How do individuals having experienced psychosis and living 'Outside Mental Health' resist the dominant discourse about psychosis by constructing a counter-discourse?

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Abstract

Since the occurrence of the psychiatric profession, many attempts have been made to challenge its dominance regarding the care for individuals with mental health problems and the ways we talk about these problems. Still, the psychiatric system holds great discursive power and is deemed very resistant to change. Patient empowerment and giving a voice to alternative discourses about mental illness is thus deemed an ongoing battle. Therefore, this paper investigates how individuals who have experienced psychosis and have been abused or maltreated in their subsequent stay in a psychiatric hospital resist the dominant discourse about psychosis by constructing a counter-discourse. In this endeavor, a Foucauldian Discourse Analysis (FDA) is conducted by analyzing 18 excerpts from the book 'Outside Mental Health' published by Will Hall. The research gap targeted with this paper is its application of FDA to autobiographic accounts of ex-patients constructing counter-discourses about psychosis. Four broader discourses in the form of two contrapositions are identified: 1) psychosis as a social phenomenon vs. psychosis as a spiritual phenomenon, and 2) the discourse of radical opposition to psychiatry vs. the discourse of reconciliation with psychiatry. Practical implications of these findings regard the circumstances under which the best possible care for people with mental health problems can be given. In particular, the reconciliation approach gains much relevance in this context as it urges to view psychiatry's wrongdoings as mere symptoms of more deeply entrenched social, political, and economic problems that have real life consequences for the quality of caregiving. Instead of resorting to trench warfare between those that provide and those that receive mental health services, the reconciliatory discourse pleads to trace psychiatry's problems upstream and shift focus to these underlying structures of oppression and disempowerment that hinder humane and progressive ways of relating with people who experience mental health problems.

Keywords: Foucauldian Discourse Analysis, psychiatric survivors, psychosis, counter-discourse

Introduction

The question of how the mad members of society should be treated has been controversially debated for ages. First accounts can be traced back to 1399 where the 'ship of fools' deported madmen out of town (Mason, 2023). Similarly, the Bedlam riots in the 17th and 18th century (Andrews, 1991), as well as protests against involuntary admission to mental clinics in the 19th and 20th century gained public recognition. It was, however, not until the 1960s and '70s that a broad movement directed against psychiatry's dominance and malpractice gained immense momentum when psychiatrists such as David Cooper, R.D. Laing and Thomas Szasz became the leading figures of the anti-psychiatry movement. They publicly demanded the abolition of psychiatry as they saw it as an invalid medical discipline which does more harm than good and is thus broken beyond repair (Ralley, 2012; O'Brien et al., 2001; Nasser, 1995). While the movement became a popular cultural phenomenon within the emerging left-wing counterculture, mainstream psychiatry felt seriously threatened by it and launched a counterattack by overhauling the diagnostic definitions in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) – with instant success. The DSM-III reaffirmed psychiatry's hegemonic power and the movement lost momentum and slowly faded away (Ralley, 2012; Double, 2006).

Nowadays, scholars highly acknowledge the movement's sustainable impact as can be seen in language modifications, advocacy groups promoting the rights of the mentally ill and most importantly the widespread provision of community care (Nasser, 1995). Other authors underline the anti-psychiatrist's unique influence of new critical movements. Their efforts to challenge paternalistic power dynamics in mental health care have achieved greater empowerment of patients as they became more actively involved in policy and decision-making. However, in a harsh economic environment involving insurance companies, the pharmaceutical industry, the psychiatric profession and the hospital industry, patients are not deemed to represent a powerful lobby (Tomes, 2006). Kazdin (2000) underlines that apart from more active patient involvement, the discerning criticism "has not yet translated into obvious

political gains" (pp. 356-357). Given the mental healthcare system's strong resistance to change (Everett, 1994), patient empowerment is thus deemed an ongoing battle (Tomes, 2006).

On these grounds, this paper reflects on the power struggles within the mental health sector and the role that critical voices play in it. By conducting a Foucauldian Discourse Analysis (FDA), the paper examines how critics of psychiatry form resistance against the dominant, biomedical discourse by employing alternative discursive constructions. This is done by analyzing excerpts of the book 'Outside Mental Health' which gives voice to individuals who have been hospitalized due to psychotic symptoms and experienced abuse and mistreatment in psychiatric institutions. The emphasis on psychosis is chosen as this stands in the tradition of the anti-psychiatrists because it was and arguably still is one of the most severe and puzzling psychological experiences. The sole focus on ex-patients who have had such experiences lies within the logic and purpose of this paper which is patient empowerment.

The dominant discourse

The dominance of the biomedical discourse can be traced back to the emergence of asylums in the 19th century which provided a convenient opportunity to scientifically study large numbers of patients. Physicians, thus, gradually assumed the responsibility to not only observe and classify, but also to treat extreme mental states as they would do with any other illness. Physicians such as Griesinger and Kraepelin established the notion that madness is an organic condition rooted in lesions or dysfunctions in the brain (Ralley, 2012; Burston, 2018). This purely biomedical understanding of madness as a disease was thought to give the patient dignity and absolve them from stigmatization and guilt (Ralley, 2012). Although contemporary approaches still emphasize genetic vulnerability, neurodevelopmental abnormalities, pre- and postnatal factors, as well as irregular neurotransmitter activity as the most reliable etiological factors (Walker et al., 2004; Patel et al., 2014), the diathesis-stress model is currently considered the prevailing explanatory model for schizophrenia. This model states that vulnerability is present at birth and later in life clinically expressed by either environmental stress or adolescent

neuromaturational processes (Walker et al., 2004). Thus, there is a tendency towards more recognition of social factors resulting in the extension of the biomedical model to a biopsychosocial model of schizophrenia (Gask, 2018). Despite these advancements, researchers, as well as institutions such as the American Psychological Association (APA) and the National Alliance for the Mentally Ill (Cooke & Kinderman, 2018), have reached a "clear consensus that schizophrenia is a brain disease" (Walker et al., 2004, p. 402).

Resulting from the complex etiology, ideal treatment for schizophrenia is considered to be a combination of pharmacotherapy, psychotherapy and community support (Walker et al., 2004). Actual practice may be far from this ideal, as the authors state: "In reality, however, medication is both the first and the *only* treatment received by many patients" (Walker et al., 2004, p. 419). In a similar vein, the official treatment guidelines by the APA note that 1) treatment systems currently fail to offer and properly implement evidence-based treatment, and 2) even the current gold standard of treatments neither satisfactorily minimizes adverse effects of schizophrenia nor enables patients to live full, productive lives (Lehman et al., 2010).

In sum, the dominant discourse views schizophrenia as a chronic brain disease but increasingly incorporates environmental factors as portrayed in the biopsychosocial understanding and diathesis-stress model. Optimal treatment consists of medication, psychotherapy and community support, even though actual practice may not hold up with this ideal. Furthermore, it is important to note that the puzzle of schizophrenia is far from being solved (Walker et al., 2004) and the above considerations are products of a long-lasting, complex discourse. Therefore, conceptions regarding the etiology and nature of schizophrenia, as well as resulting treatments may vary between countries, institutions, and individuals.

The critical discourse

The anti-psychiatrists were the first to start a broad, international movement that entirely

rejected the biomedical model of mental illness. Instead, they insisted on reconsidering sociocultural, political, and personal factors (O'Brien et al., 2001).

Cooper who popularized the term 'anti-psychiatry', understood schizophrenia not as a disease but as a response to unbearable stresses of life. These stresses originate from the own family which invalidates the person's own experiences and violently enforces a false set of ideals along the lines of society's exploitative structures (Ralley, 2012). Anyone who deviates from this norm is labeled schizophrenic. This act of fundamental violence inflicted by family and society is perpetuated in psychiatric hospitals. He reversed notions of sanity and insanity by stating that right when starting to become sane, people would often enter the hospital where they then become passive and inert, conforming to society's alienation (Double, 2006).

Laing, who is considered the true father of anti-psychiatry (Nasser, 1995), too viewed society as extremely alienating. The process of becoming schizophrenic would occur because family and society exert immense pressure to conform on individuals. Those would eventually give in to this pressure by developing false selves in order to safeguard their real selves from harm. These false selves are reinforced by society while the true self is repeatedly disconfirmed. To protect from this ongoing disconfirmation, individuals further distance themselves from their true self until it finally breaks down entirely, ironically realizing what it is supposed to defend against (Ralley, 2012). Schizophrenia, according to Laing, is thus a creative protest against society's alienation. In contrast, good adjustment to these conditions puts the individual in pseudo-realities, unable to develop genuine critical and empathic faculties (Nasser, 1995; Burston, 2018). Psychiatry, however, promotes such adjustment to "social phantasy systems" (Laing, 1961, as cited in Burston, 2018) and prevents authentic experiencing and expressing of the self. Its reliance on the biomedical model negates the social nature of schizophrenia and further invalidates the individual's attempts at unraveling the agonizing interpersonal affairs that have put them in their misery. Instead of helping the individual to heal, psychiatric agents thus exert and

perpetuate social control by coercive treatments such as medication or electroshocks (Burston, 2018).

Szasz denied the concept of mental illness altogether. He argued that disease is defined by a physical lesion that leads to an observable change in function. Since mental suffering demonstrates no such lesion, the term 'mental illness' is improperly used and should be refuted (Ralley, 2012). Consequentially, psychiatry as a medical discipline has no justification to treat any malfunction that is not physical. Such practice in fact disguises the social power that psychiatric institutions exert. By labelling unwanted behaviors as sick and treating them as symptoms, psychiatry unlawfully acts as a moral agent betraying their own scientific claims (Ralley, 2012; Moncrieff & Middleton, 2015).

As stated above, the anti-psychiatric movement greatly influenced later social movements that aimed to challenge psychiatry's dominance by documenting and analyzing its wrong-doings. The user movement and psychiatric survivor movement (Bracken & Thomas, 2010) are important contemporary critics, seen as two factions within the same movement (Everett, 1994; Rose, 2008; Ochocka et al., 2006; Tomes, 2006) with differing levels of criticism and demands. Although the distinction is not entirely clear-cut, both movements consist of individuals with lived experience of mental illness (Haslam, 2022).

The user movement criticizes the over-reliance on the biomedical model while not rejecting it completely. They propose a multifactorial interplay in the occurrence of schizophrenia, considering biological factors as only one of many explanations (Cooke & Kinderman, 2018). In contrast, psychiatric survivors reject the entire biomedical model, arguing that there is no scientific evidence linking schizophrenia to brain impairments or dysfunctions (Moncrieff & Middleton, 2015). They view schizophrenia as a spiritual, familial, or holistic crisis, valuing madness as a source of critical insight (Zucker, 2014; Speed, 2006). Survivors fundamentally challenge the concepts of mental illness, normality, and reality, seeking to overthrow established truths (Zucker, 2014). Users, on the other hand, advocate viewing mental illness as a psychiatric disability and aim to minimize stigma associated with labeling (Adame, 2014).

Regarding psychiatry as an institution, users acknowledge its legitimacy and strive for reform, seeking patient involvement, diverse treatment options, and more humane practices (Adame, 2014; Everett, 1994). In contrast, survivors entirely reject psychiatry's legitimacy, resisting treatment and challenging its core existence due to past experiences of abuse and coercion (Zucker, 2014). They advocate for alternative treatments, fight oppression through legal and activist means, and aim to establish dignity and social inclusion for (ex-)patients (Speed, 2006).

While users work with the psychiatric system, survivors work against it, aligning with the anti-psychiatrist tradition. Survivors accuse users of being too mild and eventually succumbing to psychiatric pressures, while users believe survivors' radicalism hinders meaningful change. Despite these differences, both movements are intertwined in challenging the dominance of the psychiatric system and the over-reliance on the biomedical model (Everett, 1994).

Foucault

Foucault had a rather different approach as he wanted to challenge the legitimacy of not only psychiatry but of *any* group that claims sovereignty over the interpretation of madness. He delineated how psychiatry emerged in close relation with economic and political interests (Bracken & Thomas, 2010; Walker, 2022). With the advent of reason in the Renaissance, society was in need of its counterpart, the unreason, and found it in the mad (Nasser, 1995; Erb, 2006). The resulting need to exclude and confine them led to the invention of psychiatry and the medicalization of madness which further enabled the objectification of individuals into norms and categories (Erb, 2006). This also demonstrates the technicalization of mental states as these are seen as ‘things’ that can be examined, classified, and fixed (Bracken & Thomas, 2010). It further highlights the normalization of individuals as this process creates certain values and codes such as productivity, rationality, and self-discipline that the individual is judged against and penalized in case of deviation (Burr & Dick, 2017). Paradoxically, this power/knowledge structure is not per se oppressing the individual but on the contrary, is the very thing

that gives rise to it. Through the process of normalization, power constructs the individual by creating the norms and standards that define how we understand ourselves (Khan & MacEachen, 2021). Power is thus relational and so is the alleged dichotomy of dominance and resistance with one of each always containing the other. Resistance enables power relations as otherwise, there would be nothing to exercise it against. At the same time, power always includes the possibility to resist it. Thus, "Foucault (1982) suggests that at the very 'heart' of such relations and constantly 'provoking' them are 'the recalcitrance of the will and the intransigence of freedom' (pp. 222–223)" (Roberts, 2005, p.39).

Foucault sees the solution to oppressive discursive structures, such as psychiatry's monologue about the mad in fighting these structures. He states that discourse analysis, as in his own works, is a powerful tool to re-interpret psychosis and thus re-direct power to the oppressed (Haslam, 2022).

Prior research

Existing qualitative research demonstrates some similarities to the present study.

Adame (2014) interviewed a psychiatric survivor who now works as a therapist and reports of his own experiences in hospital, as well as his conflicts in his double-identity. Ochocka et al. (2006) juxtaposed mentally troubled individuals who were either active or nonactive in consumer or survivor movements to identify helpful qualities of these initiatives. Marriott et al. (2019) examined how individuals having experienced psychosis use spiritual frameworks to achieve narrative insight into their experiences. Haslam (2022) conducted an FDA examining alternative conversations about mental health. He, however, did not include members of the user or survivor movement but focused on psychotic creativity by interviewing three individuals who incorporated their psychotic experiences in creative art forms. Walker (2022) carried out an FDA about different constructions of mental health recovery employed by mental health practitioners. She also contrasted dominant, biomedical constructions of recovery with more alternative ones which she understood as acts of resisting discursive power structures. In closest similarity with the present study, Speed (2006) compared the

discourses of classical patients, users, and survivors to identify different ways of talking about mental health. The difference to this study lies in Speed (2006) conducting an interview with three individuals himself, as well as an approach to discourse analysis derived by Gilbert and Mulkay (1984). Thus, he does not investigate these discourses in terms of power and resistance but merely seeks to empirically validate the existence of these three different types of discourses. Consequentially, the research gap that this paper targets is the examination of individuals who may or may not identify as users or survivors but have experienced psychosis and have been maltreated in their subsequent stay in a psychiatric hospital. By means of an FDA, this paper is guided by the question of how these individuals form resistance to the dominant, biomedical discourse by constructing alternative discourses about psychosis.

Method

Study Design

To answer the research question, a Foucauldian Discourse Analysis (FDA) is conducted. This is done because the book which will be analyzed is intentionally written to "create a vital new conversation about empowering the human spirit through transforming society" (Hall, 2016, preface). It is further meant to be a counterbalance to the current discourse and "a conversation that is much broader, and more honest, than the one we've been having" (Hall, 2016, pp. 12-13). These explicit claims of providing a counter-discourse in order to dismantle power imbalances strongly suggest an FDA as this type of analysis primarily addresses the connections between knowledge, discourse and power (Gray Brunton et al., 2018).

In FDA, discourse is seen as both language and practice (Kaselionyte & Gumley, 2019). Discourses "enable and constrain what can be said, by whom, where and when" (Willig & Rogers, 2017, p.112) but these discursive statements construct the very objects that are talked about. They further offer various subject positions, that are understood as "positions of one's agency and identity relating to

particular forms of knowledge and practice" (Kaselionyte & Gumley, 2019, p. 5). Discourses, thus, construct ways of being and ways of seeing the world, in both social and psychological terms (Walker, 2022). They construct certain versions of reality and these versions are not only dependent on the historic, social and cultural context, but also have real-life implications (Kaselionyte & Gumley, 2019). Discourses interact with social and institutional practices to reinforce and validate each other. In this context, FDA highlights that discourse, knowledge and power are inextricably related (Kaselionyte & Gumley, 2019). The dominant discourse privileges a certain version of reality that legitimizes existing power structures. Over time, such discourses become so entrenched that they are perceived as common sense, making it difficult to challenge them. However, language is inherently flexible and alternative constructions are always possible, leading to the emergence of counter-discourses (Willig & Rogers, 2017; Walker, 2022). At the same time, the production of knowledge is deeply intertwined with power, and certain constructions may become regarded as the truth, reinforcing power imbalances. To diffuse such power, it is important to recognize and value marginalized accounts and alternative ways of conceptualizing knowledge (Kaselionyte & Gumley, 2019). This, as emphasized previously, is one main goal of this study.

Participants

Participants were selected from the book 'Outside Mental Health' which is published by Will Hall and contains accounts of 65 people who either wrote a chapter by themselves or were interviewed by Hall. The interviews which make up the largest proportion of the book are transcriptions from real life interviews that were held in Hall's podcast "Madness Radio". The inclusion of participants was based on two criteria: 1) They must have had psychotic experiences, and 2) They must have been hospitalized for these. These two criteria have been chosen because, as outlined, the idea of this paper is patient empowerment in the context of psychosis. Thus, it was deemed important that individuals have had firsthand experiences within the psychiatric system due to psychotic symptoms. Accounts that were

excluded either had psychotic experiences but were not hospitalized or were hospitalized for other than psychotic symptoms. Most of the excluded accounts, however, did not meet any of the inclusion criteria but have gained their expertise by their profession as practitioner, researcher, journalist, activist, or artist. In the analysis, 18 texts by 13 individuals were included. Whereas one chapter is dedicated to each of these 13 individuals, the author, Will Hall, who also conducts all of the interviews, proportionately takes up most of the analyzed text as he wrote four chapters himself. Also, his preface and afterword, as well as his contributions when interviewing others are included in the analysis. Despite his dominance in the book, equal attention was paid to his accounts in comparison with the others'. In general, no measures were taken to establish any sort of balance between the 13 accounts; exclusively their content was taken as the essential criterion for being included in the analysis. However, only texts were included where the speaker refers to themselves or makes general statements; excerpts where one speaker clearly refers to another person who is not given an own voice in the book were excluded from the analysis.

Of the 18 texts, which ranged from two to thirteen pages, ten were self-written in the style of an essay and eight were interviews. Age and gender of the participants are not mentioned and their background is highly diverse. The short descriptions as summarized in Table 1 are all that is known about the authors.

Table 1

Information about participants as indicated in the book 'Outside Mental Health'

Participant	Information
Miguel Mendías	Miguel Mendías a performance artist whose work has appeared at the Maryland Institute of Contemporary Art, and is a member of The Icarus Project.
Eleanor Longden	Eleanor Longden is a researcher at the University of Liverpool and a trustee of Intervoice. She lectures and publishes internationally and is the author of Learning from the Voices in my Head (2013).
Matthew Morrissey	Matthew Morrissey MA, MFT, is a therapist based in the San Francisco Bay Area who works with children, teens, and adults.
Mel	Mel Gunasena is a video activist, writer, poet, and artist. She is the director of Evolving

Gunasena	Minds, a documentary on psychosis, spirituality and self-help; and The Mayan Word, on the spiritual view of the indigenous Maya.
Sascha DuBrul	Sascha Altman DuBrul is one of the cocreators of The Icarus Project and author of Maps to the Other Side: Adventures of a Bipolar Cartographer (2013)
Dina Tyler	Dina Tyler is director of the Bay Area Mandala Project, cofounder of Bay Area Hearing Voices, and coordinator of peer support services at an early psychosis intervention program in Alameda County, CA.
Steve Morgan	Steven Morgan was trained as a Georgia Certified Peer Specialist in 2004. He helped create a peer-run respite, was executive director of the peerrun agency Another Way in Vermont, project developer for Soteria-Vermont, and works for Intentional Peer Support as operations manager.
Paul Levy	Paul Levy is author of Dispelling Wetiko: Breaking the Curse of Evil (2013), and The Madness of George W. Bush: A Reflection of our Collective Psychosis (2006). He is the coordinator of the Portland Padma- Sambhava Buddhist Center and works with people in private practice.
Jacks MacNamara	Jacks McNamara is a genderqueer writer, artist, and healer; cofounder of The Icarus Project; and subject of the documentary film Crooked Beauty. Jacks' book of poetry is Inbetweenland (2013).
Marykate Connor	Mary Kate Connor has been working with issues of homelessness as a service provider and an advocate in San Francisco for more than 30 years. She is the founder/director of Caduceus Outreach Services, and a psychiatric survivor.
James Gottstein	James Gottstein is a Harvard-educated lawyer, psychiatric survivor, and longtime activist for change in the mental health system. He is the director of The Law Project for Psychiatric Rights.
Krista Mackinnon	Krista MacKinnon is the director of Families Healing Together, an online education and support community for individuals, families, and professionals. She practices and teaches yoga and breathwork.
Will Hall	Will Hall is a counselor, teacher, writer, and community development worker. Active during the University of California antiapartheid movement, he went on to work for the Santa Cruz Resource Center for Nonviolence and the Earth Island Institute. In his 20s he was forcibly committed to San Francisco's public mental health system, and, while in the locked unit at Langley Porter Psychiatric Institute, he was diagnosed with schizoaffective disorder schizophrenia and put on disability. He became a leading psychiatric survivor organizer, including host of Madness Radio, co-founder of Freedom Center and Portland Hearing Voices, and a co-coordinator of The Icarus Project, and he is author of the Harm Reduction Guide to Coming Off Psychiatric Drugs, translated into 15 languages. For his work Will has received the Judi Chamberlin Advocacy award, the Portland Oregon Open Minds award, and the Stavros Center for Independent Living Disability Advocacy award.

It becomes apparent that the participants are highly varied regarding their background, occupation, or characteristics. Also, many but not everyone identifies as psychiatric survivors which is why no such label will be given to them. Instead, they will be collectively referred to as 'voices' as this is

how the book calls them as well.

Method of analysis

The analysis will be conducted following the six steps of Willig & Rogers (2017) which will be briefly outlined in the following: The first step regards how the discursive object is constructed in multiple ways, not only through explicit mentioning but also through implicit references. This resulted in the challenge to filter out the vast richness of information and to break it down into more tangible discursive constructions. An analysis matrix was used in this endeavor to structure the text into broader and more concise categories and subcategories to identify recurrent themes. In the second step, differences between the multiple constructions were identified and placed within a wider discursive context. This was done by compiling the two most dominant and striking contrapositions within the text and comparing them with each other. The third step deals with the action orientation of the discourses i.e., practical gains from constructing the discursive object in the given way, and the relations with other constructions identified in step one and two. Here, the analysis starts to shift from descriptive to analytical undertakings, including more inferences and conjectures of the author. This constituted a challenging task as it required to constantly switch perspectives between the voices' and the own, being inside and outside of the discursive constructions at the same time. This was important for arriving at an optimal distance to the analyzed texts and participants but still do them justice, preventing overidentification with them as well as misrepresenting their statements. The challenge was met by brainstorming, mindful writing exercises, discussing the broader topics with many different friends and colleagues, reflecting on the own ego involvement and on the inevitability of subjectivity, switching perspectives in a meditative state, and practicing ambiguity tolerance. In the fourth step, the subject positions which denote the locations taken up by speakers as well as assigned to other speakers within a meaning-making network are analyzed. Here, the same challenges as in step three occurred and were met by taking the same measures. Step five combines the subject and the discursive constructions by

examining potential courses of action and speech within the given discursive constructions. In this step, more direct text references could be made which is why the above mentioned challenges tended to decrease here. After having analyzed speech and action, finally, the sixth step is concerned with the subjects' feelings, thoughts, and experiences derived from their positioning in that discourse. How the persons see and experience the world is made available in that discourse and creates social and psychological realities that are scrutinized here. As this constitutes the most inferential step of the analysis, the above mentioned challenges became highly significant and were met with the same procedures as before. However, speculating about a person's thoughts and feelings even felt intrusive at times which is why the conjectures are formulated in a highly cautious and tentative tone.

For better overview, the six steps as named by Willig & Rogers (2017) are:

1. Discursive constructions
2. Discourses
3. Action orientation
4. Positionings
5. Practice
6. Subjectivity

Due to the importance of implicit constructions in FDA, no computer software was used to analyze the texts. Instead, the material was initially read to familiarize with the content and identify recurrent discursive constructions. Then it was re-read to devise the analysis matrix which was then used to pinpoint the constructions, identify differences between them, as well as analyze the action orientations and subject positions. In that procedure, selective passages or chapters were repeatedly read to achieve deeper insight. Finally, the whole text was re-read a third time in order to inquire into the ways of seeing, feeling, experiencing and acting within these discursive constructions. In writing up the analysis it was tried to vividly and pointedly demonstrate how the different discourses relate with

each other, "how people think or feel (subjectivity), what they may do (practices)" (Willig & Rogers, 2017, p. 113) and how social, cultural, political, and material contexts influence these realities.

Results

This section will follow the logic of Willig and Rogers' (2017) six steps of conducting an FDA, as outlined above. The analysis will develop from a rather descriptive to a more analytical account, including first many verbatim citations in order to get a deep understanding of the voices' experiences followed by less use of direct quotes and more interpretations of the author. An extensive approach was chosen in order to give room to the detailed portrayals which entails some repetitions and content-related overlaps. In view of the author, no other approach would have done justice to the complexity and diversity of the voices' vivid and rich accounts.

Step 1: Discursive constructions

The discursive object, according to the research question, is psychosis and how to live with it. This object is constructed in many different ways that are deeply intertwined but can be distinguished by the categories: 1) Critique of mainstream psychiatry, 2) Understanding of etiology of psychosis, 3) Understanding of nature of psychosis, and 4) Remedies and living with psychosis. For a better overview, Table 2 summarizes the different constructions, subcategories, and one example citation.

Table 2

Discursive constructions, subcategories, and example citations

Discursive constructions	Subcategories	Example citation
Critique of mainstream psychiatry	1. the staff's behavior	*"I felt overall how completely dehumanized we were by the staff, how they were trained to not have feelings for us."*
	2. medication	*"It made me drool horribly, and I looked like a zombie. My friends visited and were just like 'Wow, where did Matthew go?'"*

Understanding of etiology of psychosis	1. abuse, (childhood) trauma, and relationship issues	*"I was forged in a crucible of painful abuse that created a shattered, fragmented child, who would ultimately grow into a crushed and devastated adult. I buried my past; all these terrible memories of fear and shame, horror and terror, I pushed them into a box and sealed it over. But I had essentially buried it alive. This unresolved pain was screaming to get out, and ultimately, of course, it did."*
	2. society's ills and pressures	*"I want us to talk about how oppression makes us crazy: how race class and gender are more important than 'brain chemistry.'"*
	3. drugs, clash of cultures, and unguided spirituality.	*"And while I was in India, in the Himalayas, I started using LSD as a psychological healing tool…I was spending a lot of time in the wilderness in the mountains, and began experiencing increasingly powerful dimensions. I didn't have the proper support or guidance, though, and this led me to lose my way."*
Understanding of nature of psychosis	1. psychosis as survival mechanism	*"Often psychosis is what the psyche does to achieve some kind of balance and safety, so you can live with this mass of chaotic feelings and not be overwhelmed."*
	2. psychosis as benefit and chance	*"It's no longer justifiable to see distress as part of a disease syndrome, rather than something meaningful and real, an opportunity for learning and growth, even if the lessons are painful and difficult."*
	3. psychosis as spiritual experience and access to another reality	*"A life-transforming spiritual awakening, something that until then I had only dreamed about introduced me to psychiatry."*
Remedies and living with psychosis	1. community	*"The movement finds freaks and kids who feel really alienated and alone and gives them a space to feel like superstars, teaches them their history and gives them a community to be a part of."*
	2. lifestyle changes	*"To do well in recovery people need to be in power, actively contributing to their world. This is what being in recovery really means: going out and living life."*
	3. posttraumatic and spiritual growth	*"That was revelatory, a recognition that voice-hearing isn't an abstract, arbitrary indication of mental illness, but rather a significant and understandable experience that can be deciphered and made sense of. That you don't have to just survive, you can thrive."*

As elaborating on each of the subcategories would be beyond the scope of this paper, the further steps of analysis will refer to this categorization and expand on it.

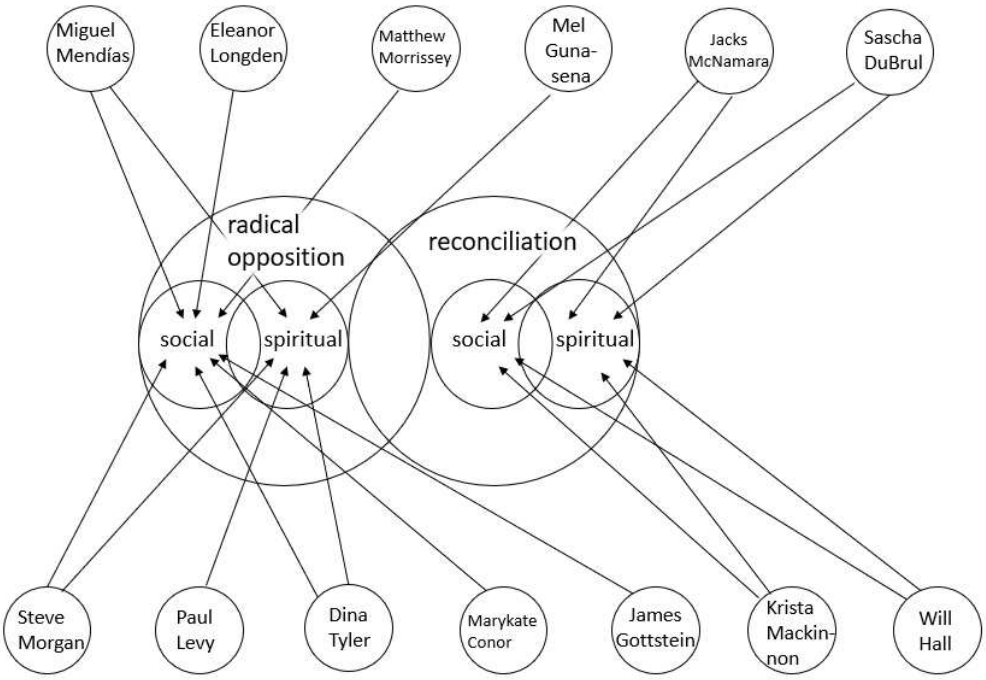
Step 2: Discourses

This step of the analysis will identify differences between the discursive constructions and place them within the context of larger discourses.

Two pairs of contrapositions could be identified throughout the discursive constructions. 1) psychosis as a social vs. psychosis as a spiritual phenomenon, and 2) radical opposition vs. reconciliation. It is important to mention that these contrapositions are not diametrically opposed and mutually exclusive but rather serve to epitomize differences in conception. One voice can thus use arguments from both contrapositions or subscribe to one aspect of a position but not the other. Also, both positions of the second pair (radical opposition vs. reconciliation) make use of both positions of the first pair (social vs. spiritual). Figure 1 contains a model of these two contrapositions, as well as an allocation of these voices to the discourses.

Figure 1

Model of the four discourses and allocation of the voices to these discourses



Psychosis as a social vs. psychosis as a spiritual phenomenon. Two very prominent overarching

themes are the construction of psychosis as either a social or as a spiritual phenomenon. The social construction contains the previously drawn categories of 1) psychosis as a result of abuse, (childhood) trauma, and relationship issues, 2) psychosis as a result of society's ills and pressures, 3) psychosis as a survival mechanism, 4) psychosis as benefit and chance, 5) community as remedy, and 6) posttraumatic growth as remedy. In this wider discourse, the biomedical model is entirely rejected and psychosis is instead constructed as resulting from trauma and abuse, either by the own family, friends, bullies, or recurrent systemic oppression and discrimination such as racism, sexism, classism.

"People become paranoid for very good reasons. When you've been let down and hurt repeatedly by people who matter to you very much, you develop a basic mistrust of other human beings. That then shows up as paranoia." (Morrissey, p. 54)

"If you can't make money for someone, if you are not a commodity, if you are not a voting bloc, then you don't have any value. You become reviled, hated, and dehumanized: no wonder people are traumatized." (Conor, p. 280)

Also, the disillusion that adults are not actually in control, that the world has a lot of problems, and the uncoupling from the family are social issues that have contributed to the developing of psychosis. Furthermore, the resulting feelings of not belonging, feeling alienated, isolated, and ostracized, as well as having to suppress their emotions, being fragmented and leading a double life due to the expectations of others are prominent in this theme. As a consequence, psychosis is understood as a survival mechanism that allows the mind to disconnect from the tormenting pain of trauma, to achieve safety and balance, or to signify fragmentation and unresolved conflicts.

"[M]y crazy mind allowed me to survive extreme situations normal people wouldn't be able to handle." (Mendías, p. 42)

"People who experience trauma often create other dimensions so they don't have to experience their trauma. Their mind goes elsewhere." (Gunasena, p. 82)

Further, psychosis is seen as benefit and chance, in that individuals can work on resolving their trauma, facing their abusers, and cultivating close and authentic relationships. As Hall states:

"The key moments were the connections I made, the risks I took to form friendships, the steps to overcome isolation, and all the ways I gradually learned to take back power in my life." (Hall, p. 188)

Also, joining movements, seeing a therapist, (re-)connecting with friends and family, or finding other ways of community healing is seen as a key remedy. Especially, feeling understood, validated, and cared for is what helped them heal.

"The biggest lesson for me was that healing is about being cared for in a very deep and unconditional way." (Conor, p. 278)

Hence, individuals engage in posttraumatic growth behaviors that provide them with a feeling of wholeness, empowerment, and self-efficacy. It can thus be seen that social matters are constructed as the cause, nature, and remedy of psychosis.

In contrast, the construction of psychosis as a spiritual phenomenon contains the categories of 1) psychosis as a result of drug use, clash of cultures, and unguided spirituality, 2) psychosis as benefit and chance, 3) psychosis as spiritual experience and access to another reality, 4) community as remedy, and 5) spiritual growth as remedy. As in the social construction, here, spirituality is seen as the cause, nature, and remedy of psychosis. It was triggered by being insufficiently grounded or guided in their spiritual expedition and is generally seen as an "altered state of mind" (Gunasena, p. 81), "a different reality" (Hall, p. 370), a connection "to the most powerful force of divine love" (Tyler, p. 95), or a "life-transforming spiritual awakening" (Levy, p. 107). Only when the connection to consensus reality was lost, the spiritual experience began to be a problem. Therefore, also the solution to this spiritual crisis is seen in finding ways "to have one foot in both worlds: to be in the ordinary yet be able to access these dimensions" (Gunasena, p. 82). If this succeeds, the dissociation in psychosis is seen as "a skill, not a breakdown" (Hall, p. 83). With reference to the myth of Icarus who also gave one of the biggest groups

of the mad movement, the Icarus Project, its name, McNamara states:

"And so the metaphor is if you have wings, how do you learn to take care of them? Instead of squashing ourselves into the maze of having a disorder, can we say 'Hmm, we have these beautiful, tricky, dangerous wings to use. Can we come together as a community and learn how to use them?'" (McNamara, p. 112)

Here, also the social aspect comes into play, as people report of the healing effect of spiritual communities which gave them a feeling of belonging, safety, and understanding. This marks an intersection of the social and spiritual construction of psychosis as can be seen in Levy's account:

"We learn that most people are secretly thirsting for a safe place to get into their stuff and play it out, to unlock and liberate the deeper energies that shape their lives. This is true evolutionary magic available to us as a species: there is a way of being together where we can activate our collective genius, conspire to co-inspire each other, and dream ourselves awake." (Levy, p. 108)

Also, in this discourse, a sense of post-traumatic growth is clearly identifiable as people work on resolving their traumas in a spiritual way. This encountering of their interpersonal traumas with spiritual means highlights another overlap between the social and spiritual constructions of psychosis.

"Spiritual awakenings typically become catalyzed by severe emotional crisis, often growing out of unresolved abuse issues from childhood." (Levy, p. 108)

By spiritually engaging with their trauma, and becoming part of a spiritual community, people find healing in their "newly emerging psyche" (Levy, p. 108) and "more integrated state" (Morgan, p. 103).

In sum, the social discourse understands trauma, abuse, and oppression as the cause for psychosis, view it as a survival mechanism to indicate a fragmented state, create the impression of wholeness or achieve distancing and escape from the trauma, and see community healing as most beneficial to their healing. In contrast, the spiritual discourse understands unguided spirituality as the

cause of psychosis, view psychotic symptoms as spiritual experiences and spiritual growth as remedy from the negative aspects of it.

Radical opposition vs. reconciliation. This contraposition does not refer to the etiology or nature of psychosis but instead focuses on the role of psychiatry in the recovery from it. While these two discourses are also not mutually exclusive but overlap significantly, most of the voices deploy the discourse of radical opposition. This discourse is characterized by denying psychiatric institutions any benevolence and value. What unifies most of the voices is their conviction that their experiences in psychiatric institutions have done them more harm than good. Many said that it was more traumatizing than the psychotic experiences that got them there.

"It's amazing that we think hospitals are places of healing, because it's just the opposite." (Morgan, p.101)

"I felt traumatized, literally, made sick, by the treatment I received." (Levy, p. 107)

"[T]he treatment of my madness was far worse than my experience of madness…Treatment contributed to my healing in no way whatsoever." (Mackinnon, p. 338)

Most of what led to that total rejection of psychiatry was based on the staff's behavior. They criticized them for their forceful behavior including restraints, forced medication, intrusion of privacy (observation, strip search) and being locked in their rooms. Further, the staff lacked respectful interaction, treated the voices like little children, spoke to them in a demeaning manner, or not at all. If they did communicate with them, the doctors said that their condition was a life-long disease and a purely genetic, biological condition, that nothing can be done except for medication, and that they should reject or ignore their voices.

"At one point I was told, 'You would be better off with cancer, because cancer is easier to cure than schizophrenia.' A message of hopelessness and helplessness; that my voices were a meaningless, aberrant bit of biological bad luck to be endured, rather than a complex, significant experience to be

explored. To be told that your mind, the essence of your humanity, is malfunctioning is profoundly terrifying. It encourages you to devolve all power and responsibility to the psychiatric system." (Longden, p. 47)

Some doctors did not even mention recovery or point a way forward. Also, the voices said they were "trained" (Hall, p. 333) or "indoctrinated" (McNamara, p. 110) to adopt behaviors expected from.

"After two weeks, I realized that to make these people let me go I had to be 'good.' Go to groups and participate and make art. It was very condescending, allowing myself to be condescended to seemed to be what 'getting well' was all about." (Conor, p. 278)

"I even started manifesting behaviors just because they were part of the diagnosis, as if I were learning to be ill." (Morgan, pp. 100-101)

Further, people's own stories, experiences, and even accounts of sexual assault or victimization were "disregarded and disrespected…minimized, trivialized and invalidated" (Longden, pp. 48-49). This made them either lose trust in the staff or in themselves. Some said they learnt to no longer talk about their thoughts and feelings. Only few stated they had the inner strength to resist this pressure. In general, people criticized a lack of dignity and basic humanity in the hospital staff. Some said that "the mental health profession is designed to stay disconnected from you, and to see you as an object" (Morgan, p. 101) and others felt "completely dehumanized" (Conor, p. 278) by them.

In sum, most of what made up the position of radical opposition was the staff's forceful behavior, their lack of or inadequate communication, as well as their 'brainwashing', 'gaslighting', abuse of power and lacking human connection.

By contrast, reconciliatory voices such as Mackinnon make minor concessions stating that for some people mental hospitals are helpful, especially in crisis intervention. Even if she had exclusively negative experiences herself (see above), she rejects a hostile, rigid opposition between those that give and those that receive mental health services and instead tries to break barriers between them.

"Everyone connected to the traditional mental health system can easily feel oppressed, alienated, and disenfranchised…The ultimate goal of the work I do is to empower the entire system. We can't do it alone. There is no us vs. them…We have to figure this out together." (Mackinnon, p. 343)

This attempt at reconciliation is shared by Hall who acknowledges survivors' "justifiable anger" (Hall, p. 380) towards their abusers but warns that anger alone is no catalyst for worthwhile change.

"Oppressive systems transform when we offer them a new way forward, not when we back them into a corner…Social movements are effective by inviting people to change together, and the greatest victory over psychiatric abuse is in regaining the full humanity of everyone touched by the mental health system, patient, professional, and family member alike. Changing the world becomes inspiring when it also means learning to change ourselves, where our opponent might be a reflection of what we find living in our very own bedroom." (Hall, p. 380)

In a similar vein, DuBrul realizes how the Icarus Project might have been too rigid and antagonizing.

"Mad Pride is a political dead end: a powerful point of unity, but doesn't give us a map of where to go next. For me 'Mad Pride' goes all the way back to the punk rock identity that I had as a teenager: 'us' against 'the world,' we're the freaks and we're the outlaws. But that's only the beginning of the story. We need to lay foundations for a movement that can embrace large segments of society, both ourselves for who we are and our differences, and also really look at our potential." (DuBrul, p. 94)

These accounts reflect that the formation of radical opposition is a necessary first step to demarcate one's standpoint but that the next step which is mutual approaching and finding a common ground is just as crucial. Hall and Mackinnon emphasize that this common ground may consist of seeing the other in oneself, realizing that the 'enemy' is equally human and may not be so different after all. Also, they both underline that psychiatric agents too are affected by the same economic and political restrictions that lie at the heart of psychiatry's structures. Hall, in particular, makes that point:

"The problems we point to in the 'mental health system' in fact originate in the society as a whole, and to find real solutions we have to trace systems upstream, to their source: disempowerment and inequality. Compared to the power of money wielded by economic elites and organized interest groups such as the insurance, medical, and pharmaceutical lobbies for example, ordinary citizens have little or no say over policymaking today. Our most intimate inner lives are fast being reshaped by huge social forces, and decisions about institutional practices affecting us are made out of reach, in a democracy corrupted by money." (Hall, p. 381)

This highlights how Hall sees not the psychiatric system itself as the root of all evil but political and economic agents that greatly influence psychiatry through policymaking and financing. His call for reconciliation with the psychiatric system results from this realization.

"But is it just the 'mad' or 'mentally ill' who are disempowered? Or do patients reflect the disempowerment of everyone in this crazy consumerist world we live in? Haven't we all to some degree lost control of our lives, our voices not heard and our visions cast aside?" (Hall, p. 381)

"Patients, family members, and professionals all feel powerless to change a broken system, and in our day to day lives we are more fragmented, more alienated, and more isolated than ever before. We are disempowered." (Hall, p. 381)

Similar differences between radical opposition and reconciliation can be found in the matter of medication. While most of the voices persist in their viewpoint that medication is outright bad, harmful, and even hindering the healing process, others say that it helped them personally or is an indispensable necessity in some cases. Next to McNamara and Gottstein, it is again Mackinnon, Hall, and DuBrul who have a more differentiated view on medication, stating that it does have benefits, can relieve suffering and thus promote healing, while also making aware of the pharma lobby's greed, and systemic inadequacies in which medication is the slightest vile. They further warn against inflationary use, the sedating effects and plead for real alternatives.

Thus, while members of the discourse of radical opposition see no benefit at all in psychiatric institutions, advocates of the reconciliation discourse see the struggles in the mental health sector as merely a symptom of deeply entrenched structures of power, oppression, and inequality. They connect psychiatry's issues with social, political, and economic interests and fight the oppressive structures by dismantling them. In this attempt, the reconciliation discourse tries to join forces with the psychiatric system as they are seen as equally affected by these issues.

Step 3: Action orientation

As could be seen from the previous chapter, the two contrapositions of larger discourses are 1) psychosis as a social vs. psychosis as a spiritual phenomenon, and 2) radical opposition vs. reconciliation. This step of analysis will elaborate on the functions and achievements of these discursive constructions guided by the question of what is gained from deploying them in this context.

Psychosis as a social vs. psychosis as a spiritual phenomenon. Constructing psychosis as a social phenomenon may have the function of having a clear guilty party and not being personally responsible for having developed psychotic symptoms. This stands in direct opposition to the aforementioned idea by Neo-Kraepelinian physicians who thought that tracing psychosis back to genetics and constructing it as a brain disease would absolve parents of sufferers from guilt and give dignity, as well as an 'excuse' to the sufferers themselves. The voices, however, found such messages hopeless and helpless because it meant being life-long afflicted and having no chance of recovery. By blaming their own family, abusers, or society at large for their symptoms, they may rid themselves of guilt and helplessness. It also makes the problem more tangible than a genetic predisposition or dopamine dysregulation. By confronting the abusers, joining social movements, or resolving their trauma, they may feel empowered and able to move forward. It also implies a much more active role than taking medication for the rest of one's life and hoping that the symptoms will not return. This need for empowerment and an active contribution to one's recovery is also reflected in the construction of psychosis as a survival mechanism, as benefit

and chance, or themselves as psychiatric survivors. Having survived abuse and trauma, being able to take profit from the psychotic experiences, and engaging in post-traumatic growth behaviors, all imply some sort of strength, responsibility and moving forward. At the heart of this overarching feeling of activity, growth and empowerment lies the construction of psychosis as a social phenomenon because social problems can be fixed, genetic bad luck cannot.

In a similar vein, the construction of psychosis as a spiritual phenomenon may also serve to give individuals a feeling of empowerment. As stated above, oftentimes the 'mistake' that led to psychosis was having taken too many drugs or not having been guided and grounded enough before embarking on a spiritual journey. In contrast to the construction of psychosis as a social phenomenon, people deploying this discourse, thus, take full responsibility for their experiences. Having made a 'mistake' and taking the responsibility for it, enables to learn from it and do better in the future, as McNamara demonstrates:

"And so the metaphor is if you have wings, how do you learn to take care of them? Instead of squashing ourselves into the maze of having a disorder, can we say 'Hmm, we have these beautiful, tricky, dangerous wings to use. Can we come together as a community and learn how to use them?'"

(McNamara, p. 112)

This quote highlights that the spiritual component of psychosis is something that you can influence, work on, and get better at. This is also reflected in the accounts that constructed spirituality not only as their trigger but also as the remedy for psychosis. Similar to the construction of psychosis as a social phenomenon, the very thing that led to their problems can also cure them. Thus, these voices advantageously reframe psychosis as "a skill, not a breakdown" (Hall, p.83), as having benefits to the self, and as something that can be productive, or even revolutionary, leading to greater highs than 'ordinary' people can access.

"My reality is a construct that shifts, and when I am freed of that construct I can explore things

other people would be much too afraid to." (Mendías, p. 42)

Constructing psychosis as a spiritual phenomenon may thus reverse unwanted/valuable dichotomies and lead to a desirable distinction from the ordinary, perhaps even a feeling of superiority, as Morgan warns:

"So for example, I used to meditate in the woods and harmonize with the wind, and I found a lot of power in that, but one step too far and it's 'Wow, I am special,' or worse, 'I'm superior to others.' I have to be very careful about that." (Morgan, p. 106)

Besides the conversion of psychosis from something bad and unwanted to something valuable and beneficial, constructing psychosis as a spiritual phenomenon may also serve to immunize against counterarguments. Entering the spiritual realm, one leaves that of science, evidence, and arguments. Instead, one appeals to matters of faith, feelings, and idiosyncratic experiences, which are all irrefutable. The spiritual construction may thus serve to protect from scientific argumentations regarding genetics, brain structures, or neurotransmitters, where right and wrong, true and untrue are prevalent or at least attainable. By denying the concept of reality altogether or arguing from positions of faith and transcendence, one simultaneously protects from the possibility of being outright wrong.

The most decisive function of both of these constructions, however, is that besides the feeling of empowerment individuals free themselves from the dependency on the psychiatric system. Neither working on their problems on a social nor on a spiritual level necessitates hospitalization or medication. Even though some may opt for taking medication or seeing a therapist, they do so of their own free will.

Thus, both constructions may serve to empower the individual by taking on responsibility and an active role. Whereas the social construction may additionally serve to have a clear guilty party, the spiritual construction may have the extra benefit of being immune to scientific argumentation. Also, while the social construction may absolve the individual from blame and guilt, the spiritual construction implies full responsibility for the occurrence of psychosis.

Radical opposition vs. reconciliation. In a similar vein, these constructions may also achieve feelings of empowerment, self-efficacy, and clear concepts of the enemy. In the case of radical opposition, the culprit is the psychiatric system. By denying any benefit of psychiatry and medication, as well as entirely rejecting the biomedical model, their position is clear-cut. This may reduce the matter's complexity and create firm boundaries between friend and foe. It may also express their anger, hurt, and disappointment in the psychiatric system in an authentic way. As Hall pointed out:

"Survivors of abuse, including myself, have justifiable anger towards those who have done violence to us." (Hall, p. 380)

Furthermore, by joining groups such as the Icarus Project, people may attain a feeling of belonging and identification. As DuBrul outlined, the Mad Movement made lonely and alienated individuals "feel like superstars" (DuBrul, p. 93) taking pride in being mad and an outlaw. He also states that there was a great spiritual component in the Icarus Project, giving people meaning and a feeling of oneness.

In contrast, the reconciliation discourse draws another line between friend and enemy. They see the capitalist system as the villain, including "economic elites and organized interest groups such as the insurance, medical, and pharmaceutical lobbies" (Hall, p. 381). The concept of the enemy is thus displaced but still clear-cut. In contrast to the radical's critique that reconciliation with the psychiatric system would stand in the way of real change, this move is probably motivated by the exact same goal. Instead of approaching the psychiatric system as the opposition negotiating minor demands, such as more patient involvement in advisory councils, the reconciliation may serve to join forces, identify a common enemy, and fight them with greater power. This may be driven by a threefold realization: 1) that psychiatry's wrongdoing is merely a symptom of the capitalist system, 2) that psychiatry too is disempowered and equally affected by capitalism's alienation and oppression, and 3) that interest groups such as the Icarus Project are way to small and powerless to achieve any worthwhile outcome.

Fighting capitalism, nowadays, may be more in vogue and promising of large influx of comrades-in-arms than fighting psychiatry, a field that is much less present on the public agenda and still largely unquestioned by many (Cooke & Kinderman, 2018). The shift from psychiatry to capitalism as the bogeyman may thus have the function of attracting a larger audience, promising greater discursive power, as well as more fundamental and long-lasting change.

It could be seen that in the contraposition of radical opposition vs. reconciliation, probably both groups have the same intent which is profound change of the psychiatric system. However, they have a different approach by demarcating the line narrower or broader either excluding or including the psychiatric system in their interest group. It could be argued that whereas the radical opposition gives individuals a feeling of belonging and identification, the reconciliation discourse may be less 'ego-driven' and includes psychiatry as a tactical move to gain political power and relevance.

Step 4: Positionings

This step asks for the subject positions that are made available by the aforementioned constructions. Subject positions "offer discursive locations from which to speak and act" (Willig & Rogers, 2017, p. 116) and have "direct implications for subjectivity" (Willig & Rogers, 2017, p. 116). Firstly, each of the four discursive constructions are unified by positioning themselves outside the mental health sector. They seek to be free from their dependency on it and from the power imbalance that results from being a mental health patient. Instead, they seek alternative treatments or opt for mental health services of their own accord.

The closest cooperation with the psychiatric system is sought by advocates of the reconciliation approach, but on eye-level, with mutual agreement and joined forces. Also, this cooperation takes place exclusively on a macro-level in the joint enterprise of overthrowing fundamental oppressive structures which is hoped to trickle down and eventually also resolve psychiatry's oppression. This peace offer reflects a subject position of 'better to bend than to break', or 'a wise man changes his mind, a fool

never will'. Supporters of this discourse repeatedly pointed out that the stance of radical opposition was way too stubborn, short-sighted, and ego-driven. In stepping back from their ego, reaching their hand out to their abusers, they show true grandeur and nobleness. Furthermore, they compare the medical industry's oppression and disempowerment with "the fossil fuel industry's corruption of environmental policy, the financial industry's corruption of economic policy, and the military industry's corruption of foreign policy." (Hall, pp. 381-382) In their quest to change the world, they aim for nothing less than revolution:

"It is a very intimate question, how to listen so deeply that we discover the other person is also within us. It invites a kind of listening that reaches deeper than words, into the very felt sense of what it is to be human. It is a sense of humanity central to the world's spiritual traditions, and at the core of the revolutionary nonviolence practiced by Gandhi and Dr. King, by Ella Baker and Harvey Milk…To understand and change the other we must understand and change ourselves." (Hall, p. 380)

"I want to see the marriage of social justice and visionary spiritual movements, and a reinvention of what it means to be 'healthy' and 'sick.' I want us to talk about how oppression makes us crazy: how race class and gender are more important than 'brain chemistry.' I want us to cultivate skills to take better care of one another. I want us all to make maps to break out of the biopsychiatry labyrinth, and build a new world from all of our beauty and brilliance." (DuBrul, p. 94)

Here, it can be seen that proponents of the reconciliation discourse position themselves as revolutionary, spiritual leaders.

In contrast, the radical opposition discourse claims a subject position of the outlaw, renegade, and 'diehard freedom fighter'. The experiences of abuse, coercion, and dehumanization they had in psychiatric hospitals have created an unsurmountable divide between them and the psychiatric system. For lay people that are unfamiliar with the ethical dilemma of coercive treatment, their experiences may make them be in the right at face value. This may also be due to the aforementioned reduction of

complexity achieved by deploying the discourse of radical opposition. Having been abused, victimized, and traumatized by mental health providers and constructing themselves as a marginalized minority may evoke sympathy, maybe even pity and position them as progressive and humanistic.

Similarly, advocates of the social discourse emphasize their double victimization, first by their abusers and second by the hospital staff which may evoke comparable, maybe even greater feelings of sympathy and pity. In addition to the radical opposition discourse, they underline that they are not to blame for the occurrence of psychosis, having been abused and traumatized and having had to suppress their emotions due to their social environment.

"People become paranoid for very good reasons. When you've been let down and hurt repeatedly by people who matter to you very much, you develop a basic mistrust of other human beings. That then shows up as paranoia." (Morrissey, p. 54)

However, the conversion of taking matters in their own hands, of taking on the responsibility for their healing and engaging in post-traumatic growth behaviors may position them as victims rising like phoenix from the ashes. They embody a doer mentality refusing to be destined by their past and taking on an active role in shaping their positive future.

"I realized that if I wanted things to change, then I had to be an active part of the process." (Longden, p. 50)

"To do well in recovery people need to be in power, actively contributing to their world. This is what being in recovery really means: going out and living life." (Mackinnon, p. 341)

This may not only render them independent and empowered but also a respected role model.

Advocates of the spiritual discourse may achieve a rather different subject position. First, they take full responsibility for their psychotic experiences and do not blame it on abuse or society which may be viewed as an honorable move. Further, however, by employing the spiritual discourse and leaving the scientific and argumentative realm, they make themselves somewhat incontestable. This is

vividly demonstrated by Morgan:

"Symbols and myth express something that we can't describe in language. It's definitely not 'evidence based practice!'" (Morgan, p. 104)

By arguing from a transcendental standpoint, they may obtain an elevated position, floating above the discourse. In parts, it also seems as if supporters of this discourse withdraw from the 'unawakened' population, rather moving in circles of like-minded people which further adds to their untouchable positioning.

In sum, the subject positions differentiate quite much between the discursive constructions. While the reconciliation discourse positions its supporters as grand, noble revolutionary leaders, members of the radical opposition discourse position themselves as marginalized outlaws and progressive freedom-fighters. Proponents of the social discourse obtain the subject position of 'phoenix from the ashes', whereas advocates of the spiritual discourse render themselves untouchable and floating above the discourse.

Step 5: Practice

This step asks for legitimate behaviors and practices resulting from the interplay between discursive constructions and subject positions.

The highly prominent theme of empowerment and active contribution translated in almost all cases into some kind of social or community commitment. The voices' own bad experiences with the psychiatric system, their rejection of its hegemonic dominance in the mental health sector, and their refusal to see psychosis as an incurable brain disease has led them to engage in the mental health system according to their own ideas and convictions. Different fields of engagement are work, activism, and art. As mentioned earlier, however, the voices cannot be clearly allocated to one discourse which is why their level and field of engagement are rather loosely connected to the different discourses as well. Some differences that connect people's discursive constructions with their practices, however, will be

exemplified in the following.

Mackinnon, for instance, who can be seen as endorsing the reconciliation discourse, also employs a reconciliatory stance in her work. She reports about her fundamental attitude in her work as a family counselor:

"It's not about alienating medical professionals, it's about collaborating together." (Mackinnon, p. 340)

"Everyone connected to the traditional mental health system can easily feel oppressed, alienated, and disenfranchised…I approach this by being as inclusive as possible, accepting all perspectives, and creating a safe space to discuss, connect, and grow. The ultimate goal of the work I do is to empower the entire system." (Mackinnon, p. 343)

Furthermore, McNamara who pleads for staying grounded in consensus reality and who opted for taking medication as a tool to stay functioning wrote a book titled "Inbetweenland" which they comment:

"Well Inbetweenland kind of chose me. As much as I try to pick a side to be on and say 'This is my side,' there isn't a side, there isn't a box or a category that fits. And so how do we learn to just live in Inbetweenland? It's an ongoing struggle for me, daily. But Inbetweenland is where I am, and where a lot of power is. This culture has a lot of boxes I don't want to fit into." (McNamara, p. 113)

This illustrates their rejection of a radical oppositional position and their conviction that not tying oneself down to one side or another enables much more freedom and scope of action. As Hall comments their decision to take medication:

"The question of medications is related to the image of Inbetweenland: if we're trapped in either/or, either meds are bad or meds are good, we can miss the reality of what might help." (Hall, p. 114)

It becomes clear that the reconciliation approach aims to prevent being limited by ideologic one-

sidedness and instead tries to offer a more pragmatic view, as well as greater freedom of action when compared with the radical oppositionists who are viewed as too rigid and stubborn.

Practices resulting from the radical opposition discourse can be exemplified by Gottstein who after having had abusive and dehumanizing experiences on a psychiatric ward, founded the Law Project for Psychiatric Rights. The project's mission "is to mount a strategic litigation campaign against forced psychiatric drugging and forced electroshock, and to stop the drugging of children, particularly children in poverty receiving Medicaid." (Gottstein, p. 301) This legal undertaking vividly demonstrates how psychiatric survivors (to which Gottstein counts himself), as well as advocates of the radical opposition discourse strive to work against the psychiatric system instead of with it. His remark "I've had some victories" (p. 301) underlines this friend/foe identification. Another prominent theme in this discourse is joining movements such as The Icarus Project, Hearing Voices Movement, Recovery Movement, or Mad Pride Movement. As stated previously, The Icarus Project, for instance, employed this same us vs. them mentality, and also the Hearing Voices Movement contains much of the aforementioned minority identity as progressive, humanitarian freedom-fighters, as well as the firm boundaries between psychiatry and its opponents:

"The Hearing Voices Movement is so powerful, articulate and political. It adopts a Civil Rights outlook shared by many minority experiences; agitation for social change, emancipation, actions for respect, and working in ways that don't blame or pathologize the individual. It's about changing society's perceptions and psychiatry's perceptions as well." (Longden, p. 52)

Thus, the radical opposition discourse is clearly characterized by practices that are directed against psychiatry and its dominant position. Noteworthy, however, is that many of the people who claimed to see no benefit at all in psychiatric institutions still ended up working in some mental health profession. For instance, Longden helps professionals support people that hear voices, Tyler and Morgan work in peer support, Conor works in a residential treatment center for young adults, and Morrissey

became a psychotherapist. Applying their own, alternative approaches that are in stark contrast to the biomedical understanding, it seems like they aim to change the system from within. This is clearly demonstrated in Morgan's account who reports that in his work he "trains people who've been psychiatrically diagnosed to work in the mental health system for change" (Morgan, p. 104). This combination of having nothing good to say about psychiatry but still working in the mental health sector also constitutes an overlap between the discourses of radical opposition and reconciliation. Thus, it becomes apparent that members of the radical opposition discourse take on practices that either directly work against the psychiatric system or aim to change it from within. The latter can be interpreted as a minor reconciliatory move, working with or within the mental health sector at large instead of seeking to be liberated from it altogether.

Practices in the discourse of psychosis as a social phenomenon are motivated by their critique that psychiatric staff were invalidating, uncaring, and dehumanizing. They reported that all they needed in their own suffering was someone who would listen to them, understand them and care for them in an authentic way. It becomes apparent that this motivated them to do better in their own work.

"I practice a being with approach that I would have wanted when I was struggling: forming a relationship, putting the person at ease, and showing them I am not there to judge." (Tyler, p. 96)

"My writing, art, and healing work are motivated by trying to be there for people in ways no one was there to help me. Trying to fill the voids I saw, to write the book I needed that wasn't there when I was fifteen." (McNamara, p. 111)

"We had a welcoming, safe drop-in space for respite from the streets, with food, phones, computers, a private bathroom, art supplies, and a living room. And all of this was designed to reflect the worth and value of people, without fear, judgment, or blame for having become outcasts by society…A model that is both professional and non-professional, but everyone is treated equally. Clinicians have to actually engage at a deep level with the people they are working with, so that they could say honestly, 'I

really love my clients.'" (Conor, pp. 283-284)

These accounts of their own work vividly demonstrate how they turned their adverse experiences into something worthwhile by prioritizing the care, closeness, respect, and humanity that they missed in their own treatment.

Proponents of the spiritual discourse also engage in community work, as is illustrated by Levy's meditation circle.

"I bring people together in what I call 'Awakening in the Dream Groups.' We take seriously, and step into, the idea that we are actually inhabiting a collaboratively created dream. The group is a ritually-created alchemical container, tailor-made for this contemplation." (Levy, p. 108)

This suggests the aforementioned notion of the spiritual discourse leading to a kind of withdrawal from the 'unawakened' and towards a niche sector as the group seems to be directed not at people with psychotic experiences or mental health diagnoses but at those "with the intention of waking up" (Levy, p. 108). Morgan, however, who also largely employed the spiritual discourse contests this notion:

"Some people think Buddhism is nihilistic, that you give up on life and repudiate worldly things. You don't. When you learn how to just be, you end up getting what you really need but didn't know you needed. And that can manifest in so many ways. It doesn't mean you abandon your family, leave your job, and go live in the desert." (Morgan, p. 103)

Him starting to work as a peer support worker, highlights that resorting to spiritual niches is not the default. The same goes for Gunasena who directed a documentary about psychosis, spirituality, and self-help. Also, DuBrul highlights that the Icarus Project has had a great spiritual component providing individuals with a feeling of oneness and meaning. Similarly, McNamara reports how learning to be sufficiently grounded in one's spiritual expeditions was understood as a community task.

Employing the spiritual discourse can thus lead to either withdrawal or active community involvement. This variety of different practices resulting from the spiritual discourse may highlight the

idiosyncratic and liberating dynamic of transcendence. It further emphasizes the notion that understanding psychosis as a spiritual phenomenon makes it hard to pinpoint individuals' agenda, becoming less tangible and floating above the discourse. It becomes apparent that the spiritual discourse provides individuals with a great deal of freedom with regard to what can be said and done. This may in large parts be due to the aforementioned incontestability of their experiences and way of life.

In sum, the different discourses result in a variety of practices that are made available. The reconciliation approach obtains a great scope of action by refusing ideologic one-sidedness and instead embracing a pragmatic 'whatever helps' approach. The radical opposition discourse seems to either direct their actions against the psychiatric system as in civil movements and litigation campaigns, or aims to change the system from within by working in it and employing an alternative approach to the biomedical model. The social approach tries to converse their own bad experiences by implementing exactly those interpersonal aspects that they have missed in their own treatment such as validation, respect, and dignity. Finally, the spiritual approach also claims great freedom of action by withdrawing from the discourse either to resort to niches or to the irrefutability of their experiences. It could be seen, however, that in every discourse the overarching theme of empowerment and active involvement was very dominant. Most of the voices engaged in some kind of community work and were motivated by their own adverse experiences to improve the psychiatric system in one way or another to ensure that other people would not suffer the same conditions as they did. It seems that in this regard, the voices are more unified by their commonalities than they are divided by their differences.

Step 6: Subjectivity

Whereas the previous chapter was concerned with what can be said and done from the various subject positions, this chapter inquires into the subjective experiences, what can be thought and felt from the different discursive constructions. It should be noted that this is the most speculative step as it

can only be estimated what the individuals may actually feel and experience.

Proponents of the social discourse may have a strong feeling of empowerment, self-efficacy, and responsibility. This is due to having taken matters in their own hands, staying up to abusers and engaging in post-traumatic growth behaviors. They may further feel strong and independent as they refused to be destined by their past of double victimization and having risen like 'phoenix from the ashes'. They may also view this as having opened a new chapter, of looking ahead instead of back and cherishing the present, their health, and the person they are today. Furthermore, due to working in close congruence with their values and convictions, basing their work ethic on the key aspects of common humanity, dignity, and respect that they were denied themselves may provide them with a feeling of authenticity and self-alignment. It may further fill them with a sense of altruism, feeling needed, contributing to, and shaping the world according to their own ideas and philosophies.

Advocates of the spiritual discourse may similarly feel empowered, as they are not only freed from the influence of the psychiatric system but also from expectations of others and themselves, as well as from the construct of *one* reality. They may thus feel truly liberated, and as became apparent from their accounts, truly self-aligned, at peace, and in unison with themselves. Further, by constructing themselves as 'awakened', perceiving dissociation as "a skill, not a breakdown" (Hall, p. 83), thus reversing dichotomies of wanted/unwanted, they may feel somewhat superior to others, at least different in a desirable way. In combination with the withdrawal from the scientific, argumentative discourse, and the resorting to spiritual niches, all the above adds to their supposed feeling of incontestability and untouchability ('It is true because I've seen it'). This, in turn, may provide them with a sense of security and a justification for their way of life. They seem to be freed from the approval or disapproval of others regarding their experiences and content themselves with their own truth. This self-legitimacy may further provide them with peace and comfort.

Proponents of the discourse of radical opposition may also have a strong feeling of

empowerment and self-efficacy due to their clear-cut position and their efforts to fight the psychiatric system either from the outside or from within. They may also feel very authentic due to their open and pure expression of anger, hurt, and disappointment. Their oppositional stance, as well as their membership in Civil Rights Movements and their construction as marginalized minority may provide them with a feeling of belonging and identification, as well as with meaning and pride. Similarly, their construction as die-hard freedom fighters promoting humanistic and progressive values may bestow on them a feeling of morality and being in the right.

By contrast, advocates of the reconciliation discourse may feel somewhat grand and noble. Surely, they will also feel empowered and self-efficacious due to their separation from psychiatry's dominance; however, reaching their hand out to their abusers to join forces with them, as well as their appeal to first understand and change themselves in order to understand and change the other may provide them with a feeling of wisdom and overcoming the ego. Here, again the saying 'a wise man changes his mind, a fool never will' seems very striking. Moreover, their comparison with spiritual and revolutionary leaders such as Gandhi and Martin Luther King, as well as their explicit quest to change the world may be indicative of their conviction that they are part of something big. Wanting to get to the root of disempowerment and oppression and being convinced "to believe that a different reality is possible" (Hall, p. 382) demonstrates a great will, self-confidence, and optimistic assuredness.

In sum, the voices are unanimously unified by their feeling of empowerment and self-efficacy due to their liberation from psychiatry's dominant power over them and their active contribution in shaping a better world. Also, they supposedly all feel very authentic and self-aligned as they act in close congruence with their values and convictions. Differences consist of the social discourse advocates potentially feeling strong and altruistic, facing the future, and cherishing their current situation. Members of the spiritual discourse may feel truly liberated, desirably different from the ordinary, self-legitimate, at peace and in unison with themselves. Proponents of the radical opposition discourse may

have feelings of belonging, identification, pride, and morality. Advocates of the reconciliation discourse may feel grand, noble, self-confident, and determined.

Discussion

This paper reflected on power struggles in the mental health sector and the role that critical voices play in it. With the purpose of patient empowerment, it asked how activist individuals who have been hospitalized due to psychotic symptoms and experienced abuse and mistreatment in psychiatric institutions form resistance to the dominant discourse by constructing alternative discourses about psychosis. The answer to this research question is manifold. Four alternative discourses in the form of two contrapositions were identified: 1) psychosis as a social phenomenon vs. psychosis as a spiritual phenomenon, and 2) the discourse of radical opposition to psychiatry vs. the discourse of reconciliation with psychiatry. While there were many differences between these counter-constructions, some unifying themes could be identified in the analyzed texts. Firstly, all voices rejected the biomedical disease model of psychosis. They denied its biological roots and opposed the conception that psychosis is a life-long affliction which can only be tamed by taking medication. Secondly, all voices criticized psychiatry's way of treating psychosis and themselves as patients. They strongly condemned the forceful behavior, violations of personality rights, and the disrespectful, dehumanizing, and disconnected manner with which they were treated. Thirdly, all four discourses confer feelings of empowerment, self-efficacy, and authenticity on its proponents. These feelings manifested themselves not only by actively resisting treatment and countering the dominant discourse but also by growing from their traumatic experiences and putting them into practice, thereby constructively shaping the mental health sector according to their own ideas and values.

To highlight the differences between the four discourses, as well as the ensuing action orientations, subject positions, practices, and subjectivities according to the scientific interest of FDA, a brief overview is given in Table 3.

Table 3

Overview of the four discourses, action orientations, subject positions, practices, and subjectivities

	Social discourse	Spiritual discourse	Radical opposition	Reconciliation
Discourse	Social factors as cause, nature, and remedy of psychosis	Spiritual factors as cause, nature, and remedy of psychosis	no benefit at all in psychiatric institutions	Rejecting hostile, rigid opposition; join forces with psychiatry to fight oppression
Action Orientation	Clear guilty party, absolved from blame & guilt	Desirable distinction from the ordinary, immunization against scientific argumentation	Reduce complexity, authentically express anger	achieve greater discursive power & more fundamental change
Subject Position	'phoenix from the ashes'	'floating above the discourse'	'diehard freedom fighter'	'revolutionary leader'
Practices	Conversing own bad experiences into desirable work ethics	Resorting to spiritual niches, active community involvement	Work against the system or change it from within	collaborate with psychiatric agents, empower the whole system
Subjectivity	Responsibility, strength, altruism	Freedom of action, liberation, self-alignment, peace, comfort	Belongingness, identification, pride, morality	Nobleness, wisdom, overcoming the ego, self-confidence, optimistic assuredness

Reflecting on these results, it becomes apparent that much of the voices' counter-discourses stand in close similarity to those of the anti-psychiatrists. Especially the social discourse and the radical opposition discourse closely connect with the ideas of Cooper, Laing, and Szasz, as outlined in the introduction. The most profound overlaps regard the social nature of psychosis, capitalism's oppression and alienation, the reversal of unwanted/valuable and sane/insane dichotomies, as well as psychiatry as social control and counter-productive for healing. These two discourses, with special emphasis on the radical opposition discourse, are also in close alignment with the survivor discourse seeing no benefit in psychiatric institutions and medication and seeking to be entirely liberated from the psychiatric system.

By contrast, the reconciliation approach also makes use of the anti-psychiatrists' rhetoric but does so in a different manner. Its proponents also strongly condemn the wrongdoings of psychiatry but instead of demonizing them, they see it as merely a symptom of deeply entrenched structures of oppression and disempowerment. Thus, they much more follow the tradition of Foucault by connecting psychiatry's issues with social, political, and economic interests and fighting these oppressive structures by dismantling them. By joining forces with psychiatry in an attempt to gain more discursive power, they also more closely resemble the user movement that intends to work with psychiatry than the survivor movement who aims to work against it.

Noteworthy in this context, however, is that many proponents of the radical opposition discourse try and change the system from within by working in the mental health sector. This may reflect that it is nearly impossible to change the system without interacting with it in any way. It may also show that radical opposition against the system while working in it does not necessarily mean an insurmountable contradiction. It may actually demonstrate two counterintuitive notions: First, that the strong aversion against the system is the very motivation to work in it and second, that even working against the system may be re-interpreted as working with it. All efforts to change psychiatry – either by radically opposing it or by trying to reconcile with it – can be seen as equally for and against the system. They work against it as they both seek to overthrow the current structures and practices, and they work for it as they are eager to establish humane and high-quality ways of relating to people with mental health problems. Thus, the end goal of both positions is basically the same: a system of caregiving that is free from power struggles, abuse, and alienation, but instead offers help in a respectful and empowering manner. Hence, the two positions may overlap more than presumed in the earlier stages of analysis and the biggest difference between them may be the subjectivities that deploying one or the other bestows on its proponents. An individual's decision to endorse either the radical opposition or the reconciliation discourse may be greatly influenced by their need to feel proud and belonging, identifying

as ‘diehard freedom-fighter’ or to feel wise and noble, identifying as ‘revolutionary leader’. Here, FDA demonstrates how discursive positions may be less influenced by content-related considerations but by emotional needs and preferred constructions of selves (Willig & Rogers, 2017).

Another novelty is represented by the spiritual discourse. Even though accounts of psychotic-like symptoms in spiritual practices reach back to the 5th century (Kaselyonite & Gumley, 2019) and William James in 1902, as well as C.G. Jung in 1961 and R.D. Laing in 1967 wrote about psycho-spiritual phenomena, it was not until 1989 that the close similarity between psychosis and spirituality gained public recognition when Grof and Grof (1989) published their model of spiritual emergency (Viggiano & Krippner, 2010). This is understood “as a process of spiritual emergence or awakening (i.e., a gradual unfolding of spiritual awareness) that becomes traumatic for an individual, leading to a state of psychological crisis” (Harris, 2018, p. 6). This crisis is usually triggered by being “unprepared, unguided, and ungifted” (Campbell, 1972, as cited in Spittles, 2020, p. 4) thus resulting from “the absence of the requisite skills, or technologies of consciousness, for competently navigating psychospiritual domains of reality” (Spittles, 2020, p. 4). Despite the immense turbulences experienced in these states, scholars point at the unique opportunity for growth that is offered by spiritual emergencies. They further emphasize and provide evidence for the importance of distinguishing spiritual emergencies from psychosis or other mental disorders (Harris, 2018; Storm & Goretzki, 2021). They ascribe the wrongful pathologizing of these experiences to the lack of cultural competence and the Western overreliance on scientific rationalism and the medical model (Viggiano & Krippner, 2010). The insights arising from these considerations are twofold. First, running counter to this study’s notion that the spiritual discourse serves to immunize against scientific argumentation, there is evidence-based academic work that empirically validates the distinction between psychosis and spiritual awakenings. Even though the concept of spiritual emergency is mostly located in the realm of transpersonal psychology and may be regarded as pseudoscience by other scholars, there is increasing scientific interest in and approval of

spiritual understandings of what is commonly referred to as psychosis (Harris, 2018). This is for instance reflected by the inclusion of the v-code for Religious or Spiritual Problem in the DSM that indicates not a mental disorder but a stressful life situation and was stimulated by Grof and Grof's (1989) model of spiritual emergency (Viggiano & Krippner, 2010). Second, the novel character of this discourse is a product of discursive power dynamics. Both the long traditioned neglect of spiritual explanations for psychotic-like symptoms and the recent emergence of the like are discursive practices that follow a sociocultural logic. For example, psychiatrist J.W. Perry who himself supported a spiritual understanding of psychosis "believed that his approach was largely ignored by mainstream institutions, purporting that it represented an 'inconvenient truth'" (Harris, 2018, p. 19). On the other hand, Viggiano and Krippner (2010) demonstrate that public demand for spiritual explanations exceeds the scientific activity and at the same time stimulates it. This may indicate a power shift towards certain patient populations that actively shape the discourse by rejecting traditional explanatory models and constructing alternative, spiritual discourses. This development runs parallel to the (re-)emerging popularity of Eastern philosophy and practices (Hofmann, 2013) suggesting that this discourse is strongly influenced by sociocultural dynamics, as well as emotional and psychological needs of its participants.

In general, this study's relevance lies in the research gap it attempted to bridge by examining the power struggles and wider social implications of countering the dominant discourse of psychosis from the viewpoint of ex-patients who were abused and maltreated in psychiatric hospitals. It differs to existing literature by either the choice of participants or the method. Research by Speed (2006), Ochocka et al. (2006), and Marriott et al. (2019) did focus on the accounts of (ex-)patients but did not consider the wider social implications and power dynamics. Other research did focus on the power dynamics by conducting an FDA but either focused on mental health practitioners instead of (ex-)patients such as Walker (2022) or on artists who have had psychosis and integrated these experiences in their creative output such as Haslam (2022). The closest similarity to this study can be found in Adame

(2014) who examined the double identity of psychiatric survivor and mental health professional. In fact, investigation into her study strongly suggests that her participant may be Matthew Morrissey who was also included as participant in this study. This assumption is bolstered by the identity of names, background stories, professions, as well as the expressed ideas and convictions. Even though Adame (2014) does not apply an FDA, she goes into depth about the wider social impacts of certain discursive constructions of psychosis. Morrissey remarks "not to demonize *all* mental health professionals and set up antagonistic dichotomies between the two groups" (Adame, 2014, p. 464) and he underlines "the potential for meaningful dialogue between psychiatric survivors and mental health professionals" (Adame, 2014, p. 464). This demonstrates a broader view of the issue and goes hand in hand with the reconciliatory approach identified in this study. As the case study includes Morrissey as the only participant, the present study can be seen as an extension of Adame (2014) by incorporating more than one voice and focusing on the discursive properties and power dynamics of activist's constructions of psychosis. This can be considered a strong point of this study.

Limitations, on the contrary, could also be identified. First, there seem to be conceptual inaccuracies regarding the differentiation between psychosis and schizophrenia. These inaccuracies extend through the scientific literature, the voices' accounts, as well as the own elaborations in the introduction. In particular when I contrasted the dominant understanding with alternative explanations of psychosis, such inaccuracies can lead to false positive differences between the two and artificially inflating the alleged opposition. Second, my own background, values and convictions may have influenced the whole process of creating this work making it difficult for me to maintain a certain distance to the analyzed texts and to question its foundation and background. My own identification as left-wing, anti-capitalist, and humanistic, as well as my own occupational experiences in psychiatric institutions may have drawn me towards a rather oppositional stance, preventing me from seeing the bigger picture and acknowledging that many people might benefit from psychiatric services. For

example, in hindsight it seems important to critically reflect on the role of Will Hall in the compilation of this book. Hall, by deciding whose voices to include, leading the interviews and thus steering the conversation, and contributing four chapters himself, definitely has a gatekeeping function. By excluding voices that have benefited from mainstream psychiatry and including very well-spoken, activist voices, the book in itself is far from being balanced. However, Hall himself states in the preface that the "book doesn't try to be balanced; it tries to be *balancing*" (Hall, 2016, preface). He further admits: "I'm certainly limited by my own background and experience. There are many things that this book doesn't do, many perspectives that I wish I had been able to include. *Outside Mental Health* is a snapshot, not an overview, and offers new visions of madness, not a single new vision of what madness is" (Hall, 2016, preface). These limitations are important to keep in mind and, as stated above, I often let my own personal involvement take over and get sucked into the rather radical argumentations of the voices. It took me deep reflection and several revisions to prevent my personal background from disbalancing my work.

This reflective insight coupled with the results of this analysis also has practical implications. It lies in the realization that too much ego involvement obstructs movement in any direction but merely hardens the fronts which in turn leads to upholding the status quo. Fighting the psychiatric system in hope for patient empowerment may be a dead end and trench warfare between two parties that basically want the same which is the best possible care for people with mental health struggles. To achieve that, reconciliation and mutual rapprochement of those that provide and those that receive care on the micro-, meso-, and macro-level seem much more appropriate to me personally than sheer antagonism. This would not only lead to more constructive, solution-focused exchange of ideas but also to greater discursive power increasing the likelihood of meaningful change. Future research may expand on this idea. More qualitative inquiry into the reconciliation approach identified in this study, as well as in Adame (2014), may foster the purpose of mutual rapprochement. Perhaps in the form of interviews,

the experiences, opinions, and ideas from everyone involved in the mental health system including psychiatrists, therapists, peer support workers, nurses, social workers, (ex-)patients, families and friends, etc. could be voiced. The common thread may be the endeavor to reduce power imbalances, abuse, and mistreatment in psychiatric hospitals and increase respectful, empowering interaction between staff and patients. Other fields of research that inquire into conflict management between numerous, extremely varied, and mutually opposed stakeholders might also be of high relevance in this context. Further, to provide shared understanding, facilitate discussion, and bridge the gap between theory and practice, storytelling (Cortes Arevalo et al., 2020) and narrative futuring (Sools & Hein Mooren, 2012) approaches may be effective.

To end on a personal note, the voices in 'Outside Mental Health', as well as the process of conducting this research have deepened my stance that the main hinderance to provide the best possible care is the profit orientation of hospitals. I view the goal to make money from people's health not only as moral bankruptcy but also as self-contradictory. Thus, from my point of view, the entire health sector should be decoupled from the logic of profit maximization and subject to public ownership and control. Research by Bayliss and Gideon (2020) and Ruthjersen (2007) strongly supports the notion that the economization of the health sector undermines not only its moral purpose or ideas of the common good and social justice, but also its very nature and effectiveness. Likewise, Markström and Karlsson (2013) and Boyle et al. (2007) point at the great potential that health-related non-profit organizations hold regarding the effective provision of mental health services and the promotion of users' *and* carers' interests. I do know that these demands may sound utopian and unrealistic but the voices in 'Outside Mental Health' demonstrate that dreaming big and starting small are not mutually exclusive. In fact, their stories might give hope that even in the face of a giant, authentic expression of one's values may represent the slingshot bringing him down eventually. Thus, I fully affirm Hall's closing remarks:

"The people gathered together in this book found the courage to create a more honest conversation about what it means to be called crazy in a crazy world. Their courage inspired me to believe that a different reality is possible, and I hope their courage can inspire you." (Hall, p. 382)

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