# CONCLUSION

## AN 'OTHER' ETHIC

> Simply by listening to and supporting our consumers, we helped them achieve more therapeutic success than could ever have been possible through conventional means (Macek, 2000).

Touraine's account of new social movements has highlighted issues of identity as central to the new social movement's opposition to totality. The consumer/survivor movement attempts to disrupt the accepted power and legitimacy of mental health services in preference for a model of recovery. To achieve this, the consumer/survivor movement, characteristic of other social movements: 'draws strength from its past in order to hurl itself toward a future that is to abolish the present dependence' (Touraine, 1977: 324). Similarly, psychiatric professionals draw on their own past learning and experience in order to persuade consumers of the benefits of 'biological treatments'. Consequently, the consumer/survivor movement continues to battle with its adversary in an attempt to redress the abuses of the past by redefining the future. As Touraine states:

> A social movement can be recognised by the fact that it speaks both in the name of the past and in the name of the future, never solely within the categories of the present social organisation (Touraine, 1977: 324).

The conception of the subject is at the heart of the debate in acute psychiatric services and, as identified in the preceding chapters, varies according to the social, political and economic factors that influence what conceptions are valued or legitimised. Dominant conceptions of

the subject are necessarily driven by professionals' vested interests. The consumer/survivor movement articulates a perspective otherwise silenced through social and legal sanctions. The failure to recognise the ethical, legal and social subject in acute public psychiatric services has resulted in coercive, involuntary and impersonal treatment. The removal of civil rights through social practices and involuntary detention, authorised by the *Mental Health Act 1986* (Victoria, 1998), leaves inpatients without voice and without recourse. It is time for the limitations of the psychiatric perspective to be conceded and the consumer/survivor perspective recognised.

According to Rorty (1979: 318), social processes rather than epistemology account for the 'transaction between the knowing subject and the reality'. Psychiatry's epistemology justifies the technical approach of diagnosis and treatment but this prevents understanding the patient as a person. The conception of the professional as 'knowing' is denied to patient and this means the patient is predetermined: he/she is reduced to an object and, in the process, eliminated as a subject. The way to address this problem is by disarticulating the power and legitimacy conflated in culturally acceptable mental health practices hidden from appearance through legal and cultural sanctions. This in turn facilitates the acknowledgement and validation of consumer/survivor ways of knowing.

To acknowledge the view of consumer/survivors is not to deny the validity of professional knowledges—indeed these have their place—but

to entirely disregard the views of consumer/survivor promotes a passive ignorance of the differences between them. That is, utilising a scientific epistemology alone is problematic as it assumes that consumer/survivor needs are commensurable with the scientific ones, which as we have seen, they are not. Any dissenting views are constructed as irrational, cognitively disordered or illogical, rather than as having an inherent logic. Epistemology, then, assumes totality and commensurability and to suggest the possibility of incommensurability questions the rationality of traditional epistemology in its own terms.

The incommensurability of psychiatric and consumer understandings of problems is due to the fundamental difference in the *way of seeing* or philosophy between them which has implications for how the subject is treated. The differences between these approaches are entrenched in the different traditions of practices and methods accompanying these different conceptualisations. Understanding is incongruous with a scientific methodology, which is dependent on what is seen.

What is required to respond to the consumer movement's demands is a different rationality and practice: rationality based on dialogue or conversation in an exchange based on consent. This is reached, as Levin notes through an:

> open democratic processes of communication in which all those affected, concerned or influenced by the matter in question have been able to participate without coercion (Levin, 1989: 35).

The implication of the recognition of a consumer/survivor perspective is an ontological approach that legitimises *being with* and *listening to* a person in distress as opposed to doing something.

To listen to a consumer/survivor and their perspective is to affirm the incommensurability of these discourses with scientific ones. If the gap between the consumer and provider discourse is a difference in perspective, this gap is not going to be bridged by a single all-encompassing discourse or an alternative conceptualisation as such. What is required is to not interpret consumer/survivor accounts into professional epistemology, but to 'pick up the language of the interlocutor rather than to translate it into one's own' (Rorty, 1979: 103). This requires alternative methods and approaches in mental health services, which attend to the different conceptualisations utilised by the consumer/survivor perspective.

In practice, this would call for recognition of the acute psychiatric subject as an ethical, legal and social subject. This recognition would be made available through listening to consumer/survivor narratives. Listening is the portal, access or doorway through which people get to experience themselves as ethical, legal and social subjects. It is the route through which a person experiences him/herself as a subject. Listening to peoples' narrative accounts involves valuing being with people. It is about understanding a person through being in their world. It is convivial rather than interventionary. This requires listening not for the narrative as such, but for subjectivity. It is *being-with, being-*

*understood* and *being-connected* that facilitates recovery, as it validates the person in their world as a *human being*. Failure to provide this validation through an absence of listening indicates a lack of respect for the patient as a person.

Listening to a person's narrative can also identify breaches to the ethical, legal and social subject. Listening to a consumer/survivor reveals what is meaningful for him/her and acknowledges, rather than disregards the processes of identity formation and recreation. What facilitates recovery is working with processes of identity through identifying and responding to the meaning of symptoms. This requires discovering what is meaningful for a person. This requires being with a person and providing an opportunity for a person to express and therefore process what he/she experiences as causing symptoms. This ethical approach is urgently needed in acute psychiatric services.

Structures need to be put in place that facilitate this process. As we have seen, professional dependence on explanatory models in the process of psychiatric hospitalisation, diagnosis and treatment mean: 'there is only as much movement toward the object as is necessary for distancing it even more' (Fiumara, 1990: 107). The problems of the professional failure to understand could be overcome by deploying as professionals as has been outlined in chapters six, seven and eight through the work of Laing, Ricoeur, Levinas and Honneth, what Fiumara (1990) calls the 'listening subject'. Otherwise, Fiumara (1990: 67) suggests 'there are no listening subjects but simply objects in a

relation that is not founded upon dialogue but possibly a sadomasochistic interaction'.

What has been suggested here is that people with 'mental health problems' are no different from other humans: all human beings give meanings to events in an attempt to bring order to the chaos of their lives. These meanings have implications for identity. As such, the humanity of mental illness could be reintroduced back into psychiatric treatment by inculcating an ethic of practice in line with the concept of the subject as a narrative subject. Narrative methodology is the means whereby the patient as a person can be understood in terms of their own interpretative framework. Recognising the context of symptoms in terms of the history of events makes symptoms understandable, while the narrative provides coherence, meaning and structure for the otherwise uninterpretable events of life.

This narrative understanding of the subject explains why practices, which disregard the narrative, are experienced as patronising, disrespectful and damaging and makes clear the importance of narrative practices to mental health services. With this in mind it seems an ethical imperative to add to current practices in mental health services the opportunity for patients to articulate their narrative account of events, and to provide patients with the opportunity to explore the function of the narrative in the construction of identity. This revised conception of the subject in acute psychiatric services requires an ethic respectful of patients' autonomy.

Introducing narrative practices into acute psychiatric services would be a means of introducing ethical practices. This would involve the introduction of services that offer respect for the patient as a human being, rather than as an ill object. That is, practices of being with and listening to patient narratives would become legitimate in acute public mental health services. Survivors claim they are experts on their own experience and healing. That expertise needs to be framed within rather than excluded from a conception of the physical, sexual, emotional, and spiritual damage caused by life events to survivors, thereby legitimising their discourse.

Evidence of an ethical practice would include recognising patient narratives as a legitimate point of view. Under this model, expression of acute psychiatric patients' unarticulated feelings would be made possible through a variety of artistic means such as through the use of music, dance and painting. Patients' narratives would be understood as providing coherence, meaning and structure for the otherwise uninterpretable events of their lives. The role of patient narratives in describing, explaining and predicting life would be central and to some extent, would make psychiatric symptoms understandable and predictable. Further, such an ethical practice would involve patients in every aspect of clinical services.

In the context of Australia's National Mental Health Plan, a strategic innovation could be the introduction of the consumer perspective, a goal which consumer/survivors, scholars and psychiatric professionals

alike could pursue. Ultimately, the goal here is for respectful relationships in mental health services. These need to be based not only upon free will, but upon positivity emerging from love. The *unique* and *absolutely other,* as Levinas (1993b: 95) reminds us, 'can only mean their meaning in the loved one and in oneself'. That is to say, there is to be a recognition of difference without indifference and a recognition of the responsibility to the other which is an 'inexhaustible responsibility' which is 'never settled' (Levinas, 1993a: 95). As I have argued throughout this thesis, it is this ethic of the other or other based ethic that is required to address the current state of crisis in the delivery of acute public psychiatric services in Australia and internationally.