the community who have subsequently committed violent or aggressive acts, including murder. The programme presents evidence from the United States, where a community supervision project (similar to CSO's) is in operation. It draws on testimony from various mental health professionals, representatives of mental health charities, politicians, service users and their relatives. The programme is relatively 'open' in its provision of communicative space for those who either support or oppose CSO's. In addition, its format is 'loose' in the sense that its argumentative structure does not converge upon one single preferred interpretation.
of the issues (Although it does emphasise in its summing up that if stricter controls are imposed on mentally ill people living in the community they will support rather than restrain them).

*All Black: 'Broken Poets', BBC2, 20 August 1993*

'Broken Poets' focuses on the treatment of black people in Britain's mental health system. Its core theme is that mental hospitals are part of a white power structure that at best, is unresponsive to the black experience of mental illness and at worst, is racist. The argument is developed in three main stages. Firstly, it mobilises testimony from an orthodox (white) psychiatrist as well as ethnic minority psychiatrists in order to present orthodox psychiatry as 'closed' around biological explanations. In contrast, the ethnic minority experts acknowledge social factors in the aetiology of mental disorder. Secondly, biological explanations are presented as helping sustain a system that victimises black people. The dynamics of this system are demonstrated by taking two particular 'patient careers' that illustrate the general themes of the programme. Two aspects are given particular attention: black people's entry into the mental health system via forced incarceration (i.e. the 'criminalization' of cries for help); and the use of strong drug regimes when in the system (regimes which fit well with biological explanations). Finally, forms of community care which return black people to local social networks and sources of support which understand their situation, are presented as offering a potentially positive alternative.

*Tom's Story, BBC2, 7 April 1994*

*Tom's Story* recounts the events leading to Tom Leader's schizophrenic breakdown and subsequent recovery. His story is told through the testimony of Tom and his
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mother, June. Both relate details of their family and social background culminating in their account of his voice hearing experiences and hospitalisation. The extent of his recovery is illustrated by footage of him performing the routine activities of daily living juxtaposed against testimony describing how his schizophrenic symptoms profoundly affected his everyday life. The latter stages of the programme follow Tom's preparations for a piano examination and a public recital to help publicise the issue of schizophrenia. Both events are presented as 'milestones' on his road to recovery. His successful recital forms the final part of the programme. Tom's Story is more than just a straightforward 'human interest' story. It operates with a metanarrative in which Tom is cast as a brilliant but bruised musician, who managed to nurture a hidden musical talent during the worst moments of his illness. In short, the programme recycles the popular myth that madness and creativity are intertwined.

People First: 'Black and Blue' BBC2, 2 June 1994

'Black and Blue' is a documentary focusing on institutional racism in Britain's mental health system. It explores white psychiatrist's' failure to understand and treat the black experience of mental illness. Its argumentative format is 'tightly' organised so as to converge on the view that orthodox psychiatry is failing to understand the cultural milieu of mentally ill black people. In contrast, 'Afro-centric' approaches to black mental illness are presented as offering more appropriate forms of treatment than Western medical models. A number of 'alternative' treatments are assumed to be sensitive to black people's social and cultural experience (e.g. yoga, massage, rhythm). This argument is developed through the testimony of a number of black alternative therapists who offer various holistic forms of psychiatric 'help'. At the epicentre of this narrative is the argument that orthodox psychiatry is dominated by a
neo-colonial power relationship between black patients and their (usually white) psychiatrists. The dynamics of this relationship is then explored through the testimony of black ex-patients who have experienced what they claim are ethnocentric forms of drug 'treatment'.

*Video Diaries: ‘Mad, Bad or Sad’, BBC2, 14 September 1994*

‘Mad, Bad or Sad’ is Sharon’s personal account of being a black schizophrenic woman living in inner city Manchester. Throughout her Diary we are introduced to significant people and places in her life. It reveals the formal and informal network of support that surrounds her. A key figure in the diary is Mickey, Sharon’s husband, also a diagnosed schizophrenic. Together, they offer a deeply personal perspective on the difficulties of living and coping with her schizophrenic diagnosis. Both are consistently critical of the mental health service for its racism and reliance on medication. The Diary reveals Sharon’s routinized experience of hearing ‘voices’ and having to take psychiatric medication. ‘Mad, Bad or Sad’ also tells the story of Sharon’s search for her mother who fostered her as a child and the stress that this causes her. She makes it clear that in her view, it is this experience which has resulted in her mental health problems. Her Diary reveals that she was conceived following her mother’s affair with a black neighbour and that her mother is white and was married with six children. Sharon was fostered to avoid family embarrassment and learns that her mother and sister have been searching for her. It concludes with Sharon preparing to meet her mother.
Horizon: ‘Hearing Voices’, BBC2, 24 April 1995

Horizon is the BBC’s ‘flagship’ science documentary series. ‘Hearing Voices’ has a clear argumentative format that challenges the orthodox medical view that hearing ‘voices’ is a sign of severe mental illness. It offers an alternative explanation in which voice hearing is acknowledged to be a psychological phenomenon. Its approach hinges on differences of expert medical and psychological opinion. The argument is developed in three main stages. Firstly, conventional psychiatric accounts of voice hearing are shown as closed around biological explanations that ignore psychological factors like stress. Secondly, research is mobilised to suggest that voice hearing is linked to ‘inner speech’ production, a finding which adds ‘scientific’ validity to the traditional psychological model of voice hearing. This approach views drug treatment as problematic because it ignores voice hearing as a meaningful human experience. Thirdly, in contrast to orthodox psychiatry, the psychological approach is shown encouraging voice hearers to talk about the content of their voices and helping them to avoid potentially dangerous incidents. The voice hearing experience in ‘Hearing Voices’ is mediated through the testimony of a number of voice hearers whose contributions are used to undermine the opinions of orthodox psychiatry and bolster support for experts advocating the psychological model.

Taken together, these nine programmes represent the range of current British television current affairs programming, from ‘classical’ documentary and current affairs formats such as Panorama and Horizon, to the most recent access forms represented by Kilroy and Video Diaries. They provide the raw materials for the detailed analysis of the ways cultural forms mediate public representations of mental health issues, which we now turn to.
Chapter 5

Knowing Madness
Introduction: The Shifting Status of Psychiatric Expertise

The interpretation and treatment of mental illness has been the prerogative of the medical profession for over a hundred and fifty years. Secure in the closed world of the asylum psychiatrists' power to define, classify and treat mental disorders appeared monolithic and unassailable. This is no longer the case. The move to community care involves a wide range of professionals in the delivery of psychiatric care. Consequently, traditional deference to the expertise of the psychiatric profession is giving way to a valorization of non-medical knowledge about mental illness, underpinned by alternative professional orientations to the care and management of the mentally disturbed.

The development of community care is closely related to shifting conceptions of both mental illness and the efficacy of the asylum. Medical interpretations of mental illness no longer have an a priori precedence in professional and lay discourses on the care of the mentally ill. Other discourses lay claim to authority but on the basis that they offer grounded 'truths' and 'mini-narratives' told by those whose professional and/or familial relationship with mental illness enable them to "tell it like it is". Consequently, their legitimacy is always provisional and contextual.

The closure of mental asylums and the policy of relocating patients into the community has destabilized the traditional knowledge claims of bio-medical psychiatry and the historical priority of expert 'knowledge' over 'experience'. For example, the notion that a patient's experience of voice hearing could be of value in understanding the concept of psychosis was dismissed within established psychiatric knowledge and until the 1960's and the onset of what became known as
"antipsychiatry" there were few voices willing (or able) to challenge its authority. In the mid nineties the babel of voices challenging psychiatric knowledge over the meaning of psychosis is almost deafening. The growth of the Hearing Voices network of self-help groups for example, indicates not only a groundswell of dissatisfaction with orthodox treatment regimes, but also a desire on the part of many voice hearers for an inversion of the established knowledge/experience dichotomy. At the core of this self-help movement is a political struggle to dismantle a hierarchy of discourse that many mental health professionals are also no longer willing to accept (Romme and Escher 1993; Barham and Hayward 1995; Rogers et al. 1993).

In this chapter we examine discourses of expertise about mental illness, particularly as they relate to schizophrenia. In doing so we encounter many of the mini-narratives noted above. The absolute dichotomy between knowledge and experience of mental illness had its epistemic moment within the context of the large mental asylums. The relocation of mentally ill people into the community provides an opportunity to explore whether new frames of understanding have developed between mental health workers and those for whom they care, and the consequences of this shifting relationship for public talk about mental illness.

The Dislocation of Psychiatric Expertise

With the closure of the asylums the historically contingent character of psychiatric practice has been strongly underlined and the structures which in an earlier period appeared to bind the 'mentally ill' together as a homogenous group have collapsed bringing about a 'marked diversification of experience among different social groups in their encounter with mental illness and European psychiatry' (Barham and
Knowing Madness

Hayward op cit.: 4). Ethnicity in particular has been shown to have distinctive and controversial consequences for the ways mental illness (especially schizophrenia) is identified and dealt with. Moreover, the weight attached to biological processes in understanding mental disorder is viewed with increasing suspicion by mental health professionals (including some psychiatrists), many of whom favour more inclusive biosocial or biopsychosocial models of disorder (Busfield, 1996).

The shift to Community Care has produced a proliferation of mental health professionals. Many of these practitioners - counsellors, psychologists, psychiatric nurses - deploy skills and expertise often partly grounded in psychodynamic ideas. As a consequence, their adherence to medical models of mental illness is at best, provisional. Consequently, while psychiatrists, as medical specialists, still have prime responsibility for the care and treatment of the mentally disturbed, in the world of community care other professionals compete with them for influence and power. Underpinning this contest is a recognition that many of the services that fall under the umbrella of community care are delivered in practice by a range of formal and informal carers. Indeed, the imprecise definition of what constitutes community care 'does not require that there be any professional service at all, and informal care by family and friends... can all fall within the framework of community care' (Busfield, op. cit.: 135). As a result, openings for more fragmented, contingent and unplanned approaches to mental health have appeared (Samson, 1995) within the already conflictual domain of psychiatry.

The dismantling of the asylum system and its replacement with a network of professional and voluntary agencies might be interpreted as a sign that the psychiatric knowledge has been all but displaced by the weight of 'alternative' ways of knowing...
Knowing Madness

about mental disorder. However, while there is little doubt that the professional dominance of psychiatrists has diminished with the decline of the asylum Enlightenment convictions about the advance of medical knowledge still run deep and psychiatric medicine retains a key position within the community mental health system. Nonetheless, the growth of many different types of mental health service within the broad framework of community care means that no one professional body has an exclusive claim to knowledge, expertise and authority about mental disorder. Consequently, definitions of what constitutes ‘expertise’ in an era of community care are increasingly contingent and can no longer be guaranteed by appeals to the traditional authority of bio-medical concepts of ‘mental illness’.

The Dominant Discourse of ‘Madness’

Those who point to the apparent levelling of knowledge among the psychiatric professions do not take account of the extent to which professional interpretations, perceptions and accounts of mental illness, although wide ranging, remain saturated with a vocabulary in which bio-medical explanations of illness are dominant. The psychiatric nursing lexicon for example, rests firmly on the familiar discourse of disease. Categorical notions such as ‘neurosis’ and ‘psychosis’ continue to govern the practitioners’ conceptual landscapes and terminology. Many critics of psychiatry have noted the difficulties of articulating an alternative vocabulary of mental illness. In their pioneering work on the social genesis of schizophrenia within the family, Laing and Esterson (1984: 19) acknowledge a paradoxical dependency on the clinical term ‘schizophrenia’ whilst rejecting the ontological validity of the concept:

Although we ourselves do not accept the validity of the clinical terminology, it is necessary to establish the fact that the persons whose families we are describing are as ‘schizophrenic’
as anyone is. By ‘schizophrenic’ we mean here a person who has been diagnosed as such and has come to be treated accordingly. Thus we have begun each account [of the eleven case-studies employed] by a description, couched in clinical terms, of the experience and the behaviour of the person to whom ‘schizophrenia’ is attributed. We reiterate that we ourselves are not using the term ‘schizophrenia’ to denote any identifiable condition that we believe exists ‘in’ any one person. However, in so far as the term summarizes a set of clinical attributions made by certain persons about the experience and behaviour of certain others, we retain the term for this set of attributions. We put in parenthesis any judgement as to the validity or implications of such a set of attributions.

The problem of finding a vocabulary that can *precisely* articulate an ‘alternative’ concept of mental illness has resulted in a structural imbalance in the vocabulary of psychiatry, such that any attempt to displace medical terms is immediately regarded as either ‘political’ (and therefore suspect), or simply ignorant. The language and nomenclature of biomedical psychiatry, then, still shapes public discourse on mental health to such an extent that even its sharpest opponents and critics (such as Laing and Esterson) have to rely on it in order to appear informed and credible. To reject it completely risks appearing inarticulate and less than competent when discussing mental health issues in the public domain.

*The (Partial) Erosion of Bio-medical Authority in Psychiatry*

As noted earlier, bio-medical explanations of mental illness have traditionally been most secure within an asylum environment in which doctors hold legal and professional power over both staff and patients (Samson 1995). In an era of community care medicalized definitions, interpretations and treatments of mental disorder have become contested terrain.
While the voice of medicine no longer controls the discursive field surrounding mental illness and community care however, it still retains a significant presence in professional and public talk about psychiatry. Consequently, constructing an explanatory discourse on mental illness outside the voice of medicine is difficult. This is not simply a theoretical concern. For many psychiatric patients medicine's way of 'knowing' about their 'condition' has real material effects. This can sometimes involve them in conflicts with their psychiatrist over diagnosis and treatment plans to the extent that doctors may eventually rely on some form of physical restraint (such as forced incarceration in hospital) in order to 'care' for them. The erosion of medical expertise in the mental health field is thus both a differential and partial process.

Nevertheless, it can be seen as part of a more generalised collapse of trust in the authority of experts and 'expert systems' of knowledge (Giddens 1990). For many commentators, this declining faith in expertise is part of a post-modern condition in which provisional, local and contextual 'truths' have displaced outmoded 'universal truths'. In this situation, the articulation of one type of knowledge need not be at the expense of other forms since there is no longer agreed ways of adjudicating on 'truth claims'. The post-modern insistence on a plurality of heterogeneous claims to knowledge appears to have some validity in the context of modern psychiatry. In the UK the development of a multi-disciplinary approach to mental health care has helped give voice to a widening range of psychiatric professionals, pressure groups and interested lay people, all of whom want their points of view about psychiatry to be heard in the public domain. In short, the once privileged discourse of psychiatric medicine now has to take its place amongst a plurality of other ways of talking about mental health, none of which can be neatly assigned within a clear hierarchical order.
TV Current Affairs and the Voices of Psychiatric Expertise

For those producing TV programmes about mental health issues this altered situation means that a range of voices might now be considered "knowledgeable enough" to contribute public testimony on psychiatric and community care topics. The extent to which different forms of current affairs programming accept or reject a traditional hierarchy of expertise - in which medical knowledge is placed firmly at the top - is the main focus of concern for this chapter. In exploring this issue two key questions are addressed. Firstly, how is 'expertise' defined within current affairs programmes dealing with mental health issues? Are definitions grounded in medical models or do they extend to other kinds of professionals, and beyond them to others? Secondly, which kinds of current affairs formats are open (or closed) to differing interpretations of psychiatry and mental illness? We can begin to explore these questions by looking at 'A Place of Safety' from the Granada Television series, Disguises.

Disguises: 'A Place of Safety'

Consider the following extract from Part One of 'A Place of Safety' in which the reporter, Adam Holloway, outlines the key questions he hopes to answer in his role as a 'schizophrenic':

Holloway: Why are there so many mentally ill people roaming the streets of our cities? Mental hospitals are closing but what's been put in their place? To find out I'm going to pose as a schizophrenic on a journey starting from the Midlands ending in central London where more than one in a hundred people suffer from schizophrenia, the illness that can destroy a victim's personality.
At this point the visual and voice tracks cut to the testimony of Dr David James of the Riverside Mental Health Trust:

Dr James: The voices may criticise the person concerned or comment on their actions but more importantly they may actually give directions as to what the person should do. In some instances these are fairly trivial things. People may be instructed to stand up and sit down or to take their clothes off and feel obliged to obey. In other instances the consequences may be more serious. The voices may tell people to harm themselves or even on occasions to harm other people.

By describing schizophrenia as an illness in which people ‘suffer’ and are ‘victims’ Holloway valorizes an orthodox medical model and displaces other possible (e.g. socio-psychological) explanations. It is necessary for him to do this because the coherence of his in-role behaviour depends upon his ability to authentically play the part of a ‘voice hearing’ schizophrenic who is in need of medical treatment but is unable to get it. For example, when later in the programme, he fails to get medical help in seven different GP surgeries he comments: ‘It may be understandable when the public shy away from the mentally ill but it should be different in a doctor’s surgery’. The significance of his failure to get treatment as a ‘schizophrenic’ depends on the programmes’ endorsement of a medical model of schizophrenia. There is no opportunity for this interpretation of schizophrenia to be challenged (including the taken for granted assumption that schizophrenics need treatment) because the programme’s raison d’être is a concern with community care for the mentally ill and not with the causes of schizophrenia per se. Nonetheless, Holloway’s closing definition of schizophrenia as an illness ‘which can destroy a victims personality’ invites some explanation as to why this happens. It is at this point that we hear Dr. James’ testimony concerning ‘the voices’.
By mobilising Dr. James' description of 'the voices' immediately after Holloway's comment that schizophrenia can destroy a victim's personality, a complex and contested experience is reduced to an irrational and mechanical symptom. This reduction is pragmatic rather than ideological since Holloway's role as a 'schizophrenic' centres primarily on his pseudo voice-hearing 'experiences'. So, for dramatic - and therefore entertaining - purposes schizophrenia is rendered synonymous with hearing 'voices' so that Holloway's 'strange' behaviour can be understood by viewers (its strangeness is underlined by the tension-building music that accompanies Holloway, as in-role, he later begins to take his clothes off in the street in order to attract police attention). However, the main significance of Disguises' use of Dr. James' technical explanation of 'the voices' lies not simply in the fact that his status as a psychiatrist is taken as giving him the authority to speak on this topic, but that his presence as an 'expert' lends validity to the programmes' dramatic representation of schizophrenia as a visually strange, disturbing, and exciting 'problem'.

'A Place of Safety's' deployment of medical knowledge is not confined to 'technical' explanations of schizophrenic 'voices' however, it is also generalised to give authority to speakers on the topic of Community Care. Thus, in the following sequence from Part Two of 'A Place of Safety', an 'independent' psychiatrist (posing as a relative) has been asked to assess the medical care being provided to residents of Mayfield Court, the hotel in which Holloway has been living as a 'schizophrenic':

Psychiatrist: Right it's dirty. The people here look uncared for. They don't look as though they've had much treatment for for their illnesses. The majority of them have probably got some form of chronic mental illness such as schizophrenia. I should think some of them have probably got learning disabilities, which is what used to be called mental handicap.
Holloway: With er with seventy-five people in here how many nurses do you think would be able to appropriate appropriate number?

Psychiatrist: For adequate adequate care you I would have thought you'd need probably about ten nurses per shift really not unless they wouldn't necessarily all have to be trained but certainly sort of like you know probably five sort of decently trained nurses (unclear). Its clear that a lot of these people haven't had baths for ages.

By introducing the psychiatrist as an 'independent' witness she is immediately signalled as someone without a particular axe to grind, and whose 'assessment' of Mayfield Court's' medical care will be neutral and objective. The 'assessment' comprises of five observations based on her inspection of the 'hotel'. Each presents as the categorical 'findings' of an expert who has investigated the 'hotel' and uncovered severe defects (e.g. 'The people here look uncared for'). The psychiatrist duly notes the existence of 'chronic mental illness such as schizophrenia' as well as the presence of 'learning disabilities, which is what used to be called mental handicap' (simultaneously re-emphasising her credentials as a clinician and further amplifying her status as someone we should trust). This latter point is important because the programme mobilises her testimony not simply to identify and label mental disorders but to provide authoritative 'proof' that community care is failing the residents of Mayfield Court. In the process, her medical knowledge is rendered secondary to her more general knowledge of what should constitute “proper” community care.

Once the psychiatrist's authority to speak is established she is then asked about the 'appropriate' number of nurses needed to care for seventy five people - an aspect of community care where others (most obviously nurses) arguably have more of a claim to relevant knowledge. However, her knowledge is simply assumed to extend beyond
Knowing Madness

medicine and to encompass knowledge of psychiatric nursing. By using medical authority in this way the programme makers not only validate psychiatric medicine as the dominant source of technical knowledge about mental illness (including schizophrenia), they also situate it at the centre of understanding community care. In doing so, the expertise of other mental health professionals working in this area (such as community psychiatric nurses) is ignored.

Kilroy

In contrast, Kilroy acknowledges the involvement of a whole range of people in the community care enterprise and opens up space for a number of non-medical voices. This is accomplished by presenting Community Care as a problem, not for the psychiatric profession, but for the families of schizophrenics. After listening to the experiences of relatives of schizophrenics Kilroy-Silk addresses Martin Eede, the Chief Executive of the National Schizophrenia Fellowship (NSF):

Kilroy-Silk: A lot of people outside of the people here don't understand the impact it [schizophrenia] has upon the families and the devastation and what people are just going through and that in itself is important. Is this, Martin, a typical kind of thing (unclear)? How much I mean how much is this a part of the problem of schizophrenia, the impact on families, the lack of understanding, the lack of knowledge of how to deal with it?

Eede: The National Schizophrenia Fellowship works with thousands of families who've experienced very much what these people here have. The problem with schizophrenia and the treatment of it is so often it is the family who has to provide the care and it tears families apart so that you end up with one carer having to look after someone whose ill, or at times no carer, so there is no community and you end up with no care, and you end with people wandering the streets and going through all the sort of terrible experiences that families here have gone through.
By widening definitions of the ‘problem’ of schizophrenia to include its impact on families Eede is signalled as someone with specialist knowledge (e.g. ‘Is this, Martin, a typical kind of thing?... how much is this a part of the problem of schizophrenia, the impact on families... the lack of knowledge of how to deal with it?’). His status as Chief Executive of the NSF is presented as qualifying him to speak authoritatively on this topic. In particular, it enables him to re-define schizophrenia as a familial/social rather than individual/biological problem: ‘The problem with schizophrenia and the treatment of it is so often it is the family who has to provide the care and it tears families apart.’ However, although Eede’s formal status licences him to speak as an authority on the impact of schizophrenia on families, his interpretation of the situation does not go unchallenged. A range of other voices are called upon to participate in the discussion. In the following sequence, for example, Eede is joined by two participants with practical knowledge and experience of community care.

Martin Eede: What I was going to say was that the Salvation Army does wonderful work but we know that there are sixty thousand people in London alone who are either roofless or living in temporary accommodation. The government has only provided spaces for 73 people with planning for 77 more spaces so what we’re ending up with is community care effectively being on the streets.

Salvation Army spokesperson: That’s right and our hostels are not appropriate places. Research that’s been done shows that people in hostels are not as comfortable with themselves or they’re more likely to depression, more likely to to become ill again. Also, we get the families, family members where there’s a schizophrenia sufferer in the in the household, sometimes they end up in the hostel. We had a whole family come once because they couldn’t get attention.
Audience member: My brother suffers from schizophrenia. He's 24 and he's got to the point where he's had hospital care and been on medication and he's going to a hostel. Now, I'm very concerned about the aftercare erm. It's not comprehensive in my mind. They have two weekly visits to start with at the hospital erm which then deteriorates down to a month, two months, three months. Now this is a time it's an illness which erm has a lot of or relapse and it goes on there's a vicious cycle that goes on and goes on and for the family it's really bad because you know you you're never safe in the knowledge that even though they're having treatment that this is adequate, it never is.

This sequence is a good illustration of our argument, made earlier, that the transition from the asylum to the community allows a range of voices to be considered 'knowledgeable enough' to contribute testimony to TV talk on psychiatric and community care issues. No single, overarching voice of authority is allowed to dominate this part of the discussion to the exclusion of other relevant voices. On the contrary, in this sequence, three different kinds of testimony blend together to form a critique of community care which Kilroy-Silk then uses to challenge a Conservative MP about his government's policy of closing the asylums. There is no boundary or clear hierarchy of credibility demarcating each speaker's contribution. Kilroy-Silk makes no attempt to bracket off the testimony of the final speaker as being too subjective and specific in contrast to the first two speakers, both of whom base their knowledge of the topic on their 'professional' involvement in community care. This confirms experientially-based testimony as a valid contribution to public discourse concerning care in the community.

However, in explaining schizophrenia, Kilroy, like Disguises, relies on an orthodox medical model. The only voice mobilised is Dr. Tim Crowe, identified as a consultant psychiatrist by an on-screen caption. His contribution is sought by Kilroy-Silk.
following testimony from a number of schizophrenics who have described their experiences of hearing 'voices':

Kilroy-Silk: Is that typical of what we've heard schizophrenics go through?

Dr Crow: There are many different features of the disease and I think we've heard some some of the spectrum so far erm we've heard examples of hallucinations, delusions erm disturbed perception. These are these are characteristic, these are these are the features that that define the disease. There are two big categories: hallucinations - disorders of perception; delusions - disorders of belief and er

Kilroy-Silk: What causes it?

Dr. Crow: We don't know what causes it erm er that's er a big problem. Probably there's a genetic factor.

Kilroy-Silk: How how much does hereditary play a part? Does it play a part?

Dr. Crow: Certainly it plays a part, we don't know what part er we don't know that anything else is relevant so at the moment we think that probably the genetic part is over overwhelming but its unclear exactly how that how that comes about.

Kilroy-Silk: But does it...

Audience member: What about it being socially constructed?

Kilroy-Silk: Say it again.

Audience member: Er er er the theory, the the the anti-psychiatric theory movement which sort of suggests that that these kinds of things are brought on through erm you know it being a social construct.
Dr. Crow: I think that's unconvincing. We know that the disease occurs in all societies probably at about the same rate erm it seems to be a characteristic of the human condition I think erm.

Audience member: But there are many (unclear) there are some some some societies erm you now the the hearing of voices etcetera isn't classified as an illness.

Dr. Crow: I I think erm that that's er it seems as though similar erm psychotic conditions occur and I as far as I'm aware all societies would regard the sort of symptoms we've we've we've heard about as abnormal.

Kilroy-Silk: Hang on. What about er it tends to be generally men. Is it is it there a greater propensity for men to have the ill the disease?

Dr. Crow: That's not clear the onset is earlier in men...

Kilroy-Silk: We've only talked to men so far of course.

Dr. Crow: That's right erm and probably the outcome is a little bit worse but certainly women can affected with as severe illnesses erm.

Kilroy-Silk: Is there a cure?

Dr. Crow: Treatment the drug treatment we have is quite good. We've had it for thirty years erm it it improves the acute episodes and er it er prevents relapse which is very important.

What is immediately apparent is that this extensive question and answer exchange is used to elicit purely medical information about schizophrenia. By engaging Dr. Crowe in this pedagogic way (within a format more usually given over to experiential based testimony) Kilroy Silk is clearly signalling him as a source of specialist knowledge about schizophrenia. That Dr. Crowe is indeed a specialist on this topic is then
confirmed as he proceeds to define and classify the testimony of previous speakers in recognisably medico-technical terms: ‘we’ve heard examples of hallucinations, delusions... disturbed perception’. Indeed, the extract illustrates the extent to which a medical discourse is allowed to dominate the interpretation and experience of schizophrenia (a point underlined by the amount of deference that Kilroy-Silk gives to Dr. Crow’s technical knowledge). Thus, when an audience member interrupts and challenges Dr. Crow, pointing to alternative interpretations of the ‘voice hearing’ experience in other countries, Kilroy-Silk allows the interruption (in keeping with the programme’s general aim of calling experts to account for their claims), but then returns to his dialogue with the psychiatrist and continues to probe for technical information about schizophrenia ignoring the implications of the challenge just made.

The challenge to the psychiatrist’s way of ‘knowing’ schizophrenia is not pursued because it does not fit with the programme’s main aim, which is to probe the provision of community care for schizophrenics (the corollary of which is that schizophrenics need care because they are ill). Thus, although Kilroy’s debate format allows some scope for challenges to be made to the bio-medical view of schizophrenia such challenges have no opportunity to develop within a discursive arena in which the limits of the debate have already been set.

Kilroy’s closure around an orthodox medical explanation of schizophrenia reminds us that expert knowledge, while susceptible to criticism and rejection by the laity, remains an important tradable asset in audience discussion programmes. This is most apparent in relation to topics where highly technical or scientific matters are assumed to lie at the heart of the issue under debate. Because schizophrenia is treated as a complex medical/scientific phenomenon in the extract above, only Dr. Crow is
signalled as having the relevant knowledge concerning what it is, what causes it and whether or not there is a 'cure'. Kilroy's representation of medical knowledge of schizophrenia as authoritative is conveyed then, linguistically, in Dr. Crowe's ability to medically define various features of schizophrenia ('we've heard examples of hallucinations, delusions... disturbed perception') It is also signalled by the amount of space which Kilroy-Silk gives him to define the 'features' of the 'disease' and then to reject the challenge made by a lay member of the audience.

*All Black: 'Broken Poets'*

At the same time, the brief appearance in Kilroy of the 'social constructionist' view of schizophrenia reminds us that the meaning of the condition is no settled matter. The cause of the high incidence of schizophrenia amongst Britain's black population is a particularly fiercely contested issue, in which biological explanations of 'disease' clash with alternative accounts of ethnocentric and racist diagnostic practices. In 'Broken Poets', part of BBC2's *All Black* series, this disagreement is presented as a fault line separating two opposing camps of medical knowledge. In the following sequence from the programme, biological and social interpretations of schizophrenia are presented as contrasted ways to explain its high incidence in the black population. The sequence follows testimony from a black research psychiatrist that the higher incidence of schizophrenia amongst Britain's second generation black immigrants compared to the host white population remains unexplained:

Presenter: It's this increase among black second-generation migrants that's most surprising. One school of thought believes that the human brain may provide possible answers.
Prof. Simms (identified by caption as a former President of the Royal College of Psychiatrists): That generation has got a very much increased incidence of schizophrenia and erm er its difficult to know exactly why this is so but most people now believe that schizophrenia is an illness like any other er only of course its effects are upon the brain. I would have thought that er it would be regarded by er most psychiatrists now as the evidence as being overwhelming. Er there are abnormalities shown er with er various erm new methods of imaging the brain er there are some neurological abnormalities and so on so erm there would be very few people who would argue with schizophrenia being a disease of the brain.

Dr. Fernando (identified by caption as a Consultant Psychiatrist): Brain and the body you know has an effect on everything you know. If I get angry you can say well that's a disease of the brain. I mean it is - there are things that are different in the brain when we're angry but that's not er that's not the most er useful explanation for why I might be angry er especially when I hear things like that.

Dr. Coker (identified by caption as a Research Psychiatrist): I don't think there's any evidence that ehm Afro-Caribbean people have more brain disease as such than white people. What we're seeing here is that there are factors causing Afro-Caribbean people to present with higher rates of severe mental illness like schizophrenia. And we're trying to find out what these factors are which could be several - from the social to the biological - we're not sure yet.

Dr. Moodley (identified by caption as a Consultant Psychiatrist): Within psychiatry there are not many people who take a firm either/or view er but there are some people who believe that maybe the emphasis has been misplaced to put it on a biological theory and that it is more social causes er and racism being one those social causes. I think most practicing psychiatrists think it's probably a bit of both.

The sequence begins with the presenter identifying, as 'one school of thought', the orthodox bio-medical view (represented in the programme by Professor Simms) that abnormalities in the brain can explain the high incidence of schizophrenia amongst Britain's black population. Immediately following Simms' presentation however, a
counter-argument is mobilised that defines this point of view as racist. In this respect it is significant that Simms is a white psychiatrist whereas the three other speakers are from ethnic minority backgrounds. The framing of the biological model as racist stems from 'Broken Poets' sequential construction of an 'anti-biological' discourse in which each testimony builds upon the preceding one to produce a powerful counter-argument which establishes Simms' position as closed around a biological model which ignores alternative explanations. Simms therefore appears as a minority of one set against a majority of three more credible medical experts.

The 'anti-biological' argument takes as its point of departure Professor Simms' view that 'there would be very few people who would argue with schizophrenia being a disease of the brain'. At this point the sequence cuts from his testimony and we encounter exactly the opposite of what Simms has just said: three people who do in fact argue with the idea of schizophrenia being a disease of the brain. The first two speakers are mobilised to establish two key counter-arguments to Simms: first, (from Dr. Fernando) that diseases of the brain are not the most useful explanations for the high incidence of black schizophrenia and second (from Dr. Coker), that there are a number of possible factors 'ranging from the social to the biological' which might explain such a high incidence. However, the full significance of these two points only becomes apparent in the final contribution from Dr. Moodley. This begins with the claim that, 'Within psychiatry there are not many people who take a firm either/or view...' concerning the biological and social causes of schizophrenia. Here, the sequence turns full circle away from Simms' view that very few people would argue with schizophrenia being a disease of the brain, to one in which having a firm 'either/or' view is, at best, dubious and, at worst, racist.
Rather than allowing Professor Simms' biological discourse to displace social explanations of the causes of schizophrenia, his viewpoint is itself marginalized in the course of the sequence. It is through the cumulative construction of the 'pro-social' position as considered (e.g. Dr. Fernando: 'there are things that are different in the brain when we're angry but that's not er that's not the er most useful explanation for why I might be angry), open to negotiation (e.g. Dr. Coker: 'We're trying to find out... we're not sure yet'), and balanced (Dr. Moodley: 'its probably a bit of both') that the labelling of Simms' biologism as marginal and racist is accomplished. In contrast, the three ethnic minority psychiatrists readily acknowledge the influence of social factors like racism on the diagnosis of schizophrenia, an acknowledgement which, as can be seen in the following comment from the 'Broken Poets' presenter (immediately after Dr. Moodley's contribution above), the programme seems to support: 'If there's more to schizophrenia than brain disease then this could account for the high rates among the second generation...'.

By presenting the controversy surrounding black schizophrenia as more than a medico-technical issue, 'Broken Poets' offers an 'alternative' explanation in which racism plays a central role. But while the programme supports the view that racism influences the diagnosis of black schizophrenia, participation in the programme's debate is restricted to opposing camps of medical expertise. In other words, 'Broken Poets' explanation of the issues is presented as the exclusive concern of the psychiatric profession rather than any other professional group working in black mental health. In doing so, the programme confirms a hierarchy of expertise in which the (albeit conflict-laden) voice of the psychiatric profession is privileged over other voices.
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This elevation of an authoritative medical voice is also evident in the programme’s later presentation of the issue of the misdiagnosis of schizophrenia in the black population. Here the only voice heard is that of another ethnic minority psychiatrist, Dr Sashidharan. In the following sequence his testimony is used to problematize the process of psychiatric diagnoses and highlight the difficulty of diagnosing schizophrenia based on observations of black patients’ behaviour:

Presenter: Dr Sashidharan, a senior consultant psychiatrist in Birmingham, believes that the lack of diagnostic consensus among psychiatrists lead to further difficulties in the plight of black people.

Dr Sashidharan: The problem with psychiatric diagnosis unlike a medical diagnosis is that er such a diagnosis cannot be confirmed or validated by reliance on an external criteria. The level of agreement between psychiatrists for a diagnosis is somewhat poor, we cannot validate it, we cannot establish its presence using any other means so there are fundamental problems in the in the process of psychiatric diagnosis and that is not erm a not a new problem within psychiatry. But when western psychiatry comes into contact with people who are non-European these problems are revealed much more clearly to us.

Presenter: Patients’ behaviour is an influential factor in the diagnosis of schizophrenia but more often than not it’s the behaviour of black patients which is not always properly understood.

Dr Sashidharan: Psychiatrists tend to attach a pathological meaning to the behaviour of the black person, the distrust that is expressed by a black person more often than they would do in erm in a clinical situation with a white patient. And also the diagnosis of schizophrenia seems to be applied somewhat uncritically when black patients come into contact with psychiatrists even in the absence of some of the core symptoms of schizophrenia which er are usually required for such a diagnosis within Western psychiatric tradition.
As the sequence begins the presenter’s opening comments are juxtaposed against a shot of an open window, which the camera then pulls away from revealing the facade of a large Victorian-built asylum (fig. 5.1). This image of the asylum together with the presenter’s identification of Dr Sashidharan as a ‘senior consultant psychiatrist’ is crucial to his construction as an authoritative voice. His authority to speak on the issue of misdiagnosis is grounded in his practical knowledge and experience of diagnosing psychiatric patients - a practice that traditionally occurs within an asylum/hospital setting and to which we are normally denied access. Dr Sashidharan’s contributions provide our “access route” to the interior of the asylum and in particular, to the ‘clinical situation’ in which the (usually) invisible process of (mis)diagnosis occurs.

As we continue to look at the asylum’s exterior we hear Dr Sashidharan’s voice as though it were beckoning us inside. The image track then cuts to a shot of Dr Sashidharan seated in front of an open window within the asylum (fig 5.2) and we are now (literally and symbolically) on his professional territory.

By anchoring the misdiagnosis issue within an asylum context ‘Broken Poets’ inevitably mobilises the conventional view of psychiatric expertise in which the psychiatrist is assumed to “know best”. No counter-argument is mobilised against his testimony in order to challenge the validity of his claims. On the contrary, his views are given precedence on an issue on which many psychiatrists and mental health workers would disagree. By allowing him exclusive access, other relevant voices are excluded from participation (most obviously, the voices of black people whose behaviour may have been wrongly diagnosed as ‘schizophrenic’). Because ‘Broken Poets’ presents the issue of psychiatric misdiagnosis as something that happens to patients as a consequence of medical misunderstanding their voices become irrelevant to understanding the medical problem of (mis)diagnosing. Reproducing the silence
historically imposed on patients within mental asylums Dr Sashidharan is licensed to speak on their behalf.

*People First: ‘Black and Blue’*

In contrast, ‘Black and Blue’ presents its critique of psychiatric diagnostics (and other related issues) from outside the institutional boundaries of the asylum/hospital and orthodox psychiatry. In doing so it gives space to a number of non-medical voices. In the following sequence, the experience of receiving a psychiatric misdiagnosis is articulated through the testimony of Adrian, a black ex-psychiatric patient and Nicky Olaiton, a black mental health counsellor:

Adrian: One doctor classed me to be schizophrenic, a next doctor just classed me to have a nervous breakdown, so I’ve got two doctors with two different opinions and the medication is the same all round. Some those with breakdowns, those with depression, its the same medication all round, well that’s what I heard that’s what I was cos when I asked the others what they’re taking for medication they told me the same, Clo Clopixol. And I was trying to get off the medication and take counselling like talk talking therapy but that that didn’t help because I got manhandled in the hospital erm when I suggest it. I was dragged and put in the seclusion room.

Nicky Olaiton: Firstly there is the problem of misdiagnosis, mistreatment. Because psychiatrists and psychologists don’t always understand the needs of black people, or why black people behave in a certain way in a given circumstance, and because the way they behave is different from what the psychiatrist would expect, then he terms that kind of a dysfunction.

From a post-modern viewpoint the combination of Adrian and Olaiton’s voices might be seen as an attempt to give a ‘post-medical’, user-led perspective on psychiatry.
However while Adrian is allowed to speak about his experience of being misdiagnosed (e.g. ‘I was dragged and put in the seclusion room’) he is not entitled (within the programme-as-broadcast) to express an opinion on that experience. This is the exclusive entitlement of Olaiton. Her knowledge of psychiatric diagnostics is mobilised so that Adrian’s particular experience of psychiatry can be ‘correctly’ understood as ‘misdiagnosis, mistreatment’. ‘Black and Blue’s’ strategy of authentication then, privileges Olaiton’s voice and in doing so helps establish her (and not Adrian) as an authority/expert in the field of black mental illness. The issue of whether or not Adrian recognises his reconstructed experience remains a moot point.

Despite his status as an ‘experienced person’ (who has been accessed specifically to recount his experience of ‘misdiagnosis’ and ‘mistreatment’), Adrian’s grounded knowledge is rendered inferior to Olaiton’s mode of knowing about psychiatric diagnostics. Olaiton’s entitlement to speak is on the basis of her occupational status, as a community-based mental health counsellor who has specialist knowledge of psychiatry derived from practical experience of counselling the mentally ill.

‘Black and Blue’s’ basic argument is that culturally sensitive modes of healing offer black people a more appropriate mental health service than conventional hospital-based psychiatry. Consequently, Olaiton’s access derives not simply from her professional ‘know-how’ as a counsellor, but also from the thematic privileging of ‘the community’ as a more appropriate space in which to provide psychiatric help for black people than the mental hospital. In the following sequence, her knowledge/experience of counselling is used to support ‘alternative’ mental health therapies. Olaiton’s contribution precedes the testimonies of a number of other community-based mental health workers:
Nicky Olaiton: I counsel and for me that really is about helping people to explore you know the issues which help which cause them to break down in the first place erm you can't just treat a er symptom with medication, it doesn't work like that, you also need to provide all the other things, the alternative therapies as they're called, such as counselling, erm relaxation techniques, massage those sort of things. It's about helping the whole person to get better, not just the person's mind. It's about their whole body.

Isha McKenzie-Mavinga: Rakyiotherapy is an ancient healing art from Japan and it involves the transference of universal energy to heal the body, mind and spirit. It can be beneficial to people who are on medication because it enhances the effect of medication to calm them and relax them. Because this is a method of relaxation they would be able to eventually reduce the amount of medication they are taking and most of all when they come out of the therapy they usually wake up with a feeling of well-being and begin to find answers to some of the problems that are happening for them.

Mark I: Psychiatry's only response has been to medicate people er and mask the symptoms without really having much idea or or way of tackling underlying er problems which include er social problems indeed. So what we've tried to do here at the Afro-Caribbean Mental Health Association is try and develop complimentary, alternative and holistic ways of looking at health and mental health. The interesting thing about holistic medicine is that harnesses the body's own self-healing capabilities and potential and which er are actually quite tremendous. So yoga's just one way then of giving people self-determination and a sense of hope that they could actually help themselves.

Dr. Sashidharan: The project that I am involved with is called the West Birmingham Home Treatment Project. Our team which consists of doctors, nurses, housing support worker, social worker erm, a team largely consisting of er trained mental health workers, we are located away from the hospital in a building in the community and we respond to these crises or these referrals by getting engaged with individuals at their usual place of residence and ensuring that they are not likely to be taken into hospital. In other words we provide all aspects of what would be seen as conventional aspects of psychiatric care at the person's home. We stay with
individuals for long periods of time, we try and provide the individuals with support and
counselling, we try and support individuals with the multiple problems that they might be
experiencing in the context of their breakdown: social problems, material problems, financial
problems. In other words we try and address the overall needs of the individual client in the
context of their breakdown rather than emphasising psychiatric symptoms or mental illness as
such.

This sequence illustrates the extent to which the issue of psychiatric drug treatment is
contested terrain. Olaition’s declaration that ‘... you can’t just treat a... symptom with
medication, it doesn’t work like that...’, and Mark I’s claim that ‘Psychiatry’s only
response has been to medicate people... and mask the symptoms [of mental illness]
without really having much idea or... way of tackling underlying... [social] problems’
are unequivocal attacks on the legitimacy of medical intervention. Olaition provides
the justification for this attack: ‘Its about helping the whole person to get better not
just the person’s mind’. Her opposition to the mind/body dualism of mainstream
psychiatry is based on her practical experience of helping ‘the whole person’, an
experience which entitles her to identify the need for other, complementary, forms of
therapy (i.e. ‘... you also need to provide all the other things, the alternative therapies
as they’re called...’). The absence of any challenge to her claims suggests that the
programme’s makers support her views on alternative modes of healing. The
hierarchical positioning of her testimony gives the sequence an organising rationale
that confirms alternative therapies as more appropriate for black mentally ill people
than hospitalization and conventional drug treatment.

Underpinning ‘Black and Blue’s’ support for alternative therapies is a loss of faith in
the efficacy of psychiatric medicine and the bio-medical concept of mental illness.
Thus in the sequence above, McKenzie-Mavinga proposes that relaxation therapy can
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help mentally ill people 'reduce the amount of medication they are taking' enabling them to 'find answers to some of the problems that are happening for them', whilst Mark I claims that yoga gives people 'self-determination and a sense of hope that they could... help themselves'. Within the context of the political struggle to define the 'proper' meaning of psychiatric care for black people, and increasing popular support for alternative medicine, Olaiton, McKenzie-Mavinga and Mark I are each given space to redefine appropriate psychiatric help for black people as holistic, culturally sensitive, and rooted in 'the community'.

'Black and Blue's' antipathy towards orthodox psychiatry ensures that its representation within the programme 'fits' its general thematic rejection of the mental hospital as the best site of care for the mentally ill. This is duly provided by Dr Sashidharan’s contribution (he appears in both 'Broken Poets' and 'Black and Blue') which draws attention to a 'Home Treatment' service, one sensitive to the 'overall needs of the individual client in the context of their breakdown' and emphasises that the project team is 'located away from the hospital in a building in the community'.

In ‘Black and Blue’ the voice of orthodox psychiatric medicine is a significant absence while the presence of a number of community-based ethnic minority mental health workers signals them as more relevant to meeting the socially-generated mental health needs of black people. However, whilst the programme acknowledges ‘the community’ as the most appropriate site for the delivery of psychiatric treatment, the choice of what form of treatment to apply (if anything) is left open. Consequently, Dr. Sashidharan’s ‘conventional’ Home Treatment service is presented as one possible form of psychiatric intervention amongst many others.
The appearance in 'Black and Blue' of a plurality of treatment approaches reflects the degree to which the bio-medical model no longer has a privileged place at the apex of psychiatric knowledge. The demise of the asylum system has in fact been a precursor to a more far reaching erosion of western medicine's power as the centre of knowledge and authority about mental illness and its treatment. At the core of this newly emerging situation lies the 'legitimation crisis' of bio-medical psychiatry. No longer can it provide stability and continuity across the psychiatric arena by issuing all-embracing claims to knowledge. The plethora of treatment approaches noted above are a sign that the institutional structures which in an earlier period legitimised biomedical psychiatry have collapsed. It is in this changed context, of psychiatry as a fractured field of knowledge, that Olaiton makes the following claim (mobilised immediately after the sequence above):

'Our continuing role is one of education, we have to educate the psychiatrists er about what is mental ill health for a black person ...'.

The absence of any challenge to this claim indicates not simply that the programme makers accept the authority of her knowledge about the causes of black mental illness. It also underpins the degree to which 'Black and Blue's' argumentative structure is specifically oriented to its black audience's interests. Olaiton's comments reflect a deeply held scepticism amongst many in the black population (the programme's target audience) about the legitimacy of bio-medical explanations of black mental illness. It illustrates in particular the degree to which the universal aspirations of the biomedical model clash with particular local knowledge of the social and cultural contexts in which black people become mentally ill. Olaiton's insistence that 'we have to educate the psychiatrists... about what is mental ill health for a black person'
indicates not simply a self-conscious authority on the specific issue of the black experience of mental illness, but the importance of black people’s *situated knowledge* about the multiple and diverse causes of black mental illness. This stance subsequently enables her to re-define schizophrenia as a *meaningful* response by black people to their often difficult social and personal circumstances:

Some people retreat so far into their (laughs) to their schizophrenia or their madness that it's very difficult to bring them back and many of them don't want to come back into the real world because they see that (laughs) what has it got to offer them you know they're they're still black people at the end of the day, they're still you know the people who are gonna have the most difficulty getting housing, getting a job you know [er] maintaining relationships. Its like they're continuously battling against things that you and I just kind of like you know see as ordinary holes that you step over every day but to somebody with a mental health problem you know that little hill is a is a is an Everest.

Here, Olaiton posits a direct causal relationship between the experience of being black and the black experience of schizophrenia. In doing so she (re-)interprets schizophrenia as an *understandable* ‘retreat’ from the ‘real world’ of racial injustice and black people’s difficulty in getting housing and jobs. According to Olaiton ‘being mad’ involves a *deliberate choice* for many black people (e.g. ‘... many of them don’t want to come back into the real world because ... what has it got to offer them ... they’re still black people at the end of the day ...’). This interpretation of schizophrenia as culturally and contextually intelligible acknowledges the validity of the black experience of madness in a white dominated world and in doing so allies Olaiton’s views with the ‘anti-psychiatry’ school of thought, associated in particular with R.D. Laing. However, it will be recalled that Laing and other ‘anti-psychiatry’ writers remained dependent on the ‘official’ medical lexicon. This dependency on the
official vocabulary of psychiatry is also clearly evident in Olaiton's re-interpretation of black schizophrenia.

Thus, while making a case for black schizophrenia as a form of existential self-defence there is evident discomfort in her use of the term 'schizophrenia'. This is suggested by the short (sarcastic) laugh she gives just prior to her use of the term. Her laughter appears to signal that she mistrusts the concept of 'schizophrenia' but has no choice other than to use it in order to make her point. However, the tension apparent in her use of the term suggests that while the vocabulary of the medical model is still relied upon in public-oriented talk about mental illness, the authority of its premises is not unassailable (witness her use of the umbrella term 'madness' - replete with its unscientific connotations - to further indicate her dissatisfaction and distance from the medicalized concept of 'schizophrenia').

The difficulty of re-interpreting the black experience of schizophrenia from within a conceptual framework that always-already interprets it as an illness is apparent in Olaiton's testimony. That those labelled as 'schizophrenic' are perceived by her as being ill is beyond doubt. What is disputed is the meaning of black people's 'schizophrenia/madness' within the wider context of the social processes to which they are exposed. Underlying this dispute is a perceived ethnocentrism within the biomedical model of mental illness, in particular, its depiction of illness and treatment as phenomena external to culture. Against this, 'Black and Blue' presents a model of mental illness and treatment in which an 'Afro-centric' perspective lies at the very heart of attempts to understand and help black patients:

Dr. La Granade (identified by caption as a psychiatrist at the University of the West Indies):

There is what is known as a medical model which very much views psychiatry in a certain
way, which classifies people in a certain way and which tailors treatment according to that classification. And then there are alternate therapies or alternative therapies erm and some of very can be very Afro-centric in their in their ethos, in what they give to the patient and I think that some patients may respond better to to one or the other or some patients may of necessity have to be in one system or the other but I think that there is room for both. And in fact I would go further to say that some of the things we will start off calling the Afro-centric models may in fact prove to be so valuable in their own right that they may be incorporated into mainstream psychiatry.

Significantly, Dr. La Granade does not privilege the ‘Afro-centric’ model over the ‘medical model’. ‘[T]here is’, she says, ‘room for both’. In keeping with contemporary claims that we now inhabit a post-modern discursive order she signals that there is no single or unified voice articulating ‘true’ or authentic knowledge about mental illness. Accordingly the medical and Afro-centric models are acknowledged as relative, existing side by side with some patients responding ‘better’ within one system or the other. Nonetheless, there is a clear indication that the validity of the Afro-centric model is ultimately viewed as provisional. Thus, Dr. La Granade foresees the eventual assimilation of its more ‘valuable’ aspects into mainstream psychiatry. Ironically, despite the programme’s relativizing challenge to medical knowledge this leaves ‘Black and Blue’ committed to a universalist view of psychiatry in which informal knowledge and local understanding of black mental illness is incorporated within an enlarged (and arguably strengthened) medical model. At the very least, it leaves the viewer with a sense that the psychiatric profession is amenable to change so long as it is in the best interests of patients.
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**Horizon: ‘Hearing Voices’**

The medical model of mental illness is the object of a sustained and powerful critique however in ‘Hearing Voices’, part of the BBC’s *Horizon* series of science programmes. ‘Hearing Voices’, explores the issue of voice hearing by giving precedence to the views of those who reject the orthodox medical interpretation of the experience as a symptom of mental illness (usually schizophrenia). As the programme’s narrator puts it: ‘This film is about an alternative view of the phenomenon of hearing voices’. At various points throughout the programme the traditional medical approach to voice hearing is rejected in favour of a perspective in which the problem is not the hearing of voices, but rather psychiatry's refusal to ascribe any meaning to the voice hearing experience. In order to establish the legitimacy of this approach ‘Hearing Voices’ has to undermine the traditional medical response to voice hearing. Thus in the following sequence, from an early part of the programme, orthodox medical knowledge is presented as stubbornly ‘fixed’ in the face of compelling evidence that hearing voices is triggered by psychological trauma:

_Narrator:_ A number of recent studies have established a strong connection between traumatic experiences and the subsequent hearing of voices. Sexual abuse is one common trauma linked to the hearing of voices. Another, even more common, is bereavement.

_Ron Coleman:_ The last traumatic event I had really was erm losing my partner er who died and I think that although it didn’t show itself as voices for a long time afterwards was actually the the beginning of erm a long period of coming to terms with that event. The voices being the erm if if you like the erm the whole event being brought to me er in a very real way because one of the voices I heard was the voice of the partner. Erm she erm she got herself into quite a state erm and and she she actually killed herself which was erm was probably the worst thing, erm the second worse thing being that erm I was the one who walked in on her
and I think that hitting you and having to actually find the person you love dead then you you get caught up in all this sense of guilt and anger and er allsorts so I ended sort of cutting off all relationship with parents and family and everything for quite a long time.

Dr Adrianne Reveley (identified by caption as Consultant Psychiatrist, Maudsley Hospital): I find it very difficult to accept an explanation of voices that its a buried experience that is coming back to haunt somebody, perhaps a buried traumatic experience that then gets split off in in the form of a voice. I agree and its my very firm view that voices often have a very a a worst fear quality, that its the things the person is worried and anxious about which affect them in this way. But I don’t think you have to postulate that its a an awful experience which is being split off and and comes back in the form of a voice erm I think that’s an additional layer of explanation that we don’t need.

Dr Cosmo Hallstrom (identified by caption as Consultant Psychiatrist, Charring Cross Hospital): Schizophrenia is often caused by life events, life traumas but it triggers a process and I think that’s the problem that er the the the psychological model fails to take into account that there is a disease process which then starts running on and even if you relieve the initial life trauma the patient doesn’t get better.

Ron Coleman: I I think when I was first diagnosed I was quite relieved because erm then there was a reason for everything, there was the illness. I had an illness, it was treatable and erm I thought nothing of that. But later on when you begin to realise the implications of being called schizophrenic, like people’s perceptions of you as a mad axe-wielding er psychopath or er people treating you as a pathetic person who can do nothing for yourself that changes, that changes into anger erm and then you end up being alienated within the system because you’re called non-co-operative as a patient.

In this sequence the two psychiatrists are mobilised to represent the profession’s resistance to studies [referred to by the narrator] which have established a ‘strong connection’ between voice hearing and psychological trauma. In support of this view, ‘Hearing Voices’ introduces its own ‘case-study’ in which Ron Coleman’s traumatic
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experiences and subsequent hearing of voices is used to establish a firm 'connection' between the two. Ron's testimony thus serves a useful double function. Firstly, it frames Dr Reveley's approach to voice hearing as a refusal to accept Ron's own interpretation of hearing his dead partner's voice as meaningful (e.g. The voices being the... whole event being brought to me... in a very real way'). Secondly, it undermines Dr Hallstrom's attack on the 'psychological' models for its failure to recognise that those diagnosed as schizophrenic are able to 'get better'. Ron's ability to reflect eloquently upon his traumatic experiences (including both hearing voices and being labelled 'schizophrenic') reveals not only the insensitivity of orthodox psychiatry to the voice hearing experience. It also raises doubts about its knowledge. In short, orthodox psychiatry is presented as deeply territorial and unwilling to consider alternative interpretations of voice hearing despite 'evidence' that it should.

In a review of 'Hearing Voices' one British newspaper noted the challenge that voice hearers pose to the medical model of mental illness: 'Leading the charge [against the medical model] are the voice-hearers themselves, the vanguard of a novel kind of liberation movement - seeking rights for those labelled mentally ill, and demanding, for once, that their voices are heard' ('Hearing Is Believing', The Guardian, 22/4/95). However, it would be mistaken and overly sentimental to conclude (as The Guardian review does) that 'Hearing Voices' allows voice hearers themselves to lead the challenge against psychiatry's (mis)treatment of their experiences. Rather, the programmes' challenge to the medical model comes from a number of carefully orchestrated sequences in which the traditional medical approach of voice hearing is decisively rejected. In the following sequence for example, the medical approach to treating voice hearers with drugs is marginalized against a backdrop of scientific support for a psychological interpretation of voice hearing. (A brief outline of the
sequences structure and organisation is provided immediately after the reproduction of participants’ testimony.)

Narrator: Can research into the brain help us understand what’s happening in the mind? At Hammersmith Hospital scientists have designed brain-scanning experiments to investigate what might be happening in the brains of people as they hear voices (long pause). The first step was to look at people who don’t hear voices.

Dr Philip McGuire (identified by caption as a member of the Institute of Psychiatry): What we found was that when normal people are thinking in sentences er which is er equivalent to inner speech erm the left frontal part of the brain around this area here [points to an area on a handheld model of a brain] er was particularly active and this is an area classically associated with speech production, that is speaking out loud. So our studies suggested that the same parts of the brain that are involved in speaking out loud were involved in silent articulation or inner speech. That is, thinking the words rather than saying them. One of the experiments we went on to do was to study erm schizophrenic patients who hear voices very frequently and we studied them while they were actually experiencing these voices and we found to our surprise that erm a similar pattern of areas were active when they were hearing voices as if they were external erm, so that is we saw activity in these kind of areas [points to a computer simulated cross-section of a brain] in the left frontal er lobe and and also to a lesser extent in the left temporal lobe and these are areas normally concerned with language erm. So this er really confirmed what a number of people had hypothesised from a psychological perspective er for some time and that was that er when people hear voices there may be a contribution from inner speech, that is thinking in words er, and we we think that that probably does er play a part in the experience of hearing voices.

Narrator: Talking to ourselves whether outloud or silently is part of human experience. At Liverpool University Professor of Clinical Psychology, Richard Bentall, relates this to hearing voices.
Professor Richard Bentall: This process of talking to ourselves is something which develops in childhood. When we’re children we learn to tell ourselves to do things and then to follow those instructions. In our adult life we do just the same although we do it silently inside of our own heads. What’s happening when somebody is hearing voices is that same inner dialogue is taking place but unfortunately the person who hears hears voices is misattributing that dialogue to an external source. In other words, they don’t realise that they are talking to themselves, they believe its coming from somewhere else. One of the things we noticed was that many er people who hear voices are advised by traditional psychiatrists that they should ignore those experiences, that those experiences are meaningless and this seems to increase people’s anxiety about the voices.

Dr Adrianne Reveley: I think that its very important erm when you’re concerned with helping somebody who is hearing voices to try and reassure them and support them and to tell them at every step of the way that they have got an illness erm, that we are doing our very best to help it and that we will be trying to stop these voices. I’m also very clear that the first line of treatment when somebody is psychotic, has lost contact with reality, is hearing voices is to offer them drug treatment, medication. The aim of the medication is to make the voices fade away and very often somebody who is experiencing them and whose talking to you about them will tell you that exactly this is happening. Sometimes the voices just become softer and softer and softer and then a whisper and then a murmur and then they’re gone. Sometimes they just go. Sometimes they’re absent for longer and longer periods and and then they gradually just fade away.

Alan Leader: None of the none of the medi medication I’ve ever received has ever affected the voices and I’ve told em that and they said well give it time. Well how long how long do you give it? Twenty years? You know time is (laughs) no its never, it has never ever affected the voices and I’ve told em that. It made me ill er the medication actually made me physically ill.

Ron Coleman: I woke up one morning and I I thought clearly to myself that’s it, I’ve had enough. The voices are still there whether I take the medication or not. I’m gonna stop pitying myself, being a victim if you like, and start doing something about it and I think that’s when I
changed and that was the day I stopped taking the medication. I just said no more and I haven't taken any since then, and that's well over a year now I would think, about eighteen months, yer sixteen months.

Dr. Phil Thomas (identified by caption as a Consultant psychiatrist and Senior Lecturer, University of Wales): One often needs medication in order that the individual's anxiety is reduced to such a point that they can usefully focus on really what are very difficult and in themselves distressing issues to have to deal with. So I think medication has a very important role to have play in this process but it has to be seen in its context, it has to be seen that it is not the only thing that the patient is offered.

Outline of Sequence Structure and Organisation:

1. Narrator's first commentary; sequence of shots of people in a scientific laboratory connected to technical equipment; shots of white-coated scientists operating computer equipment. Image track cuts to 2.

2. Dr. McGuire's testimony; close up shot of hands holding a model of a human brain; camera pans backwards to reveal McGuire speaking in a laboratory setting. Image track cuts to 3.

3. Narrator's second commentary; panoramic shot of (presumably) Liverpool University and surrounding streets; opening sentence of Bentall’s testimony. Image track cuts to 4.

4. Professor Bentall's commentary; close up shot of Bentall in (presumably) his University office; image track cuts to medium shot of Bentall at the point at which he begins the sentence: 'One of the things we've noticed is that...'. Image track cuts to 5.
5. Dr. Reveley’s testimony; medium shot of Reveley speaking in an office; image track cuts to 6 at the moment when Reveley comments on the aim of the medication.

6. Remainder of Reveley’s testimony; footage of Reveley and male colleague walking through a hospital corridor and entering a patient’s room; camera holds the shot while the door slowly and firmly closes behind them; sound of door closing is emphasised against shot of empty corridor. Image track cuts to 7.

7. Alan leader’s testimony; medium shot of Leader speaking. Image track cuts to 8.


9. Dr. Thomas’s testimony; medium shot of Thomas speaking in a domestic context.

In this sequence any difference between brain and mind is erased. Scientific knowledge of the brain is seen as an access route to understanding the psychology of the human mind (here computerised images of the brain play a key part in convincing the viewer that brain and mind are synonymous). In the process, the psychology of voice hearing becomes secondary to scientific knowledge of the brain’s neuro-physiological structure. However, this is perhaps not surprising given Horizon’s status as a science-led documentary series. Indeed, the sequence’s visual support for the brain research at Hammersmith Hospital (shots of specialised technical equipment, people attached to monitors, white-coated scientists), coupled with the precedence given to Dr. McGuire’s testimony, provides the psychological interpretation of voice hearing with the stamp of ‘scientific’ validity. Moreover, Dr. McGuire’s claim that psychologists have only been able to ‘hypothesise’ about voice hearing suggests that
the latter are still in need of objective evidence to vindicate their claims. Significantly, ‘Hearing Voices’ fails to challenge Dr. McGuire’s authority on this point ignoring a growing body of empirical studies on the psychology of voice hearing (see Bentall in Romme and Escher, 1994), thus elevating neuroscience to the forefront of knowledge and understanding about voice hearing.

Positioning Dr. McGuire’s scientific discourse as the opening testimony is vital to the programme’s ability to convince viewers that it has accurately (i.e. scientifically) answered the narrator’s opening question concerning the usefulness of brain research. The suggested answer for viewers is “yes”, scientific research into the brain can and does help us understand what is happening in the mind. There is, however, an irony here. It will be recalled that ‘Hearing Voices’ raison d’être is to provide a psychological interpretation of voice hearing that rejects the ‘medical model’. But by collapsing any distinction between brain and mind, the programme is able to produce “signs” of abnormalities in the brain/mind which viewers can see for themselves (and which Dr. McGuire duly points to). These physical “signs” of brain/mind dysfunction are what is measured by Dr. McGuire’s laboratory procedures and communicated by voice hearers as an ordered set of complaints (i.e. their ‘voices’). The primary task of Dr. McGuire is thus presented as diagnosis - that is, the interpretation of symptoms by relating them to functional and structural abnormalities in the brain. Consequently, a distinctive medical hermeneutic presides over the interpretation of ‘voices’ which legitimises the programmes’ later concern with identifying the best mode of treatment for coping with them.

In contrast, Professor Bentall’s testimony hints at the ordinariness of voice hearing; something that occurs to people simply because they use language and engage in inner
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speech. However, Bentall's testimony has little opportunity to develop this perspective before his testimony is put to a different purpose. Midway through his testimony (at the point at which he says: 'one of the things we noticed...') there is an editorial cut. At this point his testimony changes focus and becomes an observation about the traditional medical response to voice hearing (that voice hearers should ignore their voices) and the anxiety this apparently produces. There is thus an evident lack of 'fit' between the two components of Bentall's testimony. At this point in the sequence the psychological approach to voice hearing is rendered secondary to an assault upon the traditional psychiatric practice of giving voice hearers drugs. Once again Dr. Adrianne Reveley is the target of 'Hearing Voices' attack upon the orthodox medical approach to voice hearing. The attack occurs both visually (in the particular manner with which her testimony is imaged) and in relation to the organisation of voices surrounding her testimony.

Dr. Reveley's testimony is mobilised in response (though not as a counter-argument) to Bentall's claim that voice hearers are advised by traditional psychiatrists to ignore their voices. Bentall's claim invites explanation from a 'traditional' psychiatrist as to why this practice happens. It is at this point that we hear Dr. Reveley's testimony. The first part of her testimony (see point 5 above) is at one level a straightforward account of her role as a helpful and supportive psychiatrist. However, in the context of Bentall's criticism of 'traditional' psychiatrists her testimony is used solely to redeem the validity of his claim that traditional psychiatrists are harming voice hearers (by increasing their anxiety about hearing voices) whilst under the illusion that they are helping them. 'Hearing Voices' signals contempt for Reveley's treatment of voice hearing by the manner in which the second part of her testimony is imaged (see point 6 above). Thus at the point Reveley begins to talk about the aim of medication the
image track cuts to a shot of her and a male colleague walking through a hospital corridor (see fig. 5.3) and then entering a room situated immediately off the corridor (see fig. 5.4). The symbolism of the corridor scene is particularly significant and as we shall see is used to undermine Reveley’s ‘traditional’ approach to voice hearing with devastating effect.

Corridors are (literally) marginal spaces and Dr. Reveley’s testimony concerning the use of medication occupies its own marginal space - both visually and within the wider thematic development of the programme. At the precise moment Reveley is shown opening the door and entering the room her testimony culminates in an elaborate description of the voices fading away. As she disappears from view the camera remains focused on the slowly closing door until it shuts firmly and loudly leaving the corridor empty and quiet (The whole scene is reminiscent of popular images of inmates being escorted to their cells). Her disappearance into the room amplifies the viewer’s sense that her approach to drug treatment is not just ‘traditional’ but irrational (perhaps even a little mad?). Indeed, the footage of Dr. Reveley walking through the corridor and entering a patient’s room trades on the popular genre of psychiatrist jokes in which the psychiatrist is made to seem madder than the mad. In the joke the psychiatrist ends up confined as an inmate in their own asylum. In the scene under discussion Reveley ends up inside one of her own in-patient rooms. She is thus (visually) “put away”, out of sight and out of [the viewer’s] mind.

The final attack on Dr. Reveley begins immediately after she has finished speaking. Alan Leader’s testimony is mobilised as a direct counter both to her claim that medication makes voices ‘go away’ and her assuredness that ‘someone who is
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Hearing Voices fig. 5.3

Hearing Voices fig 5.4
experiencing them and is talking to you about them will tell you that exactly this is happening'. It is here that the double meaning in the programme’s title is most apparent. ‘Hearing Voices’ communicative design does involve listening to those who hear voices and by doing so reveals a radically different view of the value of psychiatric medication. Taken together, Alan Leader’s and Ron Coleman’s testimony undermine Reveley’s truth claims by asserting that the exact opposite of what she says about the value of medication is true. In particular, Leader’s opening comment that ‘None of the... medication I’ve ever received has ever affected the voices...’ reinforces Reveley’s representative status as a ‘traditional’ psychiatrist who does not listen to voice hearers’ experiences. At this juncture the programme’s sub-text is abundantly clear - psychiatric medication is not very fruitful in helping patients deal with their voice hearing experiences.

However, despite ‘Hearing Voices’ powerful and uncompromising demolition of Dr. Reveley the programme does offer a concession on the use of medication. It surrounds Dr. Thomas’ claim concerning the ‘very important role’ that medication can play in controlling the anxiety that voice hearers experience. The programme’s sympathetic treatment of Dr. Thomas’ views on medication stands in stark contrast to its harsh treatment of Dr. Reveley. This begs the question as to why Dr. Thomas’ testimony is accepted given the degree of correspondence between his views and those of Reveley. A clue lies in the different emphasis that Dr. Thomas places on the role of medication. In contrast to Dr. Reveley’s aim of using medication to make voices ‘fade away’, Dr. Thomas claims that medication allows voice hearers to ‘focus’ on their voices and the ‘distressing issues’ that these give rise to. Thus the purpose of medication according to Dr. Thomas is as a first step towards helping people explore their voices by directly engaging with them rather than silencing them. In Dr. Thomas’s words, ‘it
[medication] has to be seen that it is not the only thing that the patient is offered'. This provides the cue for a presentation of Dr. Thomas’ approach to helping voice hearers; an approach which combines both medical and psychological elements in order to help people understand and cope with their voices.

However, in order to illustrate Dr. Thomas’ approach to voice hearing the programme first establishes the importance of talking to voice hearers about all aspects of their voices including how to communicate with them (an approach which viewers are told has been developed by Richard Bentall and is called ‘focusing’). Following a case-study in which a voice hearer describes how she attacked her neighbour with a knife the programme emphasises the dangers of not listening to the voices of the mad. Following the case study both the medical and psychological models are presented (though the psychological approach is given greater precedence). ‘Hearing Voices’ then focuses on Dr. Thomas’ approach to voice hearing. The pivotal sequence begins with an introduction by the narrator against which we see footage of Dr. Thomas driving an open topped car at obvious speed:

Narrator: If the debate about voice hearing seems polarised between those who favour talking and those who favour medication in practice there are psychiatrists like Phil Thomas who are trying to reconcile the two approaches. (long pause) Phil Thomas has been putting into practice some of Richard Bentall’s ideas about ‘focusing’ through therapy sessions with a patient called Peg. Peg’s problems appeared to stem from how she felt about looking after her elderly parents.

At this point the image track cuts to a shot of Dr. Thomas in therapy with Peg. Extracts from the therapy session last for approximately two and a half minutes and touch on a range of issues related to the form, content and meaning of Peg’s voices.
We then cut to an interview with Dr. Thomas in which he discusses his approach to Peg's voices:

Dr. Thomas: It was enormously difficult for Peg to start on this process. She had been very comfortably adjusted to the whole idea that she was a schizophrenic, that she would need medication for the rest of her life. That has to be respected. It's not my place to go changing that willy-nilly. On the other hand it's clear that she wanted to understand more about the voices and what the voices meant to her. So really what we're having to do is to try and run two models simultaneously. Keep medication going, she gets a lot of benefit from medication, she feels more confident taking medication she and that is important because its possible for her then to start exploring the emotional and psychological significance of the voices which is what we're doing. So we're really trying to run two models simultaneously but I think over a period of time hopefully one model - the psychological model - will supplant the medical model.

At this point in the programme Dr. Thomas emerges in the role of psychiatrist-as-hero. The narrator's introduction signals him as someone who rises above the professional and conceptual differences separating 'those who favour talking and those who favour medication'. His apparent attempt to 'reconcile' both medical and psychological approaches to voice hearing make him a pragmatically - rather than ideologically - driven psychiatrist (thus enabling him to offer Peg a unique form of therapy in which he extracts the best from both traditional psychiatry and contemporary psychology). Moreover, the narrator's use of the term 'reconcile' in this context implies that reconciliation between psychiatry and psychology is not only possible but desirable (perhaps even long overdue) and that patients will inevitably benefit. Underpinning Dr. Thomas' hero-like status is footage of him driving an open-top sports car (see fig. 5.5). The camera is positioned on the back seat and the impression is that Dr. Thomas is speeding towards his therapy session with Peg. The
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Hearing Voices fig. 5.5
car scene undoubtedly advances his construction as a man of 'action' rather than 'debate' and (by implication) inaction. Dr. Thomas' difference from Dr. Reveley could not be more explicit either professionally or personally.

'Hearing Voices' heroic construction of Dr. Thomas is somewhat surprising in a programme avowedly committed to an 'alternative' (psychological) interpretation of voice hearing. The choice of Professor Bentall as a candidate for this sort of heroic elevation might be thought of as more appropriate (indeed, Bentall is identified as the principal architect of Thomas' 'focusing' therapy). What underpins Dr. Thomas' advantage, in terms of the programme's argumentative structure, is his ability to 'run two models simultaneously'. Psychiatry is thus no longer bound to traditional orthodoxy's based on an outdated medical model but instead can develop as an eclectic discipline suggesting a promising future. Indeed, as Dr. Thomas finishes speaking the image track cuts to a shot of waves rolling onto a beach. The symbolism of the waves bolsters Dr. Thomas' hope that the 'psychological model will eventually supplant the medical model' by evoking a tide of change, a cleansing of the traditional psychiatric approach to voice hearing in which the experiences of voice hearers are ignored. His desire to engage with as well as to respect Peg's own interpretations of her voices signals him as a listening psychiatrist, able to work in partnership with voice hearers and explore the meaning of voices on their own terms. However, the fact that Dr. Thomas gets the last word on the issue of voice hearing ensures that psychiatry retains its centrality both within the voice hearers' world and the programme's understanding of that world.
Conclusion

Throughout this chapter the voices of psychiatric 'experts' have occupied centre stage. What emerges are plural interpretations of contemporary psychiatry, community care and schizophrenia. The appearance of voices not usually heard in public discussions of mental health might be taken to indicate that the television system is reflecting an emergent post-modern discursive order in which more voices mean more argumentative possibilities. Perhaps. But it is important not to be swept along by simple delight in such heteroglossic possibilities. The question of the regulating impact of different programme formats on public discourse remains largely unexamined in most commentary. With this in mind this chapter has shown how shifting notions of 'psychiatric expertise' impact on what 'expert' participants are allowed to talk about within and across a range of current affairs programmes. In approaching the mediating role of programme forms and formats we have paid particular attention to their degree of discursive 'openness' and explored the way relations between competing discourses are organised in order to understand how particular programmes orchestrate credibility and precedence. As we have hopefully shown, 'expert's' participation in a television programme does not automatically result in their claims being treated with sympathy and understanding. However, as we shall see in the following chapter, if claims to legitimacy is an issue for psychiatric experts, it is all the more so for those speaking about mental health issues from the vantage point of direct experience.
Chapter 6

Experiencing Madness
Introduction: Relocating Schizophrenia

For most of this century schizophrenia has been viewed as a hopeless, degenerative condition fit only for long-term confinement within the walled and locked asylum in which the 'natural' course of the condition could be allowed free rein. However, de-institutionalization policies have brought this regime to an end and transferred mentally ill people from hospital settings to the community. As a consequence, the notion that the mentally ill embark on 'careers' as institutionalized mental patients (see Goffman, 1961) might, like the asylum system itself, become a thing of the past. The rationale for this optimistic view is that since the hospital teaches patients their role as patients, with their closure the role of 'mental patient' will become extinct. This begs the question, though, of how those with a mental illness diagnosis perceive their new situation after being defined as a career mental patient. If we are to take the inclusion of people with mental illness in social life seriously this is a crucial issue.

The question of how schizophrenics renegotiate their re-entry into the everyday world has barely been answered (There is little research on what Community Care means to ex-mental patients). Anyone who is now admitted to a psychiatric hospital, whether as a new patient or a former long-stay patient, seldom stays for longer than a few weeks. Many return to their homes, where they can put an enormous burden of care on the family and other agencies. Many others go into group homes or hostels, or into bedsitters or boarding houses, which are often cramped or sordid. Thousands of ex-long-stay hospital patients are now homeless and sleeping rough on embankments, in shop doorways, or in reception centres. Many of these people have completely lost touch with psychiatric services while others finish up in prison because of petty offences. Despite this depressing situation, the desire to restore mental patients to
mainstream society, to remodel them as 'ordinary people', is generally perceived to be a laudable one. However, as Barham (1984: 178) cautions, 'we err if we suppose that administrative changes in the form of the transfer of those people from one category of sites to another necessarily indicate a deeper social change in the terms on which such people are to be regarded and permitted to participate in social life'.

_Schizophrenia and the Problem of the Person_

Barham's caution derives from a concern that the blunt reality of Community Care falls some way short of the rhetorical promises. Those with a mental illness diagnosis continue to be identified as 'mental patients' as though this was a permanently active status. This predicament is particularly (though not exclusively) evident in the case of those with a schizophrenic diagnosis. A return to ordinary-agent status is not guaranteed by a simple re-entry into social life. Although a schizophrenic illness does not necessarily mean that a sufferer is constantly plagued by symptomatology, for many the closure of asylums represents a failure by the authorities (including Government) to care for people in the midst of illness. The mounting public pressure to return the seriously mentally ill to secure accommodation is testament to the pull of this “get back to your wards and take your drugs” attitude. As we noted in Chapter Three, schizophrenia has long been perceived as an incurable and hopeless disorder. Even if we do not subscribe to this doctrine in its strongest form, our most basic cultural reflexes towards people with schizophrenia remain tainted by it. As Barham and Hayward (1991: 2) put it: 'Bluntly stated, we are not at all clear who has emerged from the asylum'.
The suspicion that ex-mental patients are ‘not one of us’ is glaringly present in the popular lexicon of mental illness: “mad”, “lunatics”, “crazy”, “nutters”, “barmy”, “crackers” “batty”, “psychos”, “basket cases”, “dotty”, “demented”. This vocabulary of difference easily outweighs any attribution of social membership that we care to employ. Such terminology marks out the space between ‘us’ and ‘them’. It drives home the strangeness, the remoteness, and above all the inaccessibility of mental disorder. The official aim of giving ex-mental patients “a normal life in the community” therefore has to contend with deeply embedded notions that these people are not normal, that they are different. Many ex-patients are themselves all too aware of their apparent difference. Some have had to take anti-psychotic medication for many years in order to reduce and mask the symptoms of their disorder. But drugs do not work for everyone. Many dislike taking (indeed, refuse to take) them both because of adverse effects (e.g. stooped posture, trembling limbs, facial grimacing) and because such effects publicly mark them out as different. But refusal to take medication presents its own difficulties. In some traditions of psychiatry the individual who refuses medication is announcing that they are ill (or are becoming ill) since only those whose minds are disordered would refuse ‘help’. Consequently, refusal is often interpreted as all the more reason why they should be forced to take their medication.

At the present time, then, it is clear that ex-mental patients in the community are not easily able to shrug off the label ‘mental patient’. A common assumption is that many have been forcibly injected back into society despite being ill. Even where former patients might be said to have “got better” their recovery is easily put into question (if they stop taking their medication, for example). In this respect, the person labelled ‘schizophrenic’ has a double affliction. They are designated ‘ill’ in the sense of
having a biological disease of the brain/mind\(^1\), but they are also identified as having a *social illness*. 'Participation in the social system', Talcott Parsons writes, 'is always relevant to the state of illness, to its etiology (sic) and to the condition of successful therapy' (Quoted in Doubt, 1996: x). "Being sick" thus constitutes a social role and as such is inextricably bound up with beliefs, values and judgements.

The behaviour that is called schizophrenic is, according to this perspective, an all-encompassing expression of 'mental patienthood' in which the characteristics of the disease are of less importance in producing the schizophrenic than social responses to them. Thus, the typical course of the condition is inextricably linked with the social consequences of *being* schizophrenic. As a consequence, their foothold in ordinary life is precarious and their personhood constantly on probation. This means that ex-mental patients are second-class citizens, devalued and defined by their illness (or propensity to become ill). Despite their formal inclusion in society they have not achieved social integration. This leaves us in the alarming position that

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mental patients may be more of a mystery today, living among us, than they were when

hidden away in the asylum. We do not know them, because they are neither outside society in the world of exclusion, nor are they full citizens - individuals who are like the rest of us. Being

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\(^1\) The issue of whether a 'mind' can meaningfully be 'ill' is of course the crux of the mental illness problem. Psychiatrists argue that a schizophrenic mind is the product of a biological disorder of the brain. The brain is part of the natural world and thus subject to the laws of nature. Biological disordering is something that may affect the brain and which manifests in illness-type behaviour. Critics counter by arguing that the mind-brain relation is not amenable to a scientific explanation. A 'science of mental life' is always booby-trapped since we meet not brains, but *people*. We can therefore never arrive at a 'purely' scientific understanding of mental illness because damaged minds (unlike, say, damaged arms) are impenetrable to human understanding (For a discussion of the 'mind-brain problem' in the context of the 'mental illness problem' see Healey, 1990: pp. 1-38).
neither other or self, they are a new kind of social construction (Lewis et al, quoted in Barham and Hayward, 1991: 143).

But if they are neither other nor self then who (or what) are they?

Lost People, Lost Voices

Formally, the person with a history of mental illness is a citizen alongside others. However, they often carry with them an ambiguous and sometimes conflictual relationship with the meanings that have traditionally attached to the category ‘mental patient’. For those with a diagnosis of schizophrenia, misconceptions about the condition (that it means a ‘split personality’, that they are dangerous and criminal, that they are evil or unpredictable, and so on) invokes a double burden. One aspect concerns ‘their incorporation within the role of mental patient, within a service dominated frame of existence in which there are only limited opportunities to practice as an ordinary social agent. The other is incorporation within a set of images and assumptions about schizophrenia and the mentally ill that put the person ‘off the map’, outside the community of ordinary human beings’ (Barham and Hayward, 1991: pp. 74-5). These dual aspects of ‘incorporation’ mesh with the structural problems and isolation often experienced by schizophrenics following discharge from hospital (in such spheres as housing, employment, and social relations). If the realisation of personhood means receiving equality of regard and entitlement, and a feeling that one exists as a person of value, the schizophrenic has a long road still to travel to achieve this.

The tendency to identify severe mental illness in terms of a vocabulary of difference underscores the difficulties that many ex-patients experience in coming to terms with
life after mental hospitalization. Barham and Hayward (1990: 137) confirm this in a series of interviews with former mental patients. As one interviewee, Henry, commented, ‘with schizophrenia you’re not living, you’re just existing... I think that schizophrenia will always make me a second-class citizen’. His assertion is based on his experience of boredom and demoralisation following discharge from hospital. His situation is such that he feels devalued as a human being and because of his diagnosis, relegated to the margins of social life. These experiences are common amongst people with a schizophrenic illness. Equally common is the feeling that they are defined by their illness rather than as persons struggling to be taken seriously as agents in their own right (see Barham and Hayward, 1991). This confirms our earlier point that the person with a history of schizophrenic illness is perceived to be lost to the disorder. On this reading it is not surprising that efforts to attend to the voice of the (ex-) mental patient have been limited. This is borne out by the fact that public talk about schizophrenia is still to a considerable extent shrouded in a professional discourse concerned mainly with post-asylum mental health issues (e.g. lobbying for better services or more resources). We have little or no idea of what the experience of being schizophrenic is actually like for those ex-patients now receiving care in the community.

One reason for this state of affairs is that psychiatry has historically done the talking on behalf of mental patients. This, Roy Porter (1987) observes, has been due primarily to the systems and structures erected for dealing with madness. Not far below the surface, however, has been an attitude that the mad have had very little of sense to say. For reasons outlined earlier, this assumption applies particularly to schizophrenics. They are often thought of as inherently incapable of giving either genuine informed consent or valid insights into aspects of their lives as (ex-) mental
patients. Psychiatric textbooks abound with representations of the schizophrenic as a reluctant, incapacitated and largely inarticulate actor who can only achieve anything through the patient ministrations of professional carers. This negative identification of schizophrenia results in their failure to be taken seriously as agents who holds legitimate views about the nature of their condition and treatment, and about their experiences of living with a schizophrenic diagnosis. This is not to deny that people with schizophrenia not infrequently put the frames of everyday life under severe strain: "Thus they may show scant regard for conventions of behaviour, exhibit peculiarities in conversational style, and demonstrate serious difficulties both in managing work routines and in forming and sustaining social relationships" (Barham, 1984: 185). But this does not mean that we should automatically capitulate to the language of 'patienthood' (albeit dressed up in a discourse of 'caring') in order to make sense of their experience of being schizophrenic.

Schizophrenia and Cultural Citizenship

Nominally, the thrust of current mental health policy is to overturn the legacy of social exclusion and devaluation and confer upon ex-patients rights and recognitions accorded ordinary people. From this perspective ‘mental illness’ need no longer be a barrier to ordinary human recognition and the entitlements of citizenship. Conceptions of citizenship are varied but Murdock (1994: 158) offers a useful general definition: ‘the right to participate fully in existing patterns of social life and to help shape the forms they may take in the future’. Murdock’s broad insistence on a right to social membership and action includes not only familiar civil, political and social/economic rights but also cultural rights. ‘Cultural rights are comprised of entitlements in four main areas: information; knowledge; representation; and communication’ (Murdock,
ibid). For our purposes the second and third of these - rights of representation and communication - provide a valuable acknowledgement of the relationship between media systems and effective citizenship. Cultural rights are not just for the few. They extend even to those with a diagnosis of schizophrenia. Indeed, given the degree of stigma, prejudice and stereotype attached to the label 'schizophrenic' one might argue that rights of representation and communication are a vital component in any serious attempt at revaluing schizophrenic lives and helping them to forge empathetic relations with non-mentally ill others. Which brings us to the relationship between schizophrenia and television.

In Britain, public service broadcasting has been based (amongst other things) on the principles of universality and equality of access. However, as we have shown earlier, rights of access to a public voice have persistently come up against professional notions of how best to organise public discourse. The result has been a continuing struggle over who has the right to speak about other people's lives, who participates in public discourse and who is excluded. In practice, the conditions of access to a public voice have fallen some way short of public broadcasting's idealised claims to provide a shared discursive space. 'Minority views' and 'alternative perspectives' have generally been confined to the outer edges of the schedule or excluded in favour of more 'reasonable' voices (often speaking on behalf of those excluded). This does not auger well for those disadvantaged groups whose social status or position in the society is less than assured, including ex-mental patients whose forcible return from social exile in asylums forms part of the contemporary experience of a diverse citizenry. Theoretically, providing communicative entitlements for this vulnerable group of people forms part of an ethical commitment to an open and accessible broadcasting system. However, having acknowledged that those with a history of
mental illness are entitled to a public voice, we are immediately confronted with the problem of whose voice should be heard. Answering this question is particularly problematic in the case of schizophrenics.

The terms on which schizophrenics should be given a public voice raises awkward issues. With the advent of community care, there is no longer a clear-cut distinction between patients who are ‘ill’, and in hospital, or ‘well’ and out of hospital. Many discharged schizophrenics receive care as day patients or out-patients. Some are long-term recipients of home-based nursing care and have only intermittent contact with hospital-based psychiatrists. Others, those who are homeless or socially isolated for example, may not be subject to any formal psychiatric intervention. Consequently, a history of schizophrenic illness (and for some, a continuing vulnerability to further periods of illness) means that many ex-patients’ entitlement to talk about their experiences is uncertain or contestable. The blurred distinction between the hospitalized schizophrenic and the ‘recovered’ ex-patient also creates difficulties for the criteria we might adopt in selecting which schizophrenic voice is worth listening to. As a result it is all too tempting to see those with a history of schizophrenia as speaking with an ‘inauthentic voice’, because whatever views or opinions they may have, there is always a lurking doubt that what is being expressed is not their ‘true’ selves, but their illness. Their right to speak about, say, previous psychotic experiences can therefore easily be countered with the claim that what they are saying is evidence they are ‘not well’. This reproduction of a medicalised way of seeing and understanding schizophrenic people under a new set of conditions may well turn out to be psychiatry’s most potent legacy.
Television Current Affairs and Schizophrenic Voices

The changing context of psychiatry has altered the discursive field around mental health in important ways. At the present time the significant debate is no longer between those who recognize the reality of mental illness and those who dispute it. Rather it is between those who are prepared to challenge the legacy of mental patienthood and those who settle for a more reductive view (Barham, 1992). Many former patients are involved in this debate and in areas such as ‘hearing voices’, taking medication, and living in ‘the community’ their points of view and concerns may well be different from those who have traditionally cared for them. The erosion of the paternalistic structures of institutional psychiatry has been accompanied by mounting criticism from ex-patients and their advocates that their views have not so far been taken seriously. In a media-based culture televised argumentation and debate is of crucial importance and in a still largely centralised television system the onus is on professional programme makers to provide the conditions of access that allow former mental patients to have a public voice.

For TV programme makers interested in schizophrenic voices Community Care presents a range of opportunities but also challenges. As the length of stay in hospital shortens, and patterns of community care diversify, access to schizophrenics becomes easier than it was in the days of the asylum. They can be talked to and talk for themselves in a variety of settings. At the same time however, the conundrum to which we alluded earlier - that is in the case of schizophrenic’s, their claims to speak authoritatively about their experiences are undermined by the dominant public perception of them as ‘unreliable’ witnesses - makes them vulnerable to the charge that they are incoherent, unintelligible and unable to advance a coherent argument.
The analysis presented here looks in detail at the ways in which a range of contemporary TV current affairs programmes access schizophrenic voices. It seeks to address two key questions. Firstly, in what formats are schizophrenic people given space to articulate their experiences? and secondly, in what formats are they allowed to offer their own interpretations of these experiences. These questions produce a matrix made up of two cross-cutting dimensions - the amount of access given to schizophrenics and the control over that access exercised by the programme makers.

Panorama: ‘Whose Mind Is It Anyway?’

By way of illustration consider the following extract from the Panorama programme, ‘Whose Mind Is It Anyway?’ This focuses on the issue of Community Supervision Orders (henceforth, CSOs), which would compel mentally ill people in the community to take medication. According to the presenter, Margaret Gilmore, ‘particularly affected [by CSOs] would be severe schizophrenic’s who often don’t realise when they are ill’. Immediately after this statement we move to a question-and-answer sequence with a patient, Gordon Harding:

Gilmore: Do you hear voices?

Gordon: I’ve only heard one it called me a creep a big one like Mo- bigger than the one on the ten commandments. I’m still trying to find out who it was. My psychiatrist said it was my monad my higher self as in cringe as in doctor Monty Python but from the highest level.

Gilmore: Are they always different voices?

Gordon: No it’s the only one I’ve ever heard never heard another one since that. I just tell it to watch out.
Gilmore: Do you feel that you need care? Does anyone supervise you at all? Do you see a doctor?

Gordon: Oh yes I go to case management that's the new psychiatric thing. Kitchen meetings are very popular these days with politicians' acts so they introduce us all to kitchen parties and meetings in the afternoon which is very interesting and fulfilling and keeping up. You see the idea is the to let the undamaged parts of the brain come out and let them enjoy themselves like any normal person but the only damaged parts are the mental mental mentals and once the fingers are gone, we're alive again.

This extract illustrates how evaluative judgements are used to undermine the credibility of schizophrenics as people worthy of being listened to and taken seriously. Gilmore's claim is that 'severe schizophrenics' are 'prime candidates' for CSOs because they hear voices and do not realise this is an illness (In other words, the fact that schizophrenics' hear voices is seen in itself as sufficient to render them incapable of recognising that they are ill). Gilmore's comments also throw into relief how the experience of hearing voices is mobilised as evidence of mental incompetence. In this case, to contribute meaningfully to the debate over whether or not schizophrenics in the community should be compelled to take their medication against their wishes. By situating Gordon's affirmative response to the question 'do you hear voices' immediately after the statement that some 'severe schizophrenic's don't realise when they are ill, he is not only identified as a 'severe schizophrenic', his admission to hearing voices is mobilised as prima facie evidence that he lacks "insight" into the severity of his condition. This initial representation of Gordon as incompetent negates any further contribution he makes before his voice is even heard. Instead of being presented as someone whose opinions need (indeed, deserve) to be heard on the issue of CSOs, Gordon's participation in the programme is deployed to confirm his
(presumed) inability to contribute anything meaningful. His license to speak is therefore conditional upon him articulating the sound/content of 'severe' schizophrenia and nothing else. Thus, despite his more or less 'appropriate' response to Gilmore's second question, Gordon's testimony is not used to advance the discussion over CSOs from a 'schizophrenic perspective'. On the contrary, the fact that he hears voices (and is willing to admit it) is used to justify his non-participation in the programme's more substantive discussion of the political, legal and ethical issues surrounding CSOs. This is the preserve of more 'credible', non-schizophrenic, participants. (The sequence quoted above is in fact Gordon's only contribution to the programme-as-broadcast.)

Gordon's exclusion from the CSO debate is even more explicit in the case of Mark Pearson, another schizophrenic participant in the same programme. In the following sequence Mark and his mother, Cindy Dowling, are juxtaposed talking about the impact of Mark's 'voices' on his behaviour. The sequence begins with footage of Mark walking on a beach.

Gilmore (speaking in voice-over): Mark Pearson, a schizophrenic, is a classic candidate for Community Supervision Orders. He's what's known as a revolving door patient whose been in and out of hospital and has a tendency not to take his drugs. Three times he's been sectioned onto psychiatric wards, deemed to be a danger to himself and his family.

Mark (speaking in voice-over): I had so much paranoia I couldn't sleep. There was lots of noise around me. And it was coming up to Christmas and er I gave the devil power over sound so he was controlling the world. He overtook my body.

At this point the visual track cuts to an interview with Mark.
Gilmore: so what did you do? can you show me?

Mark: yes it’s there. (points to a scar on his neck)

Gilmore: what did you do.

Mark: erm I got a half-pint glass and I smashed it and I was just kept ripping at my throat.

At this point the visual track cuts to testimony from his mother.

Cindy: He was still hearing the voices. All the voices were telling him to do this. Then the voices said electrocute yourself so I believe he put his tongue in a socket so far as I can gather what he told me and that threw him across the room and still he was alive. The voices were coming in really strong and powerful and when the voices come he has to go along with the voices.

At this point the visual track cuts back to Mark.

Mark: Basically in the bible it says I am standing for God, God the Father, I am you know. But the way I see the world today it’s very confusing.

Gilmore: Do you think you are God?

Mark: (long pause) I could be (laughter). I could be I might be I don’t know. I have certain I have I’ve had certain things happen to me. I’ve seen the spaceships.

As this extract shows, Mark’s participation in the programme is dependent upon the programme maker’s classification of him as a ‘classic candidate’ for CSOs. This status is confirmed by references to him as ‘a schizophrenic’ who has been ‘sectioned three times’ and has a ‘tendency not to take his drugs’ and further reinforced by his own descriptions of himself such as ‘I had so much paranoia...’. As a consequence, his
appearance is restricted to a brief supporting description of his ‘paranoia’ and a graphic account of a suicide attempt with broken glass. Along with his mother’s explanation that ‘voices’ caused this and another suicide attempt involving electricity, Mark’s description of paranoia and self-harm is mobilised as evidence of the danger presented by a schizophrenic who stops taking drugs. The juxtaposition of Mark and his mother’s testimony creates a harrowing tale of schizophrenia and its impact on their lives. But by focusing upon the severe impact of Mark’s failure to take his drugs, as evidenced by two suicide attempts, it leaves viewers in little doubt about the danger that Mark and his family are presently exposed to.

The final phase of the sequence is given over to establishing the extent of Mark’s ‘confused’ mental state. It concludes with what is in itself a bizarre question: ‘Do you think you are God?’. But it plays an important role in the programme’s argumentative structure. Although the programme employs a ‘problem-solution structure’ the question and Mark’s response contribute solely to the ‘problem’ element (the difficulties and dangers that schizophrenics present when they refuse to take their medication) not to the ‘solution’ (whether CSOs would break the cycle of mental health deterioration and relapse). Mark is in fact erected as a straw man. His response is included simply in order for it to be undermined. This is most apparent in the cut immediately after he says that he has seen ‘spaceships’ (indicating the ‘need we say more’ attitude by the programme makers). The visual track cuts from Mark to a shot of Cindy’s home and precedes a discussion of family anxiety about Mark’s suicidal behaviour. In other words, neither the question nor the response is given any further consideration. Both speak for themselves, as it were. Thus although Mark, like Gordon, is licensed to speak in the programme it is only to illustrate his incompetence and hence the problem he presents for carers.
The full significance of Mark’s positioning as part of the ‘problem’ becomes clear when the issue of compulsory medication is explored later on, using Mark’s ‘tendency not to take his drugs’ as a case-study of the civil liberties issues raised by CSOs. In the following sequence Mark’s apparent reluctance to take his medication is presented as evidence that his judgement is impaired. The sequence begins with a contribution from his psychiatrist, Dr. Angus McPherson:

Dr. McPherson: I believe that Mark needs and would benefit from a closer degree of supervision to enable a better monitoring and better treatment of his mental state to be carried out. My own view is what we need is some order which will enable us to readmit patients to hospital if they are breaking down, if they’re becoming ill again, in order to reassess and restabilize their condition and to enable us to discharge them again.

At this point the visual track cuts to a shot of carers in Mark’s community home preparing to administer medication.

Gilmore (speaking in voice-over): The [community] home [where he lives] supervises Mark’s drugs. If he refuses them there’s little at present anyone can do unless he becomes dangerous. But he doesn’t like taking them.

At this point the visual track cuts to Mark.

Mark: You go in to see a psychiatrist and erm they say you’ve got to take these pills or sometimes they don’t even say that. They you just wake up in the morning and you’ve got some new pills to take you know. It can be demoralising’

Gilmore: do you mind having treatment forced on you?

Mark: yes I do.
At this point the visual track cuts to Mark’s mother.

Reporter: do you think there should be a law then to force people like Mark to take their medication?

Mark’s mother: definitely definitely should be yes. They’re not capable of making a decision like that themselves really.

In this sequence Mark’s appearance is sandwiched between his psychiatrist and his mother. Accordingly, his testimony is framed by the viewpoints of both. In Dr. McPherson’s contribution Mark is presented as a problem-patient: ‘I believe that Mark needs and would benefit from a closer degree of supervision to enable a better monitoring and better treatment of his mental state to be carried out.’ The means by which he could achieve ‘better monitoring and better treatment’ is an ‘order’ (a Community Supervision Order). Significantly, neither Gilmore nor Mark himself challenges McPherson’s view of what Mark needs. Instead, Mark’s dislike at having medication forced upon him is mobilised as an ‘alternative’ view. However, such indirect opposition to McPherson’s view fails to elaborate on why Mark dislikes taking medication (other than a vague explanation that waking up and finding his medication has been changed is ‘demoralising’). In the context of an agenda set by others Mark is not licensed to speak on this particular issue. This stands in stark contrast to McPherson’s contribution in which he is allowed to express his view on what should happen to patients who are ‘breaking down’ (‘My own view is what we need is...’). In short, McPherson is licensed to contribute to the debate about CSOs whilst Mark is not.
Mark's appearance as a problem-patient hinges on his history of refusal to take medication. This is a crucial issue for (ex-) mental patients and one that goes to the heart of the CSO issue. Control over the type of drug and/or dosage that is administered to them is a major concern for many (see Barham, 1992: pp. 47-49). Under CSO legislation a patient would have no rights to refuse their medication. Bearing in mind the problems associated with taking anti-psychotic medication (in particular, the powerful side-effects) Mark and Gordon clearly have a stake in getting their voices heard on this issue. However, in the programme-as-broadcast neither is given an opportunity to present their point of view on CSOs and it is left to representatives of mental health pressure groups to speak on their behalf. This, as we noted above, is because they have been chosen to perform a quite different discursive function; to illustrate their mental incompetence. The nearest either of them comes to direct involvement in the CSO debate is Mark's confirmation, in response to a direct question from Gilmore, that he does mind having treatment forced upon him. At this point, though, his credibility as a person capable of providing a rational perspective on his situation is already in tatters. We know that he hears voices and thinks he might be God. We are therefore encouraged to assume that it is his incompetent/irrational status - as someone unable to judge what is in his best interests - which denies him the opportunity to expand on his opposition to forced treatment.

If Mark is not capable of recognising what is good for him, others certainly are. Thus, following Dr. McPherson's claim to know what Mark 'needs and would benefit from', his mother is allowed to express a view on whether or not there should be a law to force 'people like Mark' to take medication. However, it is the way in which her response is juxtaposed against Mark's reply to a different question that is perhaps most revealing about his status within the programme. Following immediately after
his confirmation that he does mind having treatment forced upon him, Cindy’s statement has the effect of undermining his response. Although they are responding to quite different questions Mark appears to have given an inappropriate response, which further undermines his claim to be someone whose views we should take seriously. Moreover, by ending the sequence with Cindy’s testimony the programme makers appear to endorse her opinion that people like Mark are ‘incapable’ of making decisions as to whether or not they should take their medication. As a consequence, they do not take his stated dislike of compulsory medication as an issue worth exploring further.

Kilroy

‘Whose Mind Is It Anyway’ is built on strong assumptions about the nature of schizophrenia as a disability in which Gordon and Mark’s disabilities (voice hearing, delusions) are invoked to foreclose any exploration of their ‘schizophrenic’ point of view. In contrast, Kilroy avoids an openly evaluative approach to the experience of being schizophrenic. In the following sequence for example, the host, Robert Kilroy-Silk, is interested in establishing what ‘schizophrenic voices’ actually say to those who hear them:

Kilroy-Silk: Can you describe the voices?

Audience member 1: Yer the voices are like er another person speaking in your head.

Kilroy-Silk: What kind of things are they saying?

Audience member 1: They persecute you. They can do, they can tell you jokes and you laugh. You listen to them. You sit for hours just listening to your own thoughts.
At this point a second unidentified member of the audience interrupts and continues thus:

Audience member 2: I agree with that. Its certainly not a split personality er even most Consultants agree on that er. With me its its the voices are real when its when it happens to you, they're actually real erm they torture you, they torment you er to me they are from hell as the chap over there said. Its in my mind at the time its to do with evil, for instance er alien forces, the devil rising.

Kilroy Silk: What kind of things are they saying to you?

Audience member 2: Er one chap was an old man. I mean I had up to 30 voices, young people, old people.

Kilroy Silk: Were they voices of people you knew or recognised?

Audience member 2: No. Some some of them I recognised as arguing in my favour to keep me alive er they were arguing that I should die of cancer or die of an heart attack er. But on one particular occasion I was coming back from Liverpool with my father to London where I now live and er I knew I was running out of petrol and I wouldn't stop at a motorway service station. I was doing twenty-five miles an hour on the M1 and er it's quite dangerous actually going so slow. I was recognising people who were passing me as people I knew in the other cars er I wouldn't stop at a service station for the simple reason I thought they were alien bases, they were alien people there. Consequently we ran out ran out of petrol er it was winter time my father er thought I'd got out the car to ring the AA. In actual fact I'd got out just to walk round I was going to leave him there. I got back in the car and said they'll be here soon. We waited two hours and my dad said 'when's the AA coming?' I said we're not waiting for the AA, we're waiting for the spaceships to take us home cos I thought we were going back to our original planet where we came back from.

Kilroy-Silk: And what did your dad say?
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Audience member 2: Well my dad phoned the police and the police I smoked tobacco roll ups at the time and the police checked the roll ups (laughs).

In this sequence Kilroy-Silk asks the two schizophrenics to describe their ‘voices’ whilst avoiding the kind of evaluative judgement Panorama attaches to Gordon and Mark. He is able to do this because both speakers are mobilised not as ‘mental patients’ but as persons with a particular experience of hearing voices. This is an important difference. It means that their status as ‘experienced’ people (and experience is the main form of cultural capital supporting entitlements to speak in Kilroy) overrides their identity as ‘voice hearing schizophrenics’ (which might, in other contexts, present a barrier to their being taken seriously as speakers). Thus Kilroy-Silk’s line of questioning actively encourages the second speaker to talk both about his experience of hearing voices (‘What kind of things are they saying to you?’) and later, how he experienced his voices (‘Were they voices of people you knew or recognised?’). The programme is able to mobilise these testimonies (and provide space for them to develop) because its principal aim is to access anecdotal accounts of everyday experience (including, as this example shows, an amusing story about the experience of hearing ‘voices’).

A crucial difference between a ‘classic’ television documentary, such as Panorama, and the discussion format of Kilroy is that the former adopts a problem-solving agenda whilst the latter does not. In the Panorama extracts quoted above, Gordon and Mark’s terms of access undermine their credibility as speakers. However, this does not mean that schizophrenic participants enjoy equitable discursive opportunities in Kilroy. They are mobilised as witnesses to the voice hearing experience but not given an opportunity to speak on any other issue raised in the programme. The significance
of this exclusion becomes apparent when we consider that a full 38 minutes elapses
between the end of audience member 2’s testimony and the next ‘schizophrenic’ voice
heard at the close of the programme. (Here, Kilroy-Silk asks another schizophrenic
accessee to say how he helps himself in the community but then interrupts his
testimony after 10 seconds to close the programme). In the meantime, a range of ‘non-
schizophrenic’ voices has been called on to discuss various problems raised by caring
for schizophrenics in the community. Consequently, across a range of current affairs
formats as disparate as Kilroy or Panorama, schizophrenics are represented primarily
in terms of the problems they pose for mental health policy. In neither programme are
they seen as having a coherent overall view of their situation, nor are they invited to
speak for themselves about the implementation of community care and how they think
current policies should best work for them.

Disguises: ‘A Place of Safety’

In the two part programme ‘A Place of Safety’, broadcast as part of Granada’s series’
Disguises, the restrictions imposed on schizophrenic people speaking for themselves
are built into the expositional structure. The basic idea of the series, it will be recalled,
was to employ hidden cameras as an aid to reporting areas of public controversy, and
to use reportorial disguises as a way of obtaining clandestine footage. This involves
the series reporter, Adam Holloway, acting out different roles, often over a period of
weeks. It is this in-role activity that forms the ‘core’ footage of each programme
which is then made sense of by Holloway’s address to the audience. The footage in ‘A
Place of Safety’ is presented as unmediated evidence that community care is
working/not working, conclusions then confirmed by Holloway’s claims that his ‘on-
the-ground’ experiences guarantee his status as truth-speaker. Thus, while concern
about *Disguises' format has rightly focused on the ethics of using deception to get to 'the truth' (see Dugdale, 1993), an equally problematic element of the series' format is the status of Holloway's 'experiential testimony' generated as it is out of that deception. In the following extract Holloway's taking the role of a schizophrenic is explicitly acknowledged:

Holloway: So still acting the part of a schizophrenic I arrive at the Accident and Emergency department of a main Birmingham hospital. I'm going to pretend that I'm hearing frightening voices - voices that direct me to go to a 'hazard free zone', a place of safety. The act that I'm adopting has been rehearsed with the help of two psychiatrists who believe it's authentic. It's doubtful however as a schizophrenic whether I'd be able voluntarily to submit myself first to a GP then to a hospital. Someone would probably have to help me.

Holloway's performance at the hospital is his first public 'test', both of his acting ability and the structures of community care designed to help homeless schizophrenics. It is therefore essential that his portrayal of schizophrenia is credible in two senses. Firstly, it is obviously vital that Holloway's act is believed in the hospital (and elsewhere). Secondly, it is essential that *viewers* see his act as credible. However, given that Holloway is not a genuine schizophrenic, and that he has to exercise creative license in order to obtain core footage, audience members might be tempted to question the credibility of what they are told is happening. If left unacknowledged these doubts might subvert the veracity of the visual evidence obtained. Thus, Holloway needs to reassure them that there is verisimilitude between his performance and what he claims has happened to him (or others) whilst he was in-role. In the extract quoted above queries about his performance as a schizophrenic are resolved by him telling us that although he is only pretending to hear voices, psychiatrists who can vouch for its authenticity have validated his act. The message is
clear: "because my act has been endorsed by those who know about schizophrenia viewers need have no doubt that what they are about to see happen to me would in reality happen to a genuine schizophrenic".

The 'truthfulness' of Holloway's testimony then, relies on his ability to convince others of the credibility of his performance. Since his act is not discovered to be an act (on camera) one is invited to presume that what he tells us and shows us happened to him would in fact happen to a genuine schizophrenic. In this way, his performance aims to combine an extended view of schizophrenic experience 'from the inside' while retaining the credentials provided by expert analysis and 'objective' commentary. Consider the following extract from part two of 'A Place of Safety'.

Holloway (speaking in voice-over): If Mayfield Court were a registered mental home it would have to provide substantially more medical help. But by calling it a hotel the owner, Andrew Knight, need provide the minimum of care. In return for plugging the gap in Birmingham's care needs he makes a handsome profit from the £120 in weekly state benefits he gets from each resident. There's nothing to do here but vegetate and succumb to one's own delusions. Like this man who endlessly tears paper (see fig. 6.1). Or Archie who stands all day in the same spot with his back to the wall (see fig. 6.2). Or Eric, the schizophrenic who talks to his own voices (see fig. 6.3). [My emphasis]

Holloway's commentary implies that residents at Mayfield Court (a private 'hotel' housing ex-mental patients in which he has been living) are victims of community care policies which allow them to be neglected so that their mental health deteriorates. As the image track progresses, clandestine footage shows various residents sitting slumped in chairs with apparently 'nothing to do'. Visual proof of the claim that the hotel provides only a 'minimum of care' is provided by a close-up shot of an elderly woman sitting in a chair smoking. As the camera approaches the woman it moves
downward onto her bare legs and the frame is momentarily frozen (fig. 6.4). The sequence is accompanied by a musical score of the type associated with horror films and builds to a climax at the exact moment that Holloway says, ‘by calling it a hotel the owner, Andrew Knight, need provide the minimum of care’. We are thus presented with the reality (the horror?) of community care: elderly people left with nothing on their bare feet (while the hotel owner reaps his ‘handsome profit’).

Towards the end of the extract Holloway’s commentary briefly switches from an ‘objective’ to a subjective mode (the italicised part of the extract) which invests his analysis of Mayfield Court with confirmation derived from his own experience of staying there. At the point where he says, ‘There’s nothing to do here but vegetate and succumb to one’s own delusions’ we see a shot of Holloway in-role, slumping into a chair apparently joining his fellow residents (fig. 6.5). By incorporating his own experience of being left to ‘vegetate’, an almost imperceptible blurring of boundaries occurs between his roles as an investigative journalist and as a participant.

Consequently, Disguises’ ‘truthfulness’ can rely either upon Holloway’s integrity as a reporter going to elaborate lengths to uncover ‘the truth’ about community care, or alternatively, it can make its case from subjective testimony grounded in lived experience. Either way, the view given of conditions in Mayfield Court is overwhelmingly negative. But while stark images of neglect such as bare feet might appear to indicate that community care is failing the residents, without further documentary proof Holloway’s truth-claims remain weak. In an effort to supply this evidence the programme makers exploit (literally) the appearance of three Mayfield Court residents.
Experiencing Madness

Disguises fig 6.4

Disguises fig. 6.5
The extract quoted above, is accompanied by a visual track that 'targets' three residents in order to confirm Holloway's claim that 'there's nothing to do here but succumb to one's own delusions' (see figs. 6.1-6.3). They are given no opportunity either to confirm or deny his description of their mental health status. Instead, they are positioned in a role judged by Holloway to be suitable to their situation: as victims of a policy that is failing to protect their mental health. Their inclusion is used to signify the inadequacy of community care policy by showing them doing what they apparently do every day (tearing paper, standing in one spot against the wall, talking to 'voices'). In other words, their behaviour is pathologized in order to illustrate the extent to which they have been abandoned by a community-based psychiatric system. The questionable ethics of this approach is well illustrated in the case of Eric whom Holloway engages in conversation immediately after he has been introduced as 'the schizophrenic who talks to his own voices':

Holloway: How many times have you seen a doctor since you've been here?

Eric: I'm all right, I get by without it I'm all righted (unclear). I'm all right. Are you a social worker are you?

Holloway: No I'm a resident.

The extract is a good illustration of the argument, alluded to earlier, that a diagnosis of schizophrenia often results in the patient's personhood being eclipsed. Thus we meet 'Eric, the schizophrenic who talks to his own voices' rather than Eric the person labelled as a 'schizophrenic'. The label 'schizophrenic' licenses Holloway to treat Eric as a patient although he is not now in hospital ('How many times have you seen a doctor...?'). As a result, Eric's response that, 'I'm alright, I get by without it' jars
uncomfortably with Holloway’s assumption that he needs medical help. The implication is that Eric’s claim to be ‘alright’ is mistaken because the ‘normal’ reaction to hearing voices is that one should see a doctor. Underlying this, we would argue, is a view that Eric’s mind is in some way faulty because he is ‘schizophrenic’. In other words, his belief that he is ‘alright’ is a false belief indicating both his irrationality and incompetence (to “think straight” about needing medical help). But the justification for Holloway’s concern is not immediately recognizable as being grounded in an assumption about Eric’s faulty mind, since it is presented in terms of sympathy for Eric’s suffering as a voice hearing schizophrenic. We may or may not be able to understand what causes Eric’s schizophrenic mind to hear voices and harbour false beliefs (that he is ‘alright’), but that is beside the point. In the context of a narrative exposing the failing policy of care in the community it is enough to know that he is a schizophrenic, hears ‘voices’, and has not seen a doctor.

Granada, the company that produces Disguises, promoted it as the series that can ‘get to parts of a story others can’t reach’ (Granada TV publicity material for Disguises, March 1993). But as ‘A Place of Safety’ illustrates, wearing a mask in order to unmask is an unsatisfactory basis on which to claim a purchase on the real. After all, when Holloway replies to Eric’s question as to whether he is a social worker, he is clearly being economical with the truth. Despite his intermittent first-person testimony we never come close to knowing what its actually like to be a schizophrenic living in the community. (The best we can hope for is perhaps a voyeuristic pleasure in thinking we are seeing something of the experience of the other.)
Tom's Story

This extract illustrates well our earlier argument, that a diagnosis of schizophrenia often results in an eclipse of the person within a frame of mental patienthood. In contrast, Tom's Story attempts to foreground the eponymous Tom as someone battling to overcome his entry into mental patienthood. In the following extract, Tom's mother, June, offers an insight into her son's pre-illness personality:

June: The man that Tom thought of as a father, we first split up when he was only thirteen and Tom was devastated by this. But then unfortunately, and I would take the blame that this person kept coming back into our lives for the next few years. And so it only ended erm about this time we're talking of, when Tom was becoming very ill. So I think it may not have affected certain people but I think Tom has a very thin skin and er a very artistic person.

Here, Tom's identity as a special kind of personality is signalled, one whose artistic tendencies are a clue to the continuities between his pre-illness and post-illness personae. Its appearance at an early point in the programme draws on the notion that Tom is especially prone to (mental) illness because he is an 'artistic person'. The description/explanation of him as 'very artistic' begins to account for his schizophrenic breakdown ('Tom has a very thin skin') whilst hinting that he was never completely lost to the illness. Shortly after the extract quoted above, we encounter the following sequence:

Narrator: When Tom started an English degree at Keele University he found the pressures too much retreating within himself and neglecting his work. But his mother was amazed to discover that he was finding an escape in music.

June Leader: I was just knocked out by this lad who could just sit there and he'd taught himself to read music and play and nobody knew it. He was somehow able to just concentrate
on that one sphere of his life and he seemed like he was blocking out all the other awful things that were happening to him.

The story of Tom’s ‘escape’ from all the ‘awful things that were happening to him’ is essential to the programme’s construction of him as an heroic individual. Consequently, some account of what exactly was happening to him becomes necessary. In the following sequence, Tom and June’s testimonies jointly describe his voice hearing experiences:

June: We were coming back in the car and Tom said to me “do you hear voices in the flat mum?” And I said, “no Tom I I don’t hear anything in that flat apart from people around us”. And he said that just recently he had been hearing voices and they were voices that were telling him how awful he was. The insults were all directed at himself.

Tom: The main one was that they would shoot me or cut my fingers off if I played the piano again or erm calling me you know insulting me and calling me er calling me a bastard and (pause) and erm just being really really cruel, implacably cruel, that’s how it seemed to me. I thought there were people actually saying these things so I personified these sort of voices in my mind.

June: And if he was in a room it was like they were just outside the window and that he never got to sleep because they were there all the time.

Tom: It was it was really bad [unclear]. It was like being in hell I can imagine. Its having all these demons sort of erm tormenting you and torturing you for all the day you know. When you slept it was okay but once you got up you’d hear these you’d hear these the voices would would start. And you you know I actually felt quite suicidal at one point well a few points so I’d never go through with it but I I did you know hit my against walls and things like that.
The story of Tom’s voice hearing is told through a series of binary oppositions in which the visual track plays a crucial role. As June’s testimony begins we see a shot of her and Tom chopping onions whilst talking about remedies for the onions’ pungent effects (fig. 6.6). As he speaks, the camera cuts to a shot of him using a knife to cut onion (6.7). The image track then cuts to a long-range shot of them both, revealing the flat’s interior (fig. 6.8). At this point, June begins the first of the two contributions quoted above. The cut-away signals the beginning of a visual exploration of the place where Tom first heard his ‘voices’. As she begins to speak, her testimony coincides with a shot of a miniature bird cage whose position next to a photograph casts a shadow over the image in the frame. It is a picture of Tom as a boy being carried on his mother’s shoulders (fig. 6.9). The meaning is explicit: she is recounting the moment when her son’s illness rendered him once again dependent on her. It confirms a comment made by the programme’s narrator at the beginning of the programme, ‘To Tom’s mother, June Leader, its [schizophrenia] a burden. She must help her son cope to with the condition through his life’. The image of the birdcage makes it clear that she is viewed by the programme maker’s as much a prisoner of schizophrenia as her son. In contrast with June’s representation as a mother burdened by her son’s condition, the next image shows Tom comfortably ensconced in a sitting-room drinking and reading. A glow from a lamp behind his head radiates a warm sense of domesticity (fig. 6.10). The image appears at the point in the verbal track where she says, ‘And he said that just recently he’d been hearing voices...’.

2 That June is represented as a prisoner of her son’s illness can be clearly seen in her following testimony: ‘Well, for some time I didn’t live live any kind of personal life. For the first months of Tom coming out hospital I think we held ourselves up together and sort of hugged together for comfort. Perhaps not in a physical sense but we actually were very close in keeping the world out. Gradually, I picked up on my life and you get to know who your friends are’. Shortly after this extract, we see June setting off in a taxi for a weekend break in London with her boyfriend. The suggestion is that as Tom’s mental state continues to recover she can become less of a prisoner.
tranquillity of the scene stands in strong contrast to June’s previous account of Tom’s voice hearing experiences in the flat. At this point the significance of the earlier image of Tom handling the knife becomes clear: he is now able to be trusted with a knife (providing his mother is there to supervise him?). This interpretation draws on the myth that schizophrenia is a dangerous condition in which the sufferer cannot generally be trusted. In the context of a story preoccupied with his recovery however, the ordinariness of the domestic images (chopping onions, relaxing in the flat) signify the extent to which Tom has regained his normality. That he is able to use the knife to chop onion gains added significance once his first contribution begins. His description of the voice that threatened to cut off his fingers if he played the piano suggests that during his earlier voice hearing phase, the knife might have been used as a weapon. The image of him using the knife “normally” reassures viewers that this is no longer a possibility.

Another significant image is mobilised during both phases of Tom’s testimony quoted above. As he speaks of the threats issued by his voices we see him seated in front of a piano (fig. 6.11). The lid is open and a sheet of music rests on the stand indicating that it has recently been played or is about to be played. The image of Tom and the piano together, signifies its central role in his recovery. If we return to the programme’s romantic metanarrative, Tom’s heroic struggle against madness reaches its crisis point at this particular juncture: ‘It was like being in hell... Its having all these demons... tormenting you and torturing you all the day...’. Following Vladimir Propp’s influential study of Russian fairy tales, *Morphology of the Folktale* (first published in 1928), we can argue that the piano functions as a magical agent in the story of his recovery, a helpful device that allows him to escape from the
voices/demons surrounding him. As Tom himself says immediately prior to the sequence quoted above:

Certainly when I was ill I I'd play a piece that would transport me to another world you know. Say if it was a Russian-sounding piece you know I'd be in Moscow with all the snow snow flakes coming down. Or a Spanish piece you know I'd be sitting on a beach in Spain or something. Music's got a great power to transport you and er it certainly helped me in that way.

The significance of the piano in Tom's Story should not be underestimated. It is represented as the principal resource through which his recovery from schizophrenia is achieved. Indeed, as he prepares to perform his piano recital, the narrator tells us, 'It's time for Tom to prove to himself and others that he can overcome his illness'. The recital is the key to his victory over illness.

The final segment of the programme documents the success of his piano recital and, by implication, provides proof that he has indeed overcome his illness. We see shots of Tom dressed formally for the occasion, smiling and laughing with guests. The next images we see are of him performing at the piano (figs. 6.12-6.13). As the images appear on screen, the voice track continues thus:

June: Tom underneath everything is a very gutsy, strong, individual. I feel I'm worried more about not his future, but the way people perceive people like Tom. So okay, he may not be the Tom Tom was, but another person has emerged no less a person. Tom is different.

Tom: Well I hope to go back to University now that now that I'm sane and erm and I'll study music and I hope in ten years time you know if I like practice a lot every day to be able to be er at least er an average concert pianist you know. Its er its one of my ambitions.
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Tom’s Story fig. 6.12

Tom’s Story fig. 6.13
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Tom's Story thus arrives at its resolution. Tom has emerged as 'another person' (Images of Tom in formal dress confirm this transition). This new person is one whose sanity is beyond doubt and whose resurrected personhood revolves around ambitions to return to University and become an 'average concert pianist'. Nonetheless, June's testimony reveals a note of concern. She expresses anxiety not for her son's post-illness personality (as in traditional medical accounts of schizophrenia where the post-illness person is said to still bear the marks of a "personality disintegration") but for his 'difference'. In keeping with her representation as a mother who must bear the burden of her son's illness she can foresee other, non-medical, difficulties arising from the application of the schizophrenic label. This however, is beyond the concern of the programme's makers. Their interest is in representing Tom as on the verge of a new life in which the future is all that matters.

Video Diaries: 'Mad, Bad or Sad'

In contrast, 'Mad, Bad or Sad', aims to reveal the experience of coping with the after-effects of being labelled 'schizophrenic'. Consider, for example, Sharon's opening address to viewers spoken in voice-over:

You probably don't think you'll crack up. The chances are you might then you'd be a nutter like me. A doctor will give you a label that sticks to you for the rest of your life. Mine was schizophrenic. Making this diary was hard sharing all my secrets but I really wanted you to see me the person I am behind the label. Most of my life I've spent in institutions until I met Mickey. He's a schizophrenic too. Now we live together in Manchester - me, Mickey, my two cats and my voices. I hear voices, echoes from my past. This is the root of my madness.

This perfectly illustrates the remit of Video Diaries: to allow ordinary members of the public to tell their own stories in a way that gives us new insights into the 'reality' of
their situation. For Sharon, her story is one of being permanently marked by the label 'schizophrenic'. Watching her 'diary' however, we are not asked to distance ourselves from her but to identify. We are offered a sense of intimate engagement with the otherness being portrayed. Sharon's narration draws us into her personal world of 'Mickey, my two cats and my voices'. The subjective camera and first-person voice-over, allow us to view the world entirely through Sharon's eyes: 'Making this diary was hard but I really want you to see me the person I am behind the label'. This intense involvement may have been 'hard', but it enables her to explain the 'root' of her madness from within her own life-world perspective: 'I hear voices, echoes from my past. This is the root of my madness'. The Video Diaries' format allows Sharon to not only set and control her own agenda, but to speak authoritatively and at length about the 'reality' of her schizophrenic experiences (including her and Mickey's interpretation of these experiences). She is able to represent herself as someone whose mental competence is not in question. This, for example, is Sharon's first direct piece to-camera:

I don't believe I'm schizophrenic. I think a lot of black people get labelled schizophrenia with schizophrenia. My cats love me, I love my cats. Mickey loves me and I love him. The main thing is these voices and I hear them about eighty per cent of the day slagging me off, winding me up, making me depressed. Sometimes they get so bad I have to go to bed and take a sleeping tablet and go to sleep but they wake me up, the voices.

What is immediately apparent here is Sharon's seemingly incongruous belief that she is not schizophrenic coupled with her open admission that she hears voices 'about eighty per cent of the day'. One might interpret this as evidence of her lack of insight into the nature of her condition. Indeed, one might go further and suggest that it is evidence of a 'faulty' schizophrenic mind that is unable to recognise (or rationalize)
the ‘obvious’ correspondence between her psychiatrist’s diagnosis of schizophrenia
and her own experience of hearing ‘voices’. However, the Video Diaries’ format
depends on diarists giving their own view of their world. All that matters is Sharon’s
opinion; that she is not schizophrenic, but that she hears ‘voices’. Because of the
insistence on individual diarists testifying to their experience and telling their stories
‘Mad, Bad or Sad’ is able to side-step the issue of Sharon’s
competence/incompetence.

Unlike the other programmes selected for analysis, ‘Mad, Bad or Sad’ offers a deeply
personal account of what it’s like to be a schizophrenic. Even so, we are only able to
glimpse fragments of a life lived with a diagnosis of schizophrenia rather than a
schizophrenic life. The distinction is important because we also witness aspects of
Sharon’s life in which her schizophrenic label is not a defining characteristic of her
experience. For example, Sharon and Mickey spend her birthday at Blackpool
Pleasure Beach and we see them both having fun on the rides and eating candyfloss -
in other words, doing ‘normal’ things. Nevertheless, her schizophrenic life does
occupy a significant proportion of the programme. In the following extract she
explains her daily drug regime to viewers:

Sharon (talking to-camera whilst taking boxes of tablets out of her medicine cupboard): These
are my tablets. I’m on eleven a day. I’m on this one, Carbamazipine, which is for a mood
disorder and I take this one three times a day and it makes me tired. I also take Procyclidine
for the side-effects of the injection that’s four times a day. What else? I’m also on these tablets
for migraine called Migrelief. Prothiadine yer, that’s an anti-depressant and Largactyl which is
er its full name is Chlorpromazine Hydrochloride, it’s an anti-psychotic and I take that at night
and Mellerill. This is Mellerill. No that’s Largactyl - well Largactyl and Mellerill are similar
and I take four of those a day. And that’s about it. (pause) I feel drugged up most of the time.
By filming the contents of her medicine cabinet, and explaining to-camera what her drugs are prescribed for, this sequence signals the extent to which Sharon herself considers drugs to be a defining feature of her everyday life. A more ‘professional’ telling of her story might have resulted in re-shooting the moment when she gets confused over whether her drugs are Largactyl or Mellerill. In the Diary context however, her confusion underlines her difficulty in trying to cope with so many drugs. The amateur and obviously inexperienced way in which she finishes telling us about her medication (‘And that’s about it’) jars with the significance of her final comment: ‘I feel drugged up most of the time’. Having just recited a long list of drugs this poignant comment - delivered in a tone that suggests it is as much a private reflection on her situation than a deliberate ‘public’ expression of how she feels - conveys very strongly how Sharon experiences her daily life.

*Video Diaries* thus enables Sharon’s feelings and emotions about medication to be articulated in the public domain. The programme’s format also provides space for topics outside the traditionally defined area of current affairs interest. Consider, for example, the following sequence from ‘Mad, Bad Or Sad’:

Sharon (speaking in voice-over whilst the visual track shows her receiving an injection): 
Every two weeks I get an injection of Depixol. Mickey gets one every month. He says it helps him but it doesn’t work for me. I suppose the way they [psychiatrists] see it, I’m so drugged up I can’t give them any trouble. (pause) But it just leaves me with no energy for life at all, then because I’m bored the voices I hear get worse.

At this point the visual track changes to a shot of Mickey speaking direct to-camera

Mickey (speaking to-camera): The psychiatrist is the expert and if he says you’re a schizophrenic for example, you believe him and you don’t see yourself in the same way
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any more. It changes your whole life by simply saying that word. And experts are not always right. Sha Sharon has has thought of herself as being ill since she was thirteen years old but because she thought she was ill she did mad things er. I I did mad things because I thought I was ill. I did more mad things after the like the label from the psychiatrist was put upon me than I I did before. I I feel really that that psychiatry attacked me in in retrospect. I I I felt that they no well the best word is attacked. They they they er set about me with their expertise and its taken me years and years to get back to normal you know.

At this point the visual track cuts to footage of Sharon and Mickey entering a building and congregating with other people.

Sharon (speaking in voice-over): Every week we go to the Manchester Hearing Voices group. These groups are starting up all over the country. (pause) Many people who come here are outside the psychiatric system. They're not diagnosed schizophrenic but they hear voices too. (pause) It's a self-help group with no professionals. Because we all hear voices it makes it easier to talk about them. My voices are bad memories, personalities from my past who call me wog, black bastard, coon and whore.

Sharon and Mickey³ take advantage of their editorial prerogative to voice their distrust of psychiatric professionals. In the context of another programme format, Sharon’s interpretation of her Depixol injection might easily be mobilised as evidence of her “faulty” mental state (that she is “paranoid” about her medication). But in the context of her diary, her interpretation stands as an accurate reflection of what she feels to be true. Similarly, Mickey’s view that psychiatry ‘attacked’ him with its ‘expertise’ is presented as a legitimate opinion in the sense that it expresses what he feels. As we noted in Chapter Two, Video Diaries revolves around the viewpoint of

³In ‘Mad, Bad Or Sad’ Mickey is continuously involved in all aspects of recording ‘diary’ material to the extent that he functions virtually as a co-diariist
its diarists and allows them to present their own arguments in their own words and in their own way. Despite what others might make of Sharon and Mickey's views, the fact that they interpret psychiatry in this way is what they themselves think. As Kilborn (1994: 437) puts it: 'Not only does the diarist have editorial control over what is shown, but also the material screened makes a special claim on our attention, since it represents an attempt on the subject's part to come to terms with events in, or aspects of, their lives which they consider significant' (emphasis in the original). At the very least, when watching 'Mad, Bad Or Sad' we are forced to acknowledge (though not necessarily concur with) the fact that both Sharon and Mickey distrust the very people charged with their care.

Video Diaries' ability to raise political and social questions within an access format has been welcomed by some commentators as an important contribution to democratizing the public sphere. The series' use of verite-style footage, detailed personal experience, and vernacular modes of reportage have brought into public view many 'alternative' or marginal issues. 'Mad, Bad Or Sad' contributes to this tradition by touching on the contested terrain of voice hearing and psychiatric intervention. As we noted in Chapter Three, many voice hearers reject medical intervention preferring to interpret the meaning of their voices from within their own lived experience. In the final part of the sequence above Sharon does precisely this. 'My voices', she tell us, 'are bad memories, personalities from my past who call me wog, black bastard, coon and whore'. The series' insistence upon the integrity of personal points of view means that she can interpret her voices in this way without fear of challenge or contradiction.

However, the representation of Sharon's personal perspective cannot be properly understood without acknowledging that Video Diaries is also a professionally-assisted
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documentary. Accompanying her final contribution above is footage of Sharon’s participation in the Hearing Voices group. Watching the footage we are offered a sense of intimate engagement with the ‘otherness’ being portrayed. The image track cuts to different members of the group as they speak about their voices (figs. 6.14-6.16). Sharon’s comments concerning the meaning of her voices (‘My voices are bad memories, personalities from my past...' ) are spoken contemporaneously with footage of her participating in the group (fig. 6.17). Although her voice-over has been recorded during the editing stage it complements the action of the image track (her being in the group) and connects her description of her own voices to the supportive context of the group. Here, the marks of professional intent are apparent. Immediately Sharon’s commentary concludes, another member of the Hearing Voices group is shown (fig. 6.18) speaking thus:

Hearing Voices group participant: What I see it as I don’t see it as another person’s voice, I see it as myself talking to myself inside my head and I can hear that. And if I’m in a bad mood then I can wind myself up and I can be on the edge of a bridge thinking I hate I hate you, I’m gonna throw you off the bridge you know like. That is going through my mind kind of thing. But then I stop and I have control over the voices cos then I think its only me talking to myself, so its only me that has to deal with it really.

The extract quoted above concerns the individual’s idiosyncratic understanding of her voices. Its inclusion at this point in the programme forms part of a broader obligation to Sharon, to ensure that her perspective as a voice hearer is understood. Here, the camcorder itself comes into view. Our engagement with Sharon’s view of the world is mediated through the camera. As Dovey (1996: 121) points out, ‘The camera is actually an accepted part of the event itself, neither outside, controlling and structuring, nor inside lost in the flow, but mediating for us between these positions’.
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Video Diaries fig. 6.17

Video Diaries fig. 6.18
Thus, the subjectivity mobilised here is more a product of the programme's form rather than what a particular diarist might say.

*Video Diaries* also gives diarists an opportunity to speak at length, in the context of their everyday routines, and at times chosen by themselves. The value of this flexible mode of self-presentation can be seen in the following two, separate, pieces to camera made by Mickey. The first is delivered in an armchair, the second whilst having a bath.

If I go in to a pub er and and I say er well I I had a nervous breakdown. I [unclear] spent some time in hospital you know then people are likely to say “oh yes, John had a nervous breakdown” and “somebody’s wife had a nervous breakdown” or or even, “I’ve had a nervous breakdown myself”. But but if you go into a pub and say er, “Well I’m a schizophrenic”, if you even mention the word it’s not gonna be forgotten. It’s a terrible word er socially er. I mean schizophrenic’s run about with axes you know according to public opinion you know. I mean it’s the the media that’s painted it like that. But er it’s not something you admit to, it’s not something you admit to you know. There’s very little sympathy for anyone described as a schizophrenic.

Well some people would say you live the life of bloody Riley because you get that little bit extra cos you’re on the sick you know rather than just being unemployed. But er there’s a price to pay you know. I mean if if you end up in the loony bin you know somewhere in your head that erm you’re being talked about cos you know that erm when you were out there before you got that label well you were one of them. You’d be talking about people. You’d be saying, “oh, such and such is in the loony bin” you know. “A right nutter” and all this you know. I mean if if you were to mention it to your shrink he’d probably say you were paranoid. But I know. I know what we used to say about people and I I know the jokes that were made. And consequently, I I know the jokes that are made about me and Shaz.
Such pieces to camera enable diarists' to reflect upon aspects of their life within the context of their domestic milieu. They give diarists' an opportunity to speak at length on issues that are (usually) ignored by other current affairs formats. Thus, both pieces quoted above enable Mickey to reflect on the stigma of a schizophrenic label. Being tainted by the label 'schizophrenic' is an experience that many of those diagnosed feel strongly about, but is rarely articulated in the public domain. Even though the label refers to a bona fide mental illness it nevertheless carries with it a whole set of negative assumptions about the person thus labelled. For Mickey, its application has meant that he prefers not to admit socially that he is a schizophrenic since it carries with it all sorts of pejorative assumptions. His antipathy towards the label is predicated on a feeling that he is "less of a person" because of his diagnosis, a feeling shared by Tom in *Tom's Story*:

Tom: I never thought of schizophrenia as being you know an easy thing. I've learnt yer you do find who your friends are, who are your real friends you know, not just fair-weather friends. Because because of the er nature of the illness it it does carry a lot of stigma. It's like admitting that you're a homosexual or you've got AIDS, it's one of those kind of things.

The experience of being labelled 'schizophrenic' from the schizophrenic's point of view has rarely been explored in the psychiatric literature (The work of Barham (1992) and Pilgrim *et al* (1993) being notable exceptions). In the era of community care however, this is profoundly unsatisfactory since the effects of a 'schizophrenic identity' impinges on the lives of many now living in the community.

In the second of the two extracts quoted above, Mickey expresses his dislike for the schizophrenic label based on his pre-illness experience of judging people according to their status as a mental patient. The candid nature of his testimony draws on the
popular terminology used to exclude schizophrenics from social life. Instead of avoiding derogatory words such as "nutter" and "loony bin" however, he deliberately appropriates them in order to contest the validity of such (mis)representations. Moreover, by playing with the 'shrink/paranoid' joke he signals how his own pre-illness attitude towards the mentally ill impacts on his present schizophrenic identity. He is talking to viewers as a 'schizophrenic', but also as someone ingrained within a culture that sees schizophrenics as different. The apparent deficiency of the schizophrenic ("A right nutter...") is turned on its head and becomes the deficiency of society at large; one that fails to recognise their humanity. As his testimony concludes, the image track cuts to a shot of Sharon asleep with a cat lying on her. The image of vulnerability this conveys adds to the poignancy of Mickey's acknowledgement that they are seen by others as abnormal. The final message of the Diary thus appears to be: "There but for the grace of God go I".

Horizon: 'Hearing Voices'

However, it is not only an access format like Video Diaries that can allow voice hearers extended space to talk about their experience of being labelled. Consider the following sequence from the Horizon programme, 'Hearing Voices':

Narrator: Alan Leader's first encounter with the mental health system began after he was continually distracted by voices as a child. His mother took him to see a psychiatrist.

Alan Leader: He just sat there with a pipe and just [pause] an empty pipe, I always remember him having an empty pipe, and sucking air through this pipe. "Hmmm, aha, hmm, interesting, aha, hmm". And I thought to myself, "what's this pratt talking about" you know. "This is the worse than the voices this guy. He's just sitting there, he's just patronising me" you know. He said to my mother he said to my mother, "I think this guy's got a problem".

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And my I remember my mother said, “well of course he’s got a problem, that’s why we’re here” you know. “I don’t need you to tell me he’s got a problem, that’s why we’re here!” “Hmmm, interesting” you know. So the next thing I [unclear] happened after that is I ended up in er an adolescent adolescent unit in a psychiatric hospital in Hill End in St. Albans. And er well my psychiatric career started really. [emphasis in the original]

Alan Leader’s testimony is forthright in its contempt for the orthodox psychiatric labelling process. His condemnation of the ‘patronising’ psychiatrist who interviewed him (‘... what’s this pratt talking about... This is worse than the voices this guy.’) underlines the programme’s rejection of orthodox psychiatry. His account of the psychiatrist’s assessment forms part of the programme makers’ attempts to represent voice hearing as a phenomenon unamenable to traditional medical interpretation/intervention. Against the prevailing psychiatric assumption that auditory hallucinations are devoid of significance, the argumentative orientation of ‘Hearing Voices’ constitutes voice hearing as an inherently meaningful experience.

Consider for example, the testimony of voice hearer, Susan Clarkson:

Susan Clarkson: I had a small cleaning job and I used to go clean at this private house. And one day I was there cleaning and I were vacuuming up er and I heard this voice sort of like a a thought you know not an actual voice and it said, “whose she?” Then a moment later it began to talk to me again and it said erm “you don’t know who you are do you?” and er I was thinking at the time a furniture polisher (laughs), what room I was gonna clean next and er it didn’t fit into my thought pattern at all and er I can remember thinking what is this you know, what is this happening to me. I was in utter despair about myself and confusion you know er and there were situations in my life at that time. I were having problems er with me older children er and with me husband and erm the feelings that were there underneath er about my neighbour were feelings of anger what I’d subdued and I tried to be a nice neighbour and this anger come from nowhere er just in my very being you know towards her. Over a matter of months er things had been happening like her dog was coming round and whoopsying all over
the garden and I had small children and was worried about it. The voices sort of said "you know what she's like" erm "if you don't do anything your children could become ill" we this erm you know muck that's around and various other things and they made me feel inadequate as a mother because I'd let it go er and they were on and on at me constantly erm solid for about 24 hours. I didn't get any sleep er until erm the following day they were on at me again and again. And then finally in the early hours of the morning I went round you know and er smashed the windows and hurled abuse and become very violent and everything you know which really wasn't me you know. I I didn't have any sense as though I were in control er and then there were this sudden realisation of oh my God!, you know, what have I done? [emphasis in the original]

Susan's testimony is mobilised mid-way through the programme in order to illustrate the complex social dynamics underpinning her particular voice hearing experience. Perhaps the most interesting aspect of her testimony is that she is allowed to articulate at length the stresses in her domestic life in the weeks and months prior to the onset of her voices: '... there were situations in my life at that time. I were having problems with er me older children and er with me husband...' and '... things had been happening like her dog was coming round and whoopseying all over the garden. I had small children..'. However, while Susan is given an extensive opportunity to talk about the content of her voices in the context of her life-experiences, what distinguishes her testimony from Sharon's in Video Diaries is that control over how it is presented remains firmly in the hands of professional programme makers. So, although personal testimony is a prominent feature of 'Hearing Voices', the lived experience of voice hearing is not the programme's central concern. Instead, it draws back to an 'outer' ring of expert interest in voice hearing and which effectively relates experiential discourse to a subordinate position. This can be clearly seen in the sequence immediately following Susan's testimony quoted above:
Narrator: Susan Clarkson was arrested later that night and spent some weeks in a psychiatric hospital. If she’d had the chance to talk about her voices before things had got out of hand could events have taken a different course?

Professor Marius Romme (identified by caption as Professor of Social Psychiatry, University of Limburg): There the danger always is that people always say yer when people want to kill somebody and the voices tell him to kill somebody, I think the best thing is to accept that the person has a voice and who tells him to kill a person. Because if I talk about that we can also talk about how to prevent that happens because the person also says it’s not me telling me to kill somebody but it’s somebody else. So we acknowledge that it’s somebody else but its very important to get much more defence against that other person in your head who tells you to kill. And in that sense we can make a joint venture to prevent that killing [unclear] from happening. If we don’t do that the voice keeps on telling that he has to kill and then this person lives forever on a [unclear] which on a certain moment might get out of control and then he kills somebody. So not talking is much more dangerous than talking. I have never met somebody who did some aggressive things after explorative talking about it but always with people who never got a chance of talking. [emphasis in the original]

Dr. Adrianne Reveley (identified by caption as Consultant Psychiatrist, Maudsley Hospital): I think messages that people when people are seriously ill and have messages that they should harm someone else or kill somebody else I think that that is a very serious area indeed. And I don’t believe that relying on psychological intervention erm is a very good thing at all. I would be very worried trying to persuade somebody that they shouldn’t do it by exploring their voices erm because I believe that alternative reality is something that we we’re not there with the person. We don’t know what’s affecting them from minute to minute and while you might well be able to persuade somebody that really they don’t need er to kill their mother, if you’re leaving them alone with their mother then for weeks on end erm, the alternative reality may well come back in in full force and your words of of advice and and explanation may well be gone. So I think it’s a very serious area indeed.
Narrator: It's two years since Susan Clarkson left hospital. She's actively trying to promote awareness and understanding about voice hearing in her area and the hospital now refers voice hearers to her for support. Does she understand now what drove her to act as she did?

Susan Clarkson: A lot of the emotion was the frustration and the desperation of not knowing if it was real, what was real and what wasn't real er. Because I were I knew it was real, that the voices were real. I never doubted that they were real because I were experiencing them er. I know that sounds pretty bizarre but I mean when you're experiencing something you know that it's real whatever level people want to measure that and this was er. And I just nobody would understand or taken it on board er and that's really when the desperation set in.

[emphasis in the original]

Professor Richard Bentall (identified by caption as Professor of Clinical Psychology, Liverpool University): If I'm confronted with a patient who says, and I have been confronted with patient's who say, er that the voice for example is asking them to assault somebody or attack somebody or perhaps even kill somebody, then er I can pay attention to the voice and I can encourage the patient to pay attention to the voice without encouraging them to do what the voice says er. An important point to make to people who hear voices under these circumstances is that there's a difference between understanding the content of one's own thoughts and where one's own thoughts come from, and just following them.

In this sequence Susan's voice is rendered less important than other 'expert' voices. Her account of the onset of her voices during a period of intense stress is revealed as a prelude to professional disagreement about the pros and cons of focusing on the content of auditory hallucinations. The narrator's opening question ('If she'd had a chance to talk about her voices before things had got out of hand could events have taken a different course?') is directed, not to Susan, but towards those deemed to know about such matters - i.e., psychiatrist's such as Professor Romme and Dr. Reveley. Susan herself is not given an opportunity to respond to the question which,
by implication, signals that she does not have an answer (or that others have a *more informed* answer). Consequently, her account of hearing voices and becoming violent is deemed to be the intellectual and professional property of psychiatry. In other words, her testimony becomes a *case-study* of voice hearing/aggression, an introduction to conflicting medical opinions. Despite the programme's sympathetic orientation to the voice hearing experience then, the experience itself is ultimately less important than discussion of the therapeutic strategies designed to overcome them.

Although 'Hearing Voices' accepts Susan's experience of the voices ('I never doubted that they were real because I were experiencing them') it situates it within a discourse of professional support for psychological intervention. Thus, in Professor's Romme and Bentall's contributions the emphasis is on how to help patient's communicate with their voices in order to cope with them. Susan's contribution is framed within the parameters established by their expertise and confirms the value of 'talking' about voices vis-à-vis Reveley's medical (op)position. The narrator's second question provides an opportunity for her to give her unqualified support for "talking therapy" ('Does she understand now what drove her to act as she did?') which she duly provides. Her participation at this point is not only designed to add weight to Romme's argument that to ignore the content of a voice hearer's voices is potentially dangerous. It is used to undermine Reveley's opposition to the talking approach: '... nobody would understand or take it on board... and that's really when the desperation set in.' The impression given by the programme maker's is that they value the psychological approach because it prioritises voice hearers' own interpretation and understanding of their voices over that of the traditional medical approach. But in order to illustrate this for viewers, they have to subordinate the testimony of voice
hearer’s to those of expert speakers. The irony of this situation is perfectly illustrated in our final extract:

Ron Coleman (speaking whilst participating in a Hearing Voices self-help group): [unclear] yer, especially in psychiatry. They kept on saying it wasn’t really happening, ignore it and it’ll go away. And I was thinking it’s not going way. So yer you do get angry but I think that anger is sometimes justified erm. It’s [pause] to deny anybody’s experience is bound to create anger.

Dr. Phil Thomas (identified by caption as Consultant Psychiatrist and Senior Lecturer, University of Wales): It seems to me really that erm one thing that the Hearing Voice Hearing Voice network is saying is that “these are our experiences, for God’s sake treat them with respect”. And what we have to do is to say to people who hear voices, “here you are, they’re your experiences. Let’s see what sense you can make out of them with our help”.

In this extract, Ron Coleman’s position is clearly stated: ‘to deny anybody’s experience is bound to create anger’. In the context of the programme’s argumentative orientation it registers as an appeal that the voices of voice hearer’s be heard. But instead of allowing Ron’s appeal to stand on its own merits, the programme insists on maintaining the link between voice hearing and psychiatry. So, although Dr. Thomas hands the voice hearing experience back to voice hearer’s, he does so on condition that psychiatry remains centrally involved in the process of helping them make sense of their experiences. While this may be a suitable arrangement for Dr Thomas, the question of how his benevolence is interpreted by voice hearer’s themselves is not explored.

Conclusion

In this chapter the voices of diagnosed schizophrenic’s feature prominently. Across a range of TV programmes, public discourse about mental illness includes the
testimonies of people whose experiences have historically rendered them alien and *incommunicado*. However, while the (temporary?) restoration of schizophrenic’s into the community means that new channels of communication with them are opened, the legacy of their mental patienthood looms large. In giving accounts of their experiences, people with a history of mental illness continue to be confronted with entrenched perceptions of their incompetence and vulnerability vis-à-vis “normal” people. In this sense, the traditional relationship between schizophrenic and psychiatrist, in which the latter sees only illness, is reproduced in contemporary relations between schizophrenic’s and professional programme makers. It would be naive though, to advocate that schizophrenics should be given unmediated access to the airwaves as if this could restore a century’s habit of not listening to the mad. Some people with a diagnosis of schizophrenia *are* more able to speak for and represent themselves than others with the same diagnosis. So, while the German literary critic Walter Benjamin’s view that “experience is the source of all authority” has a ring of truth, it clearly does not hold up in all cases. In the case of people with a diagnosis of schizophrenia, their experiences appear to be the very source of that which puts their authority as speakers into doubt.
Chapter 7

Visualising Madness
Introduction: Discourse and Imagery

'Television’s ability to produce moving images, live or recorded, is clearly the single most important defining feature of it as a medium' (Corner 1995: 13).

Acknowledging television as a visual medium immediately renders one open to the accusation of courting banality. The reply is usually swift and direct: of course television is a visual medium. That is why it is called television! Nonetheless, academic study of television’s ‘most important defining feature’ remains surprisingly undeveloped. This is curious because in other ways the analysis of television as a significatory system is very well developed within the humanities and social sciences (see for example the range of perspectives in Allen (ed.) 1992). One of the most fruitful avenues of recent enquiry has been the use of ‘discourse analytical’ perspectives. These view television - along with other social institutions such as courtrooms or doctors surgeries - as an important site of discursive activity in which participants’ talk is mobilised for particular argumentative or rhetorical purposes (see Fairclough, 1995; Tolson, 1995).

Critical discourse analysis is closely bound up with the study of ideology. It is important to view discourse and ideology in conjunction since even in an increasingly image saturated cultural system, language remains the principal medium of ideology. As John Thompson notes, ‘The analysis of ideology is fundamentally concerned with language, for language is the principal medium of the meaning (signification) which serves to sustain relations of domination’ (Thompson 1984: 131). Consequently, analysis of television (and other media) discourses is in large part the analysis of expressions and utterances considered within the framework of a general critique of
ideology. However, in discursively analysing television's ideologically constructed messages there is a tendency to operate with a *linguistically* grounded conception of 'text'. This has led to a marked neglect of the role of visual images in organising and conveying meaning. Murdock (1994: 114) summarises the problem thus:

> Most work on discourse, including most writing on television's handling of social issues, treats it as a purely linguistic phenomenon, analysing the utterances of participants and interviewees and the questions and comments of the programme's presenters. This misses the obvious but decisive point that television is also a visual medium. *Arguments and debates therefore proceed along two dimensions: the voice track which operates as a sequence of turn taking and the image track which works by juxtaposition and association.* [my emphasis]

This privileging of language over image is all the more surprising when one considers for example, the degree to which a non-fictional television programme's arguments are anchored in the accompanying imagery. Consequently, 'an analysis of television [form] will not get very far if it fails to keep alert to television's visualisations' (Corner, ibid: 14). Recent developments in actuality television (such as the deployment of secretly shot footage, the use of verite material, or dramatic re-enactment's) have tended to re-emphasise the visual in relation to the verbal presenting the 'dramatic' aspects of events as both the central communicative feature of the programme and, increasingly, the prime guarantor of its 'truth claims'. Thus, whilst not wishing to overstate the prevalence of clandestinely shot images within the television system as a whole, the emergence of new (or partially new) modes of visualizing actuality do underline the importance of image analysis as a central component of television analysis.
The case-study presented thus far has confirmed the importance of visual images in television’s representation of mental health issues on several occasions. In the previous two chapters the study of ‘form’ in relation to ‘content’ has meant attending to the visual and aural ‘shape’ of particular programmes. In this chapter, the form-content relationship is further explored by giving primacy to the role of visual images of mental illness. Exploring the visual depiction of mental illness on television offers us an opportunity to reconnect contemporary images of madness to those of earlier times. For example, the idea that the mad look different from other people mobilises artistic conventions for depicting madness developed over many centuries. Such depictions are not necessarily accurate, however. In the context of our argument that mentally ill people have difficulties being taken seriously in the public space of broadcasting, they may even be unhelpful. In television programmes, claims to plausibility and authority depend as much on what speakers look like as on what they say (Murdock, 1994b). Consequently, visual images of mental illness need careful attention if we are to properly understand the circumstances surrounding mentally ill people’s access to a public voice.

Representing Schizophrenia as ‘Difference’

Sander Gilman’s work on images of madness (see Chapter Four) provides a useful point of entry into television’s depiction of mental illness. Following Gilman, we can ask how TV programmes involving schizophrenia represent visually what is basically an unobservable mental phenomenon such that viewers can recognise that schizophrenia is what is being portrayed. For many programme makers communicating the condition is not just a question of accessing grounded testimony about the experience of being ill. It is often a matter of visualising that experience, of
imaging the illness so that viewers can see what it looks like. This representational challenge links contemporary television producers (and other visual artists) to painters and sculptors in earlier centuries. The idea that schizophrenia can be visualized invites consideration as to how this is achieved across a range of TV programmes. To this end, images of mental illness from four of the sample programmes are considered. The programmes are: 'Tom's Story'; 'Mad, Sad or Bad' (Video Diaries), 'A Place of Safety' (Disguises); and 'Whose Mind Is It Anyway' (Panorama).

Tom's Story

We begin with an image from Tom's Story (fig. 7.1). It will be recalled that the programme is an account of Tom's schizophrenic breakdown and his recovery through music. The image is taken from the opening scene and shows Tom playing the piano surrounded by darkness. However, it is only later, when the story of his breakdown is being told, that the meaning of the image becomes apparent. It is a visual metaphor for the schizophrenic illness that once engulfed him. The darkness surrounding Tom is the 'other world' of schizophrenia, a world that for him holds a particular terror: 'It [schizophrenia] was ... really bad. It was like... being in hell... Its having all these demons... tormenting you and torturing you for all the day'. In order for viewers to understand the significance of the image however (i.e. the degree to which his 'demons' engulfed and disabled him), it is necessary to underline the difference between his 'other' (schizophrenic) self and his present ('recovered') self. Consequently, the second half of the programme is taken up with a series of vignettes in which Tom's recovery is conveyed visually and verbally in relation to his ability to now do the "normal" things that he was incapable of doing during his illness.
The story of Tom's recovery is told as a series of images in which the difference between 'home' and 'outside' justifies the onset of his recovery. Such a binary model of representation identifies images with either the social or the individual, thereby offering a convenient form of interpretation. These images are designed to reflect the morbidity and recovery of Tom's illness. To overcome this, Tom's story is told as a series of images, each representing a different aspect of his recovery. Tom's mother, Lisa, in which she recorded the events of his breakdown as it happened. Her account provides an insightful account of the day that Tom's illness seemed to set in. Through a combination of visual imagery (Tom sitting in a chair surrounded by darkness) and a diary, revealing the depth of
For example, in one sequence Tom is shown riding on a bus (fig. 7.2). The narrator's voice-over tells viewers that as his illness intensified, 'living a normal life became impossible'. Tom, speaking whilst on the bus, then explains the significance of the bus journey:

Tom: Well, I used to hear voices on buses er. People were talking, they'd be talking about me er. I used to get paranoid about it and it became very distressing so I decided to walk into town and back again. But now it's fine you know, it's just like getting on a bus. It's just ordinary.

In another sequence, he is shown in a bookshop (fig. 7.3). Again, he explains the significance of the context in which he is speaking:

Tom: During the sort of the heyday of my illness, you know its, when it was full, when its rampancy was full, I wouldn't have been able to come out to a bookshop. I would have been too, I would have been too apprehensive of of er of the voices and er and the paranoia as well.

The story of Tom's recovery is told in a series of images in which the difference between 'now' and 'then' conveys the extent of his recovery. Such a binary mode of representation however, presents difficulties in terms of fully conveying what it was actually like for him to be suffering from schizophrenia 'then'. The problem is how to retrospectively depict Tom's illness. To overcome this Tom's Story draws upon a well-established narrative device for re-presenting past events - a diary - in this case, one written by Tom's mother, June, in which she recorded the events of his breakdown as it happened. Her account provides retrospective access to the day that Tom's illness reached its climax. Through a combination of visual imagery (Tom sitting at a piano surrounded by darkness) and a diary reading from June, the depth of
Tom's Story (fig. 7.2)

Tom's Story (fig. 7.3)
Visualising Madness

Tom’s breakdown is revealed. The image of Tom at the piano is juxtaposed with June’s testimony:

June: This episode that I have recorded in my diary was really when his illness reached crisis point and so this is Sunday 20th December 1992. He is quite groggy on the tablets but after a first few days he began to seem a little bit more lively. But on Thursday night he said the voices were very loud and aggressive and as we were sitting in my room he started beating his head with his fist. He’s actually answering the voices back. This is really awful for both of us.

As June begins to speak we see Tom’s hands playing the piano. At the point she says, ‘He is quite groggy..’, the image track cuts to a shot of Tom deep in concentration (fig. 7.4). The camera moves slowly in towards him and then pans outwards into the darkness above his head at the very moment June describes how ‘voices’ caused Tom to beat his head with his hands (fig. 7.5). The symbolism of the darkness achieves its full effect when she says: ‘He’s actually answering the voices back’. At this point the camera moves deeper into the darkness until that is all that the viewer sees (fig. 7.6). We are now immersed in the darkness of Tom’s schizophrenic world. Through a combination of June’s diary-based testimony and the symbolism of the darkness, the viewer is drawn into the private, ‘other-world’ of schizophrenia, a world to which only sufferers and their families usually have access. In this way, Tom and June’s inner emotions are given public expression both verbally and visually. This way of organising the narrative of Tom’s Story forcefully conveys to viewers what Tom was like during the worst moments of his illness. In order that his recovery from schizophrenia can be fully appreciated (indeed, celebrated) the programme makers must show its extent. Simply telling viewers that Tom is a recovered schizophrenic does not adequately convey the special nature of his recovery. The point of recounting the story of his breakdown is that viewers can see for themselves the degree to which
he has emerged out of the darkness of schizophrenia and is once again amongst “us”, being ‘normal’. However, his journey back is signalled by much more than his ability to perform ordinary tasks. Tom’s return to ‘normality’ is underlined by his extraordinary ability to perform a public piano recital in order to publicise the issue of schizophrenia. According to the narrator, this event will signal his full recovery from the illness: ‘It’s time for Tom to prove to himself and to others that he can overcome his illness’. No longer is he playing the piano alone, surrounded by darkness. Instead, he is performing publicly, in the full glare of lights and in front of an audience (fig. 7.7). He has emerged into the light and become one of “us” again (fig. 7.8).

Tom’s Story is a reworking of the long-standing myth of the mad as travellers, a myth which still enjoys considerable currency in Western representations of madness. For example, the recent and critically acclaimed film, Shine (1996) recounts the story of David Helfgott, a brilliant pianist, whose schizophrenic breakdown and recovery closely resembles the narrative construction of Tom’s Story. A number of themes from Tom’s Story and Shine overlap: the idea that madness and artistic genius are entwined; the revelation that both Tom and David could play the piano brilliantly throughout their illness; their heroic ‘recovery’ symbolised by a public piano recital. The film’s title, Shine, captures the notion that Helfgott has emerged from the darkness of his madness/schizophrenia and that his musical genius (indeed his very humanity) ‘shines’ through intact. Shine does however convey a sense that Helfgott remains different, but that it is his genius that marks him out, not his madness. Tom is presented as ‘different’ as a result of his journey through madness. As Tom’s mother puts it during film of the piano recital:
Tom's Story (fig. 7.7)

Tom's Story (fig. 7.8)
‘[H]e may not be the Tom Tom was, but another person has emerged, no less a person. Tom is
different’.

Paradoxically, her acknowledgement that Tom is different overrides earlier attempts
to show that he is now ‘normal’. However, the precise meaning of this ‘difference’ is
something that the programme maker’s leave unresolved. His difference may be a
consequence either of his illness or of his musical talent, or a combination of the two.
It is this ambivalence about Tom’s ‘difference’ which unites Tom’s Story with Video
Diaries.

Video Diaries: ‘Mad, Bad or Sad?’

Sharon’s Diary, ‘Mad, Bad Or Sad?’, is presented as a search for her mother who
gave her up for fostering as a baby and whom she has never met. Sharon identifies the
trauma caused by this as a source of mental distress: ‘I hear voices, echoes from my
past, this is the root of my madness. This diary is a journey from where it all started
and it’s a search for the mother I’ve never seen’. The implication is that by exploring
the circumstances of her adoption and perhaps meeting her mother, she might be able
to lay to rest those ‘voices’ from her past which torment her present. The notion that
Sharon is a traveller/explorer is drawn upon throughout her diary as she takes viewers
on a journey back to significant places in her personal development: a family home in
which she was fostered as a child; the asylum where she was institutionalized as a
mental patient; the prison she was sent to following an arson attack as a cry for help.
By showing these places she provides a visual map that pinpoints the principal
settings of her unfolding ‘career’ as a schizophrenic. Consequently, the possibility that
her diary has been purposefully (i.e. professionally) constructed in the form of a
journey of ‘self-discovery’ cannot be discounted.
Despite unease surrounding the editorial circumstances of its construction, the *Diary* provides a tangible opportunity to explore Gilman's assertion that stereotyped images of madness are internalized by those individuals labelled as mad. It is perhaps worth emphasising that Gilman is not using the term 'internalized' to refer to an ideological fog that descends upon and envelops those labelled as 'mad'. Rather, his thesis is that the artistic work of the mentally ill reveals 'highly symbolic representations of internal states for which a structure of expression has been found in the representation of the idea of madness' (ibid: 99). In other words, images of madness produced by the mad convey traces of the dominant modes of representing madness as difference. Stereotypes of madness as difference may shape the mad person's self-representation of their illness experience but they may also open up the possibility that they can either accept or deny the charge of being different. Sharon appears to embrace both possibilities simultaneously. Consider again, her explanation for making the *Diary*:

>'You probably don't think you'll crack up. The chances are you might then you'd be a nutter like me. A doctor will give you a label that sticks to you for the rest of your life. Mine was schizophrenic. Making this diary was hard sharing all my secrets but I really want you to see me, the person I am behind the label'.

Sharon's use of the term 'nutter' reveals her own internalized recognition of her difference from 'non-nutters', a difference she conveys throughout her diary (For example, when she introduces friends from a mental health social club she says: 'a lot of people don't want to know us so all us nutters stick together'). At the same time, by using the term 'nutter' she reveals her willingness to engage with (though not necessarily contest) the popular terminology which marks her as 'different'. It deliberately unsettles the fixity of the binary opposition 'nutter/non-nutter' as a distinction between two opposites. By using it in an address to viewers, Sharon
intentionally enters into a dialogue about the labelling of 'difference' from which she (as a 'nutter') is usually excluded. This enables her to publicly affirm her 'sameness' to other 'non-nutters' whilst acknowledging her 'difference' from them. This apparent contradiction suggests ambivalence towards her internalized sense of difference, which is encapsulated in her choice of 'Mad, Bad Or Sad' as a sub-title for her Diary. That her schizophrenic label is something she both acknowledges and resists gives the viewer an insight into the difficulties of living with and within this powerful categorisation.

Sharon's sense that she is visibly 'different' is articulated at the end of a sequence in which she, Mickey and a friend dance in front of the camera. Their dancing is self-consciously hammed up as the camcorder focuses on each of them in turn (figs 7.9-7.11). Their behaviour is recognisably 'normal' in the sense that it is a party scene and people very often exaggerate their 'performance' when being filmed by a camcorder. At one level the sequence conveys the obvious "normality" of their fun in playing to an audience (both real and imagined). On another level however, it reveals something fundamental about Sharon's internalized sense of 'abnormality'. Following her dance she collapses exhausted into a chair (fig. 7.12) and directly to-camera says, 'The lunatics have taken over Stretford'. This comment reflects her self-acknowledgement that their behaviour can be seen as something other than strictly "normal" camcorder-related behaviour. This verbal 'anchor' renders the meaning of what is shown (the dancing) in at least two distinct ways.

Firstly, her comment is a deliberate pun on the widely used aphorism, 'the lunatics have taken over the asylum'. This is something many viewers would immediately recognise as a broadly comical reference to the madcap humour/dancing often
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Video Diaries (fig. 7.9)

Video Diaries (fig. 7.10)

Video Diaries (fig. 7.11)
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Video Diaries (fig. 7.12)
generated by the presence of a camcorder at parties, weddings and other social events. At the same time, the comment appears to fix the behaviour exhibited by Sharon, Mickey and their friend in relation to her own internalized perception of what 'mad' people look and act like. In other words, she articulates her sense of difference at the same time that "normal" camcorder-related behaviour is being engaged in. That the ambiguity is not resolved reflects not only the amateur status of the Video Diary format, but Sharon's ambivalence towards her own identity as 'schizophrenic/not schizophrenic'. The absence of an authoritative interpretation of the sequence leaves the viewer with a sense of uncertainty about the status of the images as representations of 'lunatic' behaviour. How viewers respond to this uncertainty of meaning depends on the fixity of their own internalized myths about the public (and private) behaviour of those labelled as 'schizophrenic'.

*Disguises: 'A Place of Safety'*

The public behaviour of a homeless 'schizophrenic' forms a key part of *Disguises*' attempts to visualise the failure of Community Care. The behaviour in question is that of the series' undercover reporter, Adam Holloway, in his in-role journey to find a suitable place of safety in which to live in the community. The verisimilitude of his in-role behaviour is crucial to the success of his performance as a homeless 'schizophrenic'. To authenticate his performance as homeless and mentally ill, Holloway first establishes that many homeless people do act 'strangely' in public places and that this is a visible sign they are mentally ill and are not receiving proper medical help. Using footage obtained by his hidden camera, he presents the public behaviour of a number of apparently disturbed homeless people in Birmingham as icons of the failure of care in the community. His camera offers a series of brief
vignettes. His voice over commentary is minimal as the images are allowed to “speak for themselves”:

Certainly, as in any big city, there are people acting strangely on the streets. Some are clearly homeless. Are they getting medical help? Like this girl (fig. 7.13). Or this man (fig. 7.14) Or the man who endlessly plays on a pipe that fails to produce sound (fig. 7.15).

These images of the homeless mentally ill provide an essential guarantor of the truthfulness of Holloway’s own later public performance as a schizophrenic acting strangely in a London street. The girl in figure 7.13 appears to be behaving ‘strangely’ by gesticulating wildly with her hands for no apparent reason, whilst the man in figure 14 is seen exhibiting ‘strange’ jerk-like movements of the body, hands and arms. The ‘strangeness’ of the man in figure 7.15 lies in the fact that he ‘endlessly’ fails to produce sound from his pipe and more particularly in his failure to recognise that he is never going to produce any sound from the pipe. The three images serve as a document of pathology, a visual topography of what mentally illness looks like in its natural, ‘raw’, state beyond the cordon sanitaire of the asylum and the ‘medical help’ within. Showing viewers visibly ‘strange’ mentally ill type behaviour is a crucial part of A Place of Safety’s’ aim of giving them access to the ‘real’; in this case, the reality that community care policies are failing the people they are intended to serve. However, in the second part of ‘A Place of Safety’ care in the community is shown to be failing more than just the mentally ill.

Holloway arrives in London and acts out the role of a homeless schizophrenic. Following his failure to find accommodation he explains his decision to move to Hackney and impersonate a disturbed schizophrenic:
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Disguises (fig. 7.13)

Disguises (fig. 7.14)

Disguises (fig. 7.15)
With three hundred per cent more schizophrenics in this borough than the national average, there should be help here (pause). I impersonate a schizophrenic shouting at his voices in the street (pause). Nothing happens. Are people used to this kind of thing here?

Holloway's in-role plight is signified by the increasingly dramatic nature of his actions (Throughout the sequence tension enhancing music is used to heighten the sense of drama as the action unfolds). The visual track shows his attempts to attract public attention by firstly shouting at his voices in the street (fig 7.16), then lying down in the middle of the road (fig. 7.17) and finally, stripping off his clothes (fig. 7.18) with the aim of being sectioned (i.e. forcibly detained) by the police under the Mental Health Act. The veracity of his in-role behaviour is guaranteed by the 'realism' of his strange and potentially dangerous behaviour, a realism given authenticity by the earlier use of footage showing real homeless people acting 'strangely' in Birmingham. Underpinning Holloway's performance is a presumption that without medical help schizophrenics will inevitably engage in unpredictable, bizarre and dangerous acts of 'madness' (e.g. lying down in the middle of the road). This presumption reaches its climax in his impersonation of a schizophrenic whose behaviour eventually attracts the attention of the police (fig. 7.19). Holloway introduces the sequence thus:

To attract attention and get help I begin taking my clothes off in the street. As a last resort I try to get the police to section me using their powers under the Mental Health Act. The police have powers to take a mentally ill person to a place of safety, either a police station or a hospital.

Holloway's failure to get help from the police is certainly the most dramatic moment of 'A Place of Safety' and perhaps justifies the programme's use of a disguised reporter impersonating a schizophrenic (though this is arguable).
Disguises (fig. 7.16)

Disguises (fig. 7.17)
Disguises (fig. 7.18)

Disguises (fig. 7.19)
unsympathetic reaction to his in-role expression of fear about hearing 'voices' (one officer sarcastically tells him to put his clothes back on and 'go and hear your voices somewhere else' while another waves at him from close quarter and says 'bye bye' in a childish voice) provides visual and verbal confirmation that care in the community does not work (at least in Hackney) and that the public cannot rely on police protection from disturbed schizophrenics. It is here that the failure of Community Care is rendered alarmingly visible in the image of a 'mad' and potentially dangerous schizophrenic left to wander unsupervised. The policemen's actions introduce the programme's final scene as Holloway admits to-camera that his attempts to find a place of safety have been 'patchy' and that he is now forced to join the ranks of homeless mentally ill people sleeping rough. However, the social implications of the policemen's actions are left to the viewers' own imagination.

'A Place of Safety's' claim is that the closure of mental asylums leaves schizophrenics unsupervised in the community. De-institutionalization thus provides a catalyst for the programme's generation of anxiety about the public behaviour of schizophrenic people. It is the concern that they will eventually 'turn' their madness on us and hurt us, which underpins the programme maker's decision to cast Holloway as an increasingly desperate and (by implication) increasingly dangerous schizophrenic. Whilst the danger posed by Holloway in-role is self-directed, the implication established by the wider thematic development of the programme is that it is only a matter of time before self-harm becomes transformed into harm to others. Thus, the main 'finding' uncovered by Holloway is not that the mentally ill roam the streets unsupervised, but that they are allowed to do so despite their recognisably disturbed and disturbing behaviour.
The notion that the mentally ill pose a threat to public safety forms a key element of Panorama's presentation of the debate about the use of Community Supervision Orders (CSOs) to control those who fail to take medication after discharge from hospital. 'Whose Mind Is It Anyway' examines the controversy surrounding CSOs against a backdrop of concern about asylum closures and an apparent lack of community supervision of the mentally ill. The programme opens with the case-study of a woman who murdered her two children within weeks of being discharged from a mental hospital. It reveals that she was not receiving support from the hospital and was left to supervise the children alone. The story of the double murder sets the tone of the programme by constructing violent criminality as an inevitable consequence of asylum closures and lack of close community supervision of the mentally ill. The popular image of the 'mad' as aggressive, out of control, and unable to control their actions, finds support in the programme's images of the mentally ill as criminal and potentially dangerous. Like Disguises, 'Whose Mind Is It Anyway' generates anxiety about the public behaviour of mentally ill people no longer cared for in asylums.

The programme provides a concrete illustration of potentially dangerous mentally ill people who would be affected by the CSO scheme:

Only those regarded as a threat to themselves or others would have Orders imposed. The charity MIND estimates as many as four thousand sufferers could be affected.

As the narrator's voice-over proceeds, the image track shows one of the apparently 'four thousand sufferers' who represent a possible threat to self/others. We see a man playing pool (fig. 7.20), followed by a close up of his face (fig. 7.21) at the moment
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Panorama (fig. 7.20)

Panorama (fig. 7.21)
the narrator says that CSOs would only be imposed on those regarded as a threat to ‘others’. The man’s facial expression and dishevelled appearance are presented as keys to his identification as a possible threat to others. The image of the dangerous madman with dishevelled hair and tattered clothes is a long-standing icon of madness, which is fully exploited, in this particular shot. The notion that violent or dangerous mad people can be identified by their facial appearance has a long history in Western representations of madness, and according to Gilman (1988: 11) derives from ‘an anxiety tied to a perceived tenuousness of life’. By picturing those who are liable to harm us we are reassured that we can identify danger before it befalls us. In the context of Panorama’s concern about the community supervision of schizophrenics, the idea that we can see who is dangerous has obvious appeal. The CSO scheme thus finds support in the programme’s representation of the pool player as an identifiably dangerous mentally ill person.

At the heart of Panorama’s concern about community care is the apparent absence of a proper monitoring system to ensure that potentially dangerous mentally ill people take their medication (the corollary of which is that mentally ill people will not become dangerous if they take their medication). Underpinning the controversy around CSOs however, is the degree of force needed to successfully implement the scheme. According to Panorama, this entails balancing a mentally ill persons’ civil liberty (to refuse medication) against the public’s right to safety from those people who refuse to take medication and who then become dangerous. In order to explore this issue the programme makers mobilise evidence from a CSO scheme operating in the American city of Madison. The scheme is described by the presenter as offering ‘better care [than in Britain] combined with greater force’. In the process of presenting the ‘greater force’ of Madison scheme the equation of mental illness with
danger is visualised in the form of Roger Tollerson. He is represented as exactly the type of schizophrenic whose potentially dangerous behaviour necessitates the use of force in order to protect the public. In Madison, we are informed, the implementation of force to control the mentally ill is the responsibility of specialist police officers.

The sequence in question begins with the programme’s presenter inside the car of one of the specialist officers as he takes an emergency call. To-camera, the presenter explains that a ‘mentally disturbed man has been seen brandishing a knife at a local restaurant’ and that ‘if this man needs medication, as is highly likely, then come what may the police will see him put on treatment tonight whether voluntarily or by force’. We then see a shot of a police car (with siren sounding) moving at speed (fig. 7.22). In the next shot we see Tollerson in the back of a police car apparently talking to himself (fig. 7.23). The presenter describes the scene thus:

A chronic schizophrenic has been arrested. It looks like Roger Tollerson has not been taking his medication.

The myth that schizophrenics are likely to be dangerous is amplified by the dramatic image of the speeding police car and the loud flashing police siren, both of which signify immanent danger. A sense of disaster narrowly avoided is generated in the very next shot where we see a knife on the dashboard of a police car (fig. 7.24). At this moment Tollerson is transformed into a potentially homicidal schizophrenic whose unobservable violent intentions are rendered graphically observable in the image of the knife. The presenter’s own (patronising) assessment of the situation (‘It looks like Roger Tollerson has not been taking his medication’) provides a simple cause and effect explanation in which Tollerson’s dangerous behaviour is the result of a failure to take his medication. The clear implication is that without medication
Panorama (fig. 7.22)

Panorama (fig. 7.23)
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Panorama (fig. 7.24)

Panorama (fig. 7.25)
schizophrenics are *compelled* to act in a potentially dangerous and criminal manner. The connection between schizophrenia and violent criminality is fully realised (indeed, *resolved*) in a final image where we see Tollerson in handcuffs being escorted back to hospital by the police (fig. 7.25). The use of this image to close the sequence conveys a strong sense of resolution: Tollerson is about to receive appropriate and *deserving punishment* for his dangerous and menacing public behaviour. For the programme's viewers however, the image of Tollerson being led away handcuffed puts in question the wisdom of current British mental health policy in which dangerous schizophrenic's are living amongst us unsupervised.

*Conclusion*

In this chapter, TV images depicting schizophrenia as 'difference' have been discussed. Such images confirm that schizophrenia is an *identifiably different* illness, for the most part because of the 'strange' public and private behaviour of schizophrenics. Our discussion has not disputed their 'difference'. Rather, it has sought to understand such images as part of a *continuity of representation* that has been enshrined in the public imagery of madness over centuries. Today's programme maker's (including the amateur Sharon) are, in some ways, simply reproducing traditional depictions. Nevertheless, televisual representations of schizophrenia carry a heavy burden for those who are assigned the role of being different. New opportunities for schizophrenics to participate in TV programmes about mental health issues - a clear dividend of Community Care policies - are tainted by enfolding the subject in a iconographic web that generally depicts how ill they are rather than how normal they are. Such depictions make it especially difficult for schizophrenic voices to obtain a fair and sympathetic hearing. If we want to improve the citizenship
prospects of those with a history of long-term mental illness then images suggesting that psychiatric disabilities persist, even after the patient has left the asylum, can easily undermine a speaker’s claims to credibility. In short, they not only impoverish those speakers whose ‘schizophrenic’ experiences are valuable *in themselves*, but the quality of public discourse as a whole.
Conclusion
Public Debate in Post-Modern Times

The much publicised disagreement between Habermas and Lyotard on the condition of contemporary public discourse, outlined in Chapter One, set the scene for an exploration of the state of public debate in late capitalism. The intention then (as now) was not to produce a final adjudication between Habermas and Lyotard. Rather, the more modest aim has been to explore the implications of the debate that they initiated for analysing discursive practices within the major institution of the contemporary public sphere; broadcast television.

Despite their fundamental difference on the question of what constitutes a "legitimate consensus", both Lyotard and Habermas alert communications scholars to the conditions for ensuring plurality in public debate, and it is against the political background of increasing vocal claims for greater plurality, that the analysis offered here has sought to understand television's performance as the pivot of the public sphere.

However, the argument between Habermas and Lyotard about the proper constitution of a public model of rationality overshadows its relationship to individual rationality. Because they debate the question in overtly abstract and general terms, their argument does not easily account for shifting or contested notions of rationality (and irrationality) at the level of everyday social dialogue and how these affect in turn, the process of public debate. In the case of the mentally ill, their return to 'the community' not only breaks the silence imposed on them within the asylum but focuses attention on the criteria by which they are given (or denied) a public voice.
Rationality, Responsibility and Personhood

What the asylum system produced was not merely confinement for large numbers of people but a whole way of seeing and understanding irrationality at the individual level. Consequently, medical accounts of mental illness have given rise to powerful cultural narratives that have historically devalued the social and political competence of the person with 'mental illness'. In practical terms this has meant the denial of mentally ill people's civil and political rights including, for example, the right to voice their refusal of psychiatric treatment or the right to express political preferences in the form of a vote. The legacy of mentally ill people's incarceration in asylums can thus be extended to include their exclusion from the wider political community.

Whilst the 1983 Mental Health Act currently allows mentally ill people the legal right to refuse psychiatric treatment (up to the point at which they are judged a danger to self or to others) the present Labour Government has signalled that compulsory treatment for mentally ill people who refuse medication whilst in the community will soon be legally enforceable. At the same time moves allowing mentally ill people detained in hospital the right to vote are also gathering political momentum. Together, these contradictory developments signal uncertainty (perhaps even ambivalence) about the criteria for judging the mentally ill as irrational/rational people.

Both these moves reflect doubts about what is meant by 'irrationality' (for example, whether it is a permanent state). Indeed, the tension generated by the encounter between 'rational society' and 'irrational individuals', now relocated within that society, illustrates how far personhood remains vulnerable to moral judgements about 'the responsible self'.

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It is this tension, I would submit, that governs our desire to fashion the mentally ill both as people like ourselves, equal members of our political community, whilst at the same time ensuring that their difference from ‘us’ - their irrationality - is dealt with at the medico-legal (pharmacological) level. In short, if mentally ill people are to be given civil rights then we can and must expect certain responsibilities from them - at the very least, that they will act responsibly and take their medication.

Despite the unresolved relationship between rationality and irrationality our understanding of mental illness are continually susceptible to historical and cultural representations that pivot on a categorical separation of the two spheres. On this point I am reminded of Gordon and Mark, the schizophrenics whom we encountered in Chapter Six. Their treatment by the Panorama production team illustrates the ease by which mentally ill people can be made to appear irrational and how this can prevent them from speaking on issues pertinent to their situation. Rationality is not indivisible but, as Gordon’s and Mark’s contributions to Panorama illustrate, it can appear so.

The binary opposition between irrationality and rationality conveniently obscures how individuals may be irrational in some respects whilst maintaining a ‘rational self’ in others. This may be hard for ‘normal’ society to accept but is something we must countenance if we are to overcome the limitations that this regimented opposition currently imposes on mentally ill people’s encounters with non-mentally ill others. Once again, I am reminded of Gordon.

In his encounter with the Panorama presenter, Margaret Gilmore, he articulates his recognition of the co-habitation of rationality/irrationality in the context of his ‘case management’ by the psychiatric service: ‘You see’, Gordon tells Gilmore, ‘the idea is
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to let the undamaged parts of the brain come out and let them enjoy themselves like any normal person...’. My own interpretation is that living with the co-existence of irrationality/rationality is part and parcel of the human condition and that like Gordon, we have to acknowledge our own irrationality/rationality if we are to better understand and make allowance for those who appear different from us.

*Television and Public Debate*

Since John Reith’s time, a swelling chorus of voices have criticised professional broadcasters for the ways in which they orchestrate public debate. Over decades this argument has come to centre around the opposition between paternalism and populism. Attempting to navigate this modern day Scyilla and Charybdis, programme makers have sought a safe passage between respect for expertise and celebrations of common sense and vernacular experience.

But this familiar duality is over simple. It conceals a significant tension within populism, between programmes rooted in common sense as a prevailing consensus (“what everybody knows”) - which we can call ‘commercial populism’ since its heartland is in the commercial TV sector where assembling mass audiences for advertisers is an economic imperative, and programmes that seek to give a platform to voices marginalized by both expert and mainstream vernacular discourses, which we might call ‘radical populism’.

It has been widely noted that television has become much more populist in recent years and whilst some programme forms (e.g. *Video Diaries*) can be fairly seen as instances of ‘radical populism’, the majority are examples of commercial populism. Of these the new talk shows are the most ubiquitous.
Populist Television and the Representation of Mental Illness

The representation of mental illness and of mental patients provides a particularly productive case study of the organisation of public debate within the changing television system. There are two reasons why this is so.

Firstly, mental patients are the archetypal ‘other’ - representatives par excellence of the non-normal. They therefore offer a major instance of commercial populist television’s mobilisation of an imagined ‘us’, united by common sense.

Secondly, by virtue of their “condition” they are likely to judged as incompetent to speak on their own behalf. They therefore pose problems for radical populism’s ambition to give a voice to the marginal and to deconstruct prevailing stereotypes of the ‘other’.

Representing Mental Illness in an Era of Community Care

Contemporary representations of mental illness however, must be placed in the context of the major shift, from asylum treatment to care in the community. This massive reorganisation of the mental health system has several implications for the politics of televisual representation.

Firstly, the demise of the asylum means that the mentally ill are now more available to programme makers compared with the problems of gaining access to secure institutions.

Secondly, at the same time, the dominant image of the mad as “bad”, “unpredictable” and “dangerous to know” has both reinforced their ‘otherness’ and grounded it in
everyday experience. An increasing number of people now encounter the mentally ill - on the streets, in shopping centres, and other public spaces.

Thirdly, by distributing care for the mentally ill over a wide range of groups - from community nurses to family members and other voluntary carers - the shift to community care has decentred medicine and psychiatry as the sole source of relevant expertise and opened up uncertainty and debate on what sorts of expertise's/experiences mandate authoritative comment on the causes and treatment of mental illness.

Mental Illness, Radical Populism and Public Knowledge

These developments also have implications for television's future mediation of mental health issues. The greater accessibility of current and former mental patients, as well as the continuing uncertainty as to what counts as 'authoritative comment' on mental illness and community care, generate difficult questions about the 'desired' balance between testimonial and analysis in public debate about mental health. The principle issue concerns the kind of analysis one believes television should provide in order to underwrite citizens' rights of access to knowledge about mental health/illness.

The problem can be expressed as a question: what sort of knowledge about mental illness and mental patients do we get from radical populism? Certainly, self-representation formats like Video Diaries can provide valuable ethnographic insights into the world of the mentally ill 'other'. Indeed, the 'thick descriptions' offered by 'schizophrenic' subjects like Sharon may well help to build bridges between the worlds of reason (rationality) and emotion (irrationality) in ways not presently available in either the talk show or the classical documentary format.
But we are also faced with another question: what exactly does Video Diaries contribute to the stock of public knowledge? The diarist’s individual point of view certainly. But what it does not (indeed cannot) offer is any coherent analysis of the myriad factors which may have contributed to the formation of the diarists’ subjectivity and point of view or of the factors which might, in another context, oppose or challenge it.

Herein lies the rub. It is precisely because self-representational formats only generate analysis/interpretation at the situational level that we must be sceptical of any claim that they offer a ‘corrective’ balance to whatever ‘distortions’ one believes constricts a comprehensive explanation or understanding of the issues raised by individual diarists. But what sort of ‘corrections’ or ‘balances’ would be necessary if television is to further public understanding of the social world?

For example, what sort of abstracted knowledge/expertise(s) should radical populism draw upon? Whilst Video Diaries’ achievement in giving voice to ‘others’ is important, it also easy to overlook how access-led initiatives fail to make sense of the social formations and cultural patterns that constitute the contexts and resources out of which ‘inner experiences’ are constructed. The danger, quite simply, is that an anti-analytic aesthetic may come to dominate public television leaving personal biography and local ‘truths’ as the only interventions on offer.

To avoid being dragged too far into the pit of relativism it is my contention that television’s future mediation of mental health/illness needs to ‘balance’ the fleeting and superficial ‘pull’ of lived experience (however interesting it may be) with analyses of the historical situations and the cultural formations from within which
those grounded voices are speaking. This means valuing (and also continually evaluating) the role of discourses of expertise within public culture without either automatically prioritising or undermining them.

My hope is that forms of representation will be developed which combine ethnographic depth with critical social enquiry. Exactly what these future representational forms will ‘look’ and ‘sound’ like will depend on the experiments that programme makers undertake, but communications and media scholars can help to develop an informed audience for new initiatives in this area by taking more seriously than hitherto the analysis of televisual form as an object of study.

*Situating the Analysis of Television Form*

The analysis of the ways television programmes represent particular areas of social life has generally been sharply divided between quantitative and qualitative approaches. Content analyses provide a broad brush picture of the structure of attention - what/who is featured, how much prominence they receive, and what is ignored or marginalized. In contrast, studies drawing on qualitative methods - from semiotics to discourse analysis - tend to deal in detail with particular cases, but pay little attention to the problems of sampling.

The approach used here - though it has involved a close reading of particular programmes - is based on a clear sampling strategy. It is not a random sample but a quota sample. It sampled all actuality programmes dealing with mental illness broadcast on the four main terrestrial channels over a designated period (2 years) with the intention of locating ideal typical instances of the major forms of current programming.
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*Analysing Television Form*

Form is an essential (but still relatively neglected) mechanism for organising both representations and public debate. The way any actuality programme - from a ‘classic’ current affairs format to a talk show - organises discourse about a particular domain (in this case mental illness) can be looked at along three dimensions:

1. **visibility** - what is shown and who gets to speak? what range of viewpoints is brought into play? is the programme relatively open in the sense of mobilising a range of discourses or is it closed around a particular position?

2. **legitimacy** - whose views are given credibility and respect and whose are denied it?

3. **hierarchy** - whose views are given precedence in the sense of setting the agenda and prescribing the terms of debate?

The analysis offered here has attempted to show how these processes work in relation to the major forms of contemporary actuality programming.

In terms of visibility, our analysis suggests that programmes can be usefully seen as mechanisms for organising who will speak in public and how. In the ‘classic’ format of *Disguises*, the journalist Holloway speaks for and on behalf of schizophrenics living in the community. Although he encounters real schizophrenics they are only allowed to speak within the expositional structure of the programme; as victims of a system that (literally) does not care. In contrast, representatives of the psychiatric profession speak for themselves within the programme.
In *Kilroy*, the talk show format gives schizophrenic participants an opportunity to address the audience directly about their voice hearing experiences. However, the programme’s closure around a medical model of mental illness means that they are not invited to speak about their experiences of care in the community. This is the prerogative of other, non-mentally ill, speakers deemed by the host to be more qualified on this particular topic.

In contrast, *Video Diaries* provides a radical mechanism for side-stepping professional control over the means of public representation. The diary format gives Sharon an unmediated opportunity to represent herself publicly, and in her own words. Not only is she able to reject the illness label, she is able is to provide her own interpretation of why she became mentally disturbed without sacrificing her credibility in the process.

In terms of legitimacy, we have argued that the form that a programme takes determines whose views are given credibility. In *Panorama* for example, the representation of Gordon and Mark as incoherent/incompetent denies them an ‘informed’ viewpoint on compulsory treatment whereas the views of other, non-mentally ill, speakers are treated as more credible and worthy of respect. The programme’s thematic orientation, in favour of the ‘irrationality of non-compliance’, militates against the possibility that either man can make a credible contribution to the programme’s debate on this issue.

In contrast, the testimony of voice hearers in the science programme, *Horizon*, is treated with considerably greater sympathy and respect. The programme’s argumentative thrust allows voice hearers to speak about their experiences from within their own life-world perspective, and to interpret these experiences as
meaningful. However, the programme’s makers are careful to support the space given to voice hearer’s’ testimonies with strong statements from suitably qualified mental health professionals declaring that they consider it therapeutically appropriate to listen to what they have to say.

In terms of hierarchy, *Broken Poets* for example, privileges the voices of the psychiatric profession over other mental health professionals working in the field of black mental illness. Although the programme’s agenda is orchestrated around a socially grounded model of black mental illness, a traditional hierarchy of expertise is mobilised with medical knowledge placed firmly at the top.

*Black and Blue* deploys the testimony of a black counsellor to set the agenda for its critique of orthodox Western psychiatry. Within the thematic context of the programme, her testimony signals community care as an appropriate arena for treating black mental illness. However, affirmation for its core argument again comes from within the ranks of the psychiatric profession. By giving a black psychiatrist the final word in the programme, the ‘Afro-centric’ model she proposes re-asserts the psychiatric profession as the ultimate font of knowledge about black mental illness.

_Suggestions for Further Research_

This present research was intended as an extended exploration of television’s performance as the pivot of the contemporary public sphere. It suggests three lessons for further work.

Firstly, it demonstrates that sampling by programme forms, and looking in detail at the way particular forms organise representation and discourse, provides a fruitful
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base for systematic qualitative research which could and should be applied to other areas.

Ideally, such probes would include fictional genres alongside actuality programming, though time and resources did not allow the research to be extended in this way in the current work.

Secondly, the findings confirm the important role of visual images as well as discourses within orchestrated social debate.

It shows that arguments and debate are rooted not only in the juxtaposition between the voice track and the image track but in sequences of images themselves. In the context of a television system increasingly reliant upon 'imaged actuality' this has important consequences for the quality of public debate and argument.

Thirdly, the results pose important questions for future television policy. If the television system moved more forcefully towards commercial populism (as many observers are predicting) what would be lost in terms of its capacity to:

(a) offer representations of situations and issues that did justice to their complexity and which decentred or questioned prevailing stereotypes.

(b) mount a public debate on the causes of current situations and the possible responses to them, that did justice to the contestable nature of claims - including those made by designated experts.
Conclusion

Our findings suggest that democracy is best served by the maintenance of a range of contrasting programme forms that provide a variety of ways of organising public representation and debate.

Final Reflections

As I write these final remarks, the mental health field is again experiencing (sometimes bitter) winds of change. Various interest groups are gathering in order to stake out their vision of the future of mental health policy and practice in Britain. Between incarceration in 'secure' environments and the relative 'freedom' of community care, a repertoire of professional and lay discourses are engaging in a struggle to be seen and heard. The quality of this debate however, lies largely in the hands of professional broadcasters whose task it is to marshal this debate on our behalf. In an era of growing commodification of public debate and representation it is by no means certain that they will succeed. But as this thesis shows, ensuring the television system provides the widest possible range of programme forms is one of the best hopes we have for enhancing and maintaining democratic public life.
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