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FIRST PERSON ACCOUNT

Psychiatry and Oppression: A Personal Account of Compulsory Admission and Medical Treatment

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Introduction

Dr B.G. is an academic and researcher in the field of mental health and was also diagnosed with schizophrenia in 2003, when he spent a total of 12 months in a mental health hospital. In this article, he relates his personal experience and story to make a polemical and admittedly one-sided case against traditional psychiatry and compulsory medical treatment. He ties his experience to espouse a modern antipsychiatry. Dr B.G. concludes that there needs to be more attention paid to voice hearers' stories and accounts of mental illness, which he links to the rise of democratic psychiatry and the growth of the hearing voices movement, headed by organizations such as Intervoice, Asylum, MindFreedom, and the Hearing Voices Network.

Hearing Voices: A Personal Story

Certainly, my negative conception of traditional psychiatry and compulsory treatment is colored by the 12 months that I spent in a psychiatric acute unit. Kept under Section 3 of the Mental Health Act of the United Kingdom, I was both obliged to stay in hospital and forced to take antipsychotic medication against my wishes, though physical force was never used against me.

My strange religious beliefs were perhaps quite rightly classified as delusions and discounted by my psychiatrist, nurses, and also my family, but this left me with the impression that my experiences, however negative and painful, were also being discounted and that I was not being listened to in order to be more deeply and humanely understood. The famous line of Szasz[1(p113)] often came to my mind: "If you talk to God, you are praying; If God talks to you, you have schizophrenia."

Among the people I met during my time in hospital was Rosemary. She was an unassuming, quietly spoken woman, unremarkable apart from an air of sadness. Rosemary had told me and many of the nurses that she would be better off dead than hearing any more of the terrible voices that kept her from sleeping. Better up there with her mother in heaven, she told me, than down in the hell of the psychiatric ward with her voices. Within a few days of being discharged, Rosemary was with her mother again. The nurses called a meeting in the communal lounge. There had been an accident. Rosemary had thrown herself in front of a train. The girl next to me at the meeting broke into tears.

Night after sleepless night and through the long, seemingly endless days in the ward, where smoking and television stood in place of any attempt of therapy, I and my fellow patients experienced similar feelings to those of Rosemary: feelings of loss, isolation, pain, sorrow, self-pity, confusion, and helplessness.

"You're alone," an insidious voice whispered to me. "You're going to get what's coming to you." "You're going down there!" it shouted. "You wait until you see what I'm going to do to you!"

When I heard my voices, which would often shout at me, no one around me moved or looked startled. It was just me hearing the voices. I tried not to answer them. Better to ignore the voices, repress them, and soldier on, I thought. I had seen others screaming back at their voices, and it had left me with mixed feelings of consternation, pity, and fear. I did not want to look mad, like them. Any symptoms of hearing voices would go on medical case notes, be raised as proof of insanity at my case reviews, and keep me locked up in the hell of the ward away from family, friends, and what seemed like a long-distant normal life.

I learned several important lessons too: never admit that you hear voices; certainly never answer them; do exactly as you are told by staff or concerned family or you will be seen as ill; never question your diagnosis or disagree with your psychiatrist; and be compliant and admit your mental illness or you will never be discharged.

All the time, the voices got worse. "Hot fire in your eyes!" shouted a voice to me in the hell of the ward. "That's where you're going. In the fire of the sun!"

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Many of the people, and there have been hundreds, with mental illness who I have talked with both as a patient and as a researcher and academic, tell me that they have had to suppress and hide their voices in order to be considered well, stable, and healthy. Not only is this a suppression of symptoms, but it is also a suppression of people's personhood. Traditional psychiatry, in this gloomy and pessimistic view, could be argued to be little more than an instrument of social control and of oppression and a system of scientific belief that perhaps unintentionally crushes people's subjectivity, choices, human rights, and free will.

The majority of individuals with schizophrenia and mental illness that I have spoken with, and from my own personal experience in a psychiatric acute unit I have to agree, find meeting with their consultant psychiatrist threatening because any unusual thoughts or behavior can be taken out of context and construed as psychotic. Many people with mental health problems are genuinely afraid of meeting with their psychiatrist or other members of the mental health team. I remember a teenage boy in the ward literally shaking and wringing his hands with fear before his weekly case review with his psychiatrist, much to the concern of nurses, the boy's mother, myself, and the boy's mental health advocate.

Many people with mental health problems hide their symptoms, their aberrant beliefs, and their voices to stay out of hospital, but this means that they are ostracized and that there is a lack of dialogue between mental health professionals and people with mental health problems. This also means that there may be a lack of disclosure and of what is really going on in people's lives and what voices they may be hearing. Because people with mental health problems fear the psychiatric encounter and are afraid of punitive intervention or compulsory treatment, psychiatrists and mental health professionals are not getting the full picture so as to agree a consensus on care plans and treatment. This is also true of family carers, who are increasingly being called upon to provide around the clock support for people with mental health problems in the community. Family carers are often little more than the unpaid workhorses of community care, who lack the skill and information necessary to provide adequate support to their family members with schizophrenia and mental health problems who may hear voices.

More worryingly, when in hospital, violence is sometimes used as a tool for getting noncompliant patients to take their medication, usually via depot injection. This violence is often conceived of as right, as just, and in the patient's best interest. Certainly, many nurses I have spoken to have not only said that they do not like administering forcible injections but also say that they have a duty of care. Violence as care is an oxymoron and hides the institutionalized abuse of people with schizophrenia and mental health problems. I myself have witnessed 8 occasions where patients have had to be very violently restrained by staff and only 2 assaults by mental health patients on nurses. This is in line with evidence that people with mental health problems are more likely to experience violence on their person rather than attacking other people.

Psychiatry has taken a biomedical approach, with the prescription of powerful antipsychotic medication, including drugs such as olanzapine, risperidone, and clozaril, all of which I have been prescribed. These powerful antipsychotics have serious and debilitating side effects, are toxic, and have also been suggested to be harmful to those taking them in the long term. These antipsychotic medications have often been described as a "chemical cosh," leaving people who take them passive, debilitated, and zombie like. This could be suggested to lead to the tranquilization of people's personal beliefs, however irrational, and their thoughts, subjectivity, and feelings. Such an approach could certainly be argued to crush diversity and discount the diversity of people's experience of life and the world, in the name of normalization and keeping a stable social and medical order.

Put very crudely, popping a pill is far less of a burden on a health service that has limited resources, a lack of money, severe pressures on beds, and a lack of inpatient provision, which often depends on family carers who lack the knowledge and expertise of dealing with people with mental health problems who may be in distress and where care in the community is limited in scope and often means no care in the community, leaving people with mental health problems with the feeling that they are alone, invisible, and ostracized.

All this means that there is little study of what schizophrenics' voices say to them, which would make people's experiences more valid and meaningful and also lend itself to a more human account of mental illness. People's experiences of hearing voices are silenced, which can only augment ignorance and fear, both in society and in the mental health-care system. Little attention has been given to what people with mental health problems think and feel and what treatments they would prefer. Psychiatry overrelies on powerful antipsychotic medications, and there are long waiting lists for less invasive treatments such as counseling and cognitive behavioral therapy.

To complicate and make matters worse, it is almost impossible to talk with other people and relate the pain that voices inflict when they are raging inside you and shouting you down. It is even harder to face the voices and achieve what psychiatrists and mental health professionals call "insight." My voices, in particular, often sounded telepathic, as though people were speaking to me through their minds. My voices would often be racist or abusive about mental health staff and other patients. It is perhaps not surprising that voices like these, if dismissed as bizarre delusions and not discussed as at least phenomenologically or subjectively "real," may sometimes lead to violent behavior toward staff and other patients or—as I have witnessed—the smashing of hospital furniture, equipment, and the television from which the voices emanated.

The main point to reiterate is that these voices are silenced and dismissed as delusions and that they are managed mostly by medical treatment and thus not addressed in human and sympathetic terms that might begin to tackle the root cause of the problem, which in turn might help people cope more profoundly and insightfully with their voices.

Certainly, the overreliance on medication is perhaps not surprising, given that people who hear voices can be perceived as aggressive, irrational, and violent. My voices often took on a demonic or hellish quality: "You think you've been exploited and abused?" a demonic voice often shouted at me. "You wait until you see what I'm going to do to you! You wait until you see what I look like!"

But this is partly the point: other people cannot hear the schizophrenic's voice. There needs to be a dialogue so as to treat the voice hearer's experience as valid and meaningful.[2,3] A more democratic psychiatrist listens to people with mental health problems and is open to their experiences and voices, so not stigmatizing the voice hearer, which in turn may lead to more holistic, democratic, and sensitive packages of mental health care.

Discussion: The Rise of Democratic Psychiatry and the Hearing Voices Movement

What I have learnt as an academic and researcher, as well as a mental health patient labeled with schizophrenia, is that what people with mental health problems want is to be treated as equal citizens with equal human and medical rights. People with mental health problems who hear voices or hallucinate want to be valued, as we all do, not feared and ostracized. They want their views and opinions taken into account, especially as regards what sorts of treatment they have and in their care plans. They want a right to accept or refuse medication and not have it forced upon them supposedly for their own good. At the very least, people with mental health problems want their stories, narratives, and voices to be valued and taken into consideration. Such an approach would take people's diversity, and their diverse experiences and beliefs, into consideration and not label people as mad or bad but value them as human beings, with all the faults and strengths that being a human being entails. Such an approach would give rise to a more democratic and person-centered psychiatry, which would also view mental health patients' experiences as a form of expertise to be shared with professionals rather than discounted as delusions.

What is required is a balance of perspectives between traditional psychiatry and the diverse experiences of people with mental health problems, with the aim of achieving a consensus on pathways of treatment and new, innovative, and alternative methods of mental health practice.[4] Hearing voices groups and voice hearers' Internet discussion forums are just 2 contemporary examples as is the use of advance agreements and directives.

Central to this process is the rise of democratic psychiatry and the hearing voices movement, headed by the eminent psychiatrist Marius Romme and organizations such as Intervoice (http://www.intervoiceonline.org/), Asylum (http://www.asylumonline.net/ and http://studymore.org.uk/mpuzasy.htm), MindFreedom (http://www.mindfreedom.org/), and the Hearing Voices Network (http://www.hearing-voices.org/andhttp://www.hvn-usa.org/).

Democratic psychiatry and the hearing voices movement do not ostracize and silence people who hear voices but create space for their voices, narratives, stories, personal thoughts, and experiences, which will lead to more humane and holistic approaches of understanding and treating schizophrenia and mental illness in the future. This means that psychiatry rather than doing things "to" or "for" people must begin to work "with" them.

According to Romme and Morris:

> The term 'schizophrenia' is not just stigmatising, but also fundamentally flawed. It is a label without scientific validity. Diagnosis ignores connections between life experiences and core illness experiences. We urge mental health professionals to listen to what their patients are telling them and help them understand their experiences.[5(p7)]

A Call for the Personal Stories of Voice Hearers

Indeed, Intervoice and Dr B.G. are in the process of putting together a book on the experiences and stories of hearing voices, entitled *Hearing Voices: The Personal Stories of Voice Hearers*. The emphasis of this innovative book is about all sorts of voices and voice hearers and all sorts of points of view, experiences, and personal journeys. For example: What did the voices say? How did they make voice hearers feel? What was the reaction of family, friends, and mental health professionals? If we are going to change and improve the lives of people with mental health problems, then personal stories and journeys to recovery and insight are arguably the first place to start.

For more information or to contribute to *Hearing Voices: The Personal Stories of Voice Hearers*, please e-mail: voices2009@hotmail.co.uk.

References

1. Szasz T. *The Second Sin.* Garden City, NY: Anchor/Doubleday; 1973.
2. Foucault M. *Madness and Civilisation.* London, UK: Routledge; 1992.
3. Laing RD. *The Politics of Experience and The Bird of Paradise.* Harmondsworth, UK: Penguin; 1967.
4. Stastny P, Lehmann P. *Alternatives Beyond Psychiatry.* Shrewsbury, UK: Peter Lehmann Publishing; 2007.
5. Romme M, Morris M. The harmful concept of schizophrenia. *Ment Health Nurs.* 2007;27:7–11.