The discursive construction of mental illness: Conversations with community clergy

by

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ABSTRACT

This study is about how language as a form of social practice discursively produces notions of mental illness and how these notions produce a differential respect for civil rights. The conceptual framework that supports the study is poststructuralist theory particularly Michel Foucault's critical analysis of the role of language in the production and reproduction of the categories of social and cultural differences. The study has two related parts. The first part is an investigation of the historical discursive construction of mental illness. The second part is an investigation of ways that community members represented by a single occupation talk about issues of mental illness and civil rights within the context of their jobs and particularly how their language both reproduces or challenges the dominant historical constructions of mental illness in their daily work with people they recognize as mentally ill. The thesis concludes with discussion on the implications of the study for further research into the language and social practices of other community relations, implications of the research for my own practice as an adult educator working in community mental health care and possibilities for accommodating differences so as to transform repressive social practices.

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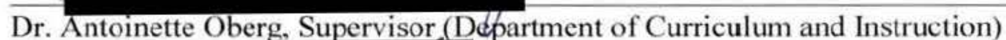

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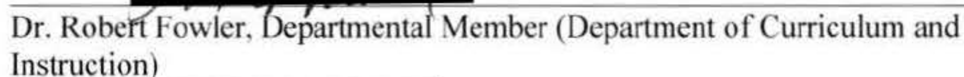

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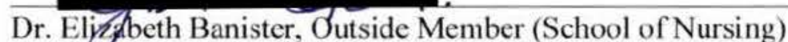

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I wish to acknowledge

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of

Dr. Antoinette Oberg

This thesis is dedicated to

Bill

INTRODUCTION

This study is about how language as a form of social practice discursively produces notions of mental illness and how these notions produce a differential respect for civil rights. The conceptual framework that supports the study is poststructuralist theory particularly Michel Foucault's critical analysis of the role of language in the production and reproduction of the categories of social and cultural differences. The study has two related parts. The first part is an investigation of the historical discursive construction of mental illness. The second part is an investigation of ways that community members represented by a single occupation talk about issues of mental illness and civil rights within the context of their jobs. I was interested to discover whether and how these community members might reproduce or challenge the dominant historical constructions of mental illness in their daily work with people they recognize as mentally ill.

This study began with an observation rooted in my work with people with mental illness whom I serve as a community based adult educator. Although I work within the mental health care system, my job is to help people access educational services in the community in ways that they choose and not to provide psychiatric medical treatment or rehabilitation. I was surprised to notice how easily I came to use psychiatric medical language to characterize the people I serve. In other community based adult education programs, where I had worked previously, people had been referred to me as students with particular qualities, for example, a history of dropout, a background as First Nation, origin in another culture, people with disabilities

or women and men with significant barriers to education and employment, to list but a few. However, in my present job, I noticed the language used in referring people to me had nothing to do with clients' educational status per se, but rather it designated them first and solely as people with mental illness. Accordingly and without even noticing it I had substituted for the language of adult education psychiatric medical terms like schizophrenia, bi-polar disorder, depression, schizoid-affective disorder, borderline personality disorder, compulsive obsessive disorder, and panic attacks. I too began to use diagnostic names and the ascribed symptoms of diagnoses to make decisions about the best ways to engage individuals in an educational system. I discovered, however, that assumptions about adult learning based upon the language of mental illness are limiting because they do not accommodate the range of other explanations which could account for people's actions in their various roles as students. I was alarmed at the ease with which I took up the language practices normalized by psychiatric medicine that label and categorize people who come for educational support first as mentally ill and only secondly, if at all, as students.

The capacity of language to construct social reality is a major tenet of post structuralist and Foucauldian theory. According to these theories language does not reflect an already given social reality but rather constitutes social reality. Meanings for constructs such as mental illness are not fixed but rather are constituted through language as systems that support social practices and institutions (Weedon, 1987). Individuals are not the makers of social meaning but rather are shaped by social institutions and discursive practices. The location of my job within the institution of the mental health

care system shaped the way I saw and referred to my clients. The dominant discourses within the mental health care system structured the social reality of myself as a teacher and clients as students.

Meaning in any particular moment depends upon the discursive relations in which it is located and is open to constant rereading and reinterpretation (Weedon, 1987). I wondered how others working in the community with people with mental illness recognized and interpreted the meanings of mental illness. Consequently I sought out members of the community who did not work within the mental health care system, but who encountered people with mental illness in the course of their daily work, as a site in which to study the social power of the dominant discourse constructing mental illness. I chose clergy as an appropriate site because the discourse that structures their occupation, in this case pastoral care, I anticipated might be publicly inclusive and might resist the categories of psychiatric medical discourse that set people apart as abnormal. To ascertain the inclusiveness of the discourse of pastoral care I included a small fieldwork component into my study by visiting a dozen churches of various Christian denominations. The major way I accessed the language of community clergy was to interview twelve clergy members.

Viewing language as Foucault does as a system always existing in historically specific discourses, I prefaced my study of community clergy with a brief account of the historical discursive construction of mental illness. Drawing on the section Madness and Civilization from *The Foucault Reader* (1984) I described how people with mental illness have been socially defined

and set apart as abnormal resulting in their political marginalization. This designation and resulting marginalization has in the past, and continues in the present, to provide justification for compromising the legal rights of groups defined by psychiatric medical discourse as mentally incapacitated. A brief examination of the language of current mental health legislation in British Colmbia shows how this is the case. In this study the restriction of civil rights is regarded as a specific effect of the discursive construction of mental illness, and it is on these two concepts-- mental illness and civil rights--that I focused my interviews with clergy. This study resists conclusions so as not to impose interpretation in place of the interpretation that has been problematized. By resisting conclusions the analysis is kept open to the question of the troublesome relations between mental illness and civil rights.

THEORETICAL FRAMEWORK AND METHODOLOGY

Chris Weedon in *Feminist practice and poststructuralist theory* (1987) describes the conceptual framework that supports this study. Although forms of poststructuralism vary in their practice and in their political implications they "share fundamental assumptions about language, meaning and subjectivity" (Weedon, 1987, p. 20). According to poststructuralism, "language is not transparent as in humanist discourse; it is not expressive and does not label a 'real' world" (Weedon, 1987, p. 44). Rather what is "real" is constituted by language and then constructed by language.

> Meanings do not exist prior to their articulation in language, and language is not an abstract system but rather is always social and historically located in discourses. Discourses represent political interests and in consequence are constantly vying for status and power. The site of this battle for power is the subjectivity of the individual, and it is a battle in which the individual is an active but not sovereign protagonist (Weedon, 1987, p. 41).

Opting for the poststructuralist focus on language instead of experience shifts attention to a site where meaning is produced and can be contested. Regarding language in this way creates a space for considering mental illness not as a fact of life to be diagnosed and treated by appropriate experts but rather as a discursive construction of language. Correspondingly it creates space for considering people with mental illness not as biologically abnormal

or deficient but rather as people who have particular characteristics that are construed in particular ways depending on the social situation in which they find themselves.

Language and discourse

Poststructuralist theory makes certain assumptions about "language, subjectivity, knowledge and truth" (Weedon, 1987, p. 22) that are useful for addressing questions of how social power is exercised and how social relations might be changed. For poststructuralist theory language is the common factor in the analysis of social organization, social meanings, power relations and individual consciousness. Language is the place where actual and possible forms of social organization and likely social and political consequences are defined and contested. It is also the place where the sense of self and individual subjectivity are constructed. The assumption that subjectivity is neither unified nor fixed but rather constructed in language in ways which are socially specific implies that subjectivity--in this study, the form of living known as mental illness--is not innate but socially produced in a whole range of discursive practices (Weedon, 1987).

Poststructuralism theorizes that language consititues social reality and the "natural" world and that neither society nor nature have fixed intrinsic meanings which language reflects or expresses. Different languages and different discourses within the same language divide up the world and give it meaning in different ways (Weedon, 1987). These different ways of dividing up the world "cannot be reduced to one another through translation or by

appeal to universally shared concepts reflecting a fixed reality" (Weedon, 1987, p. 22). Thus the meaning of mental illness, in this study, is seen not as a universally shared concept that is reflected in the language of a fixed universal reality but rather a constituted social reality that is historically specific.

Poststructuralist theory takes from Ferdinand de Saussure "the principle that meaning is produced within language rather than reflected by language" (Weedon, 1987, p. 23). Accordingly individual "signs" do not have intrinsic meaning but acquire meaning through "the language chain." Therefore poststructuralism theorizes that differences are acquired within language from other "signs." For example Saussure's theory implies that the meaning of mental illness or the qualities identified as mental illness, are not "fixed" by a natural world and reflected in the term "mental illness," but rather the meaning of mental illness is socially produced within language by the difference it represents.

Once language is viewed as discourse then language becomes a site of political struggle because it is in discourse, as a system of historically specific meaning, that differences in the organization of social power occur. The meaning of language at any particular moment depends on the discursive relations within which it is located, and so it is open to constant rereading and reinterpretation. In poststructuralism social meanings are "produced within social institutions and practices" (Weedon, 1987, p. 25) and within individuals' subjectivities which are "shaped" by these institutions. Thus individuals are not the "authors of social meaning," but rather by resisting

certain language uses can be "agents of social change" (Weedon, 1987, p. 23). In this study I sought a site where I might find different ways of giving meaning to mental illness. That site was the discourse practices of community clergy.

Language, as an "historically specific range of ways of giving meaning to social reality" (Weedon, 1987, p. 25), offers various discursive positions through which individuals consciously live. How human beings consciously live their lives, how they give meaning to their lives and how meaning is given to social relations which structure their lives "depends on the range and social power of existing discourses...access to them and the political strength of the interests which they represent" (Weedon, 1987, p. 26). Institutional sites of discourse, such as those responsible for the rehabilitation of people with mental illness, "function by the authority of what is 'natural' or 'normal' behaviour" (Weedon, 1987, p. 98), and what guarantees that authority of institutional sites of discourse has varied and will vary from "God to science to common sense" (Weedon, 1987, p. 98). The speaker who guarantees the truth of discourse sites is usually a recognized authority and the authority of such a speaker, as expert or knowledgeable, is "part of the discursive battle for subjectivity" (Weedon, 1987, p. 98).

Medical and legal discourses offer reasoned accounts of the naturalness of the ways of behaving within which the individual is constituted as a particular subject. "A scientific, medical or legal guarantee of truth helps create acceptance of the implications of particular discourses" (Weedon, 1987, p. 99). For example, particular facts must be taken as given for the

meaning of biology to be taken as natural and when biological facts must be taken as a given the meaning of biology has "inevitable social implications" (Weedon, 1987, p. 99). For a discourse to be effective and powerful, it needs "a material base in established social institutions and practices" (Weedon, 1987, p. 100).

Discourses that specify ways of being may merely imply or actually enforce particular forms of behaviour. This will depend on their social power. Along with the family and the school, psychiatric medicine and the courts can "force individuals to conform to specific forms of behaviour" (Weedon, 1987, p. 100). Mental health law, for example, distinguishes who is "abnormal" from the rest of us and in doing so "rearticulates and refixes social values" (Weedon, 1987, p. 101). Moreover particular interests, often termed "public" interests or the "general good", are at "stake in the discursive battle to determine the 'unnatural' or the 'abnormal' as threatening or dangerous" (Weedon, 1987, p. 101). In the "dominant liberal discourses of capitalist society" (Weedon, 1987, p. 28), the oppressive relationship between mental health care systems and people with mental illness is represented as a necessary contract between rational, sovereign individuals and irrational, dependent individuals. From the perspective of how individuals with mental illness and individuals without mental illness "understand their lives, this interpretation may have all the force, for them, of lived experience" (Weedon, 1987, p. 28).

Poststructuralism theorizes that people are interpellated, not socialized, into the social world. That is they are not passively shaped by others, rather

they actively take up, as their own, the discourses which shape them. This process of subjectivization is also a process of misrecognition because it relies on a structure of recognition by the individual as the subject of ideology. It is "misrecognition" in the sense that individuals "assume the authorship of the ideology which constructs their subjectivity" (Weedon, 1987, p. 30).

Common sense relies on a view of language as "transparent and true, undistorted by ideology" (Weedon, 1987, p. 77). However, if we look at examples of ideologies about mental illness it is possible to see, in general terms, "the ways in which they conceive of language and subjectivity, and how this affects their conception of the possibilities for social change" (Weedon, 1987, p. 92). In biological theory, for example, subjectivity exists prior to the language and consciousness that are "outward signs" of hormonal and chemical differences which determine the nature of the individual. Social life and communication are governed by these factors because they "determine the boundaries of what is possible and desirable" (Weedon, 1987, p. 92). In sociological theory and social psychology, biology competes with social factors in attempts to explain the acquisition of identity. "Biology and society are factors of varying importance in the acquisition of subjectivity, and language is taken to be the medium through which subjective identity is acquired in social interaction. The assumption that language is a medium implies that social relations are expressed rather than constituted in language" (Weedon, 1987, p. 93) as is assumed in poststructuralism.

In "poststructuralist theory, the structure and function of the position of the subject within discourse is the precondition for the individual to assume historically specific forms of subjectivity within particular discourses" (Weedon, 1987, p. 31). In taking on a subject position, individuals assume that they create the discourse or ideology which they are speaking and that they control its meaning. In so doing they assume they are the type of subject which humanism proposes, that is the rational and unified source rather than the effect of language.

Subjectivity in poststructuralist theory refers to all thoughts and emotions that position an individual's sense of him or herself. Subjectivity refers to the various ways people structure, by what they say and do, the sense of themselves in relation to the world. Poststructuralism assumes that it is language which enables the individual to think, speak and give meaning to the world and that meaning and consciousness, that is, subjectivity, does not exist outside language. Humanist discourse, on the other hand, presupposes that the essence of the individual is "unique, fixed and coherent" (Weedon, 1987, p. 32). Poststructuralism proposes a subjectivity which is "precarious, contradictory and constantly being reconstituted in discourse" (Weedon, 1987, p. 33) with each thought and utterance.

"Discursive fields consist of competing ways of giving meaning to the world and organizing social institutions and processes" (Weedon, 1987, p. 35). Social structures and processes that define mental illness are organized through institutions and practices such as law, psychiatric medicine, pastoral

care and education, each of which is located in and structured by a particular discursive field.

The values and interests which constitute norms for psychiatric medical care, however, are not specific to legal or psychiatric apparatuses. They have to be understood in the context of cultural narratives and ideology about mental illness, violence and the necessity to abrogate civil rights. Dominant discourses which define mental illness as naturally dangerous or harmful, together with legal and social definitions of mental illness as the inability to react normally to others and to the environment, cross a whole range of discursive fields from the family, education and employment to the representation of mental illness in the media. Conclusions widely drawn from the assumptions of dominant discourses include the belief that mental illness is a medical condition that seriously prevents people from acting in their own interest and, therefore, requires professional management and control after a medical crisis.

Differences between competing views regarding the meanings of mental illness and civil rights within the field of legal discourse are articulated in language of mental health law, government policy and in the material organization of state institutions which "control the meaning of justice, punishment, compensation and rehabilitation" (Weedon, 1987, p. 37). In this study competing views of mental illness were sought in the history of the treatment of people with mental illness, in recent mental health legislation, and in the language practices of community clergy. The meaning of treatment of mental illness varies according to the discursive position from which it is

interpreted. While legislature may explain and justify the system for treating people with mental illness in terms of a discourse of law and order based on shared values and specific notions of what constitutes the care of mentally disordered people, others may see the system in radically different terms. It is these differences this study sought to identify.

In poststruculturalist theory it is in language that individuals acquire the meaning of differences because "language differentiates and gives meaning to both assertive and compliant behaviour and teaches what is socially accepted as normal" (Weedon, 1987, p. 76). Because language is not "monolithic," meanings which are socially dominant can be "contested, and alternative meanings affirmed" (Weedon, 1987, p. 76). However, most people are concerned with the meaning of "normality" because it is in normality that social success is assured. This concern for socially defined normality will lead people to accept "dominant definitions of the necessary meanings of difference as common sense, even though common sense articulated in language, represents quite specific values and interests" (Weedon, 1987, p. 76). Common-sense assumptions are drawn from a range of sources such as education, popular culture, community standards and family, each of which propose different ways of understanding appropriate behaviour and are related to definitions of what is "natural, appropriate, moral or good" (Weedon, 1987, p. 76). "These meanings, which inevitably favour the interests of particular social groups, become fixed and widely accepted as true irrespective of sectional interests" (Weedon, 198, p. 77). In this study, community clergy were chosen as a site where the discourse of pastoral care might contain

opportunities for resistance to the uncritical adoption of commonly accepted social meanings of mental illness.

The interpretation of experience by individuals and the meaning of an event "depends on the available discourses...at any particular moment" (Weedon, 1987, p. 79). This availability has to do not just with what is known, but also with what one dares to say. In interviewing clergy, I was interested to find out to what extent their interpretations would challenge the dominant beliefs about mental illness and the political position of people with mental illness in society. Dominant discourses discredit or marginalize ways of giving meaning to experiences that redefine their preferred norms. How would clergy position themselves in relation to these common sense norms?

Humanist discourses assume that each individual possesses a unique human nature. Precisely what constitutes human nature varies between humanist discourses, but in classic liberal humanism, which is still the dominant variety, it is "rational consciousness" (Weedon, 1987, p. 80). Rationality is the the basis of the liberal political demand for equality of opportunity and the right to self-determination that is assumed to be shared by all individuals unless they are not normal as in the case of mental illness.

The assumption of the transparency of language and its appeal to experience, which distinguish common-sense knowledge, rely on a particular understanding of the individual and subjectivity which is the product of Western European humanism in which human beings are "free, rational, self-determining subjects of modern political, legal, social and aesthetic

discourses" (Weedon, 1987, p. 78). Although humanism offers people a sense of security, because they are able to see themselves as "the source of self-knowledge and of knowledge of the world, it raises some difficult political problems when subjects are socially constituted as innately lacking such knowledge" (Weedon, 1987, p. 83). If, for example, individuals are diagnosed as mentally ill or place themselves beyond the limits of what is considered socially reasonable and acceptable within the terms of the dominant beliefs and assumptions of a society, then "it is assumed that their perceptions of reality and the evidence of their experience cannot be trusted" (Weedon, 1987, p. 78). The liberal-humanist assumption that the individual subject is the source of self-knowledge and knowledge of the world can serve both as a guarantee of subjective security and "justification for repressive social relations" (Weedon, 1987, p. 79). If a person with mental illness lacks the self knowledge to manage his or her life and therefore requires treatment and rehabilitation, this means in social terms that their primary location and sphere of influence is the mental health care system and psychiatric facilities, where those with access to expert knowledge can make decisions on their behalf, effectively limiting their civil rights.

Basic principles of poststructuralism are "the plurality of language and the impossibility of fixing meaning once and for all" (Weedon, 1987, p. 85). Any interpretation is at best temporary, specific to the discourse within which it is produced and open to challenge. "The degree to which meanings are vulnerable at a particular moment depends on the discursive power relations within which they are located" (Weedon, 1987, p. 85). Poststructuralism looks to the "historically and socially specific discursive production of

conflicting and competing meanings" (Weedon, 1987, p. 85). These meanings are only temporarily fixed and this temporary fixing has important social implications in the determining effects it has on the constitution of social reality. "If language is the site where meaningful experience is constituted, then language also determines how possibilities of transformation are perceived" (Weedon, 1987, p. 86). It is precisely these possibilities that were sought in this study.

Study design

Studying discourse entails an interpretive reading of a social situation or practice focusing on language as the place where social reality is constructed and subjectivities of groups and individuals are constituted. As a researcher using Foucauldian theory I was interested in looking for underlying assumptions of ideological or cultural narratives that inform language practices and reveal dynamics of power which are invested in various and competing discourses. In the case of this study I was looking at language and discursive practice as sites where the various meanings of mental illness construct notions of civil rights and where there are possibilities for transforming oppressive social relations. Because my interest is on the way language produces and reproduces knowledge that has determining social effects I opted not to use sociological methodology because, having read a range of sociological literature, I became skeptical of the "truth" of any assumptions about people with mental illness.

Prompted by the self-observation described in the Introduction I decided to focus on the discursive construction of mental illness, and so I designed a study of language. As a researcher I was interested in the range of languages which define various meanings of mental illness, meanings which in turn produce differential respect for civil rights. Because I was particularly interested in the tensions between dominant discourses that normalize the meaning of mental illness and the potential agency of community members to resist those discourses, my strategy was to juxtapose definitions of mental illness with interpretations of the issues of civil rights particularly the abrogation of civil rights of people with mental illness as these occur in the text of mental health law and the text of clergy interviews.

To get to the crux of my interest in the problematic relations between the various meanings of mental illness and issues of civil rights, I devised a way to focus specifically on the tension between the normalizing practices prescribed by the dominant discourses of psychiatric medicine and law on the one hand and the agency of community clergy to reinterpret and redefine mental illness on the other.

In keeping with Foucault's emphasis on historically specific discourses and to create a context for both myself and readers of my thesis, I began the study with a brief social history of ways that mental illness and civil rights for people with mental illness have been constructed. A brief history of the incarceration and subsequent release into the community of people with mental illness shows that the sociohistoric construction of mental illness and the problem of social justice that it produces continues to have powerful

determining effects on people's lives. Next, a discussion of language of current legal documents that govern the freedom of people with mental illness demonstrates the meaning of mental illness, patient and treatment as constructed in law. I conclude with an interpretation of my own subjective position as a teacher employed in the mental health care system.

Having observed my own interpellation into the discourse of medical psychiatry I decided to study the language of other non-medical community workers who also worked with people with mental illness to see if they were similarily coopted (Dippo, 1990). Given a life time of concern for social justice I chose a site to study located between two extremes of the powerless and the powerful. I sought a site to study where there was some evidence of discourse practice that would be less oppressive and more inclusive than the dominant discourse must necessarily be. I did not choose to study the subjectivity of people with mental illness because they are relatively voiceless in the construction of their own subjectivity and relatively powerless to offer any resistance. I also did not choose to study the subjectivity of the most powerful voices in the social construction of mental illness because I don't perceive much possibility for change beyond what has been effected.

Situated as it is between these two extremes, as a place where resistance could be enacted and the possibility for change exists, the language of clergy offered a site which, I suspected, might work against the dividing and segregating effects of the dominant psychiatric medical discourse because their discourse of pastoral care contained a special impetus toward inclusivity. To study the social construction of mental illness and the differential respect

for civil rights it produces in the language of community clergy, I decided to ask clergy about their interpretations of mental illness in order to get at discourse practices and not just descriptions of experience. I devised interview questions with this specific aim in mind drawing on my own familiarity with behavioral manifestations that signal mental illness and the declared focus of the study on the intersections between mental illness and civil rights. The interview design and the construction of the interview text as conversation was inspired by Roth, McRobbie & Lucas (1998) and Roth & McRobbie (1999).

After the University of Victoria Ethics Review Committee on Research (Appendix A) had examined and approved my research proposal I determined to engage interview participants in metadiscussions about their experience (Roth, McRobbie & Lucas, 1998). That is, I determined to ask them about their understanding and interpretations of mental illness as they encounter people with mental illness in their daily work. I conclude the study with reflections on the discursive practices I analyzed and especially on the implications for my work as an adult educator working with people with mental illness.

In describing the use of discourse analysis as a research tool, Janks (1997) points to the importance of working simultaneously with specific verbal or visual texts, the conditions under which these texts are produced, and the sociohistorical context of this production. In this study I focused on the interview texts of clergy and I contextualized these texts with field observations of church services and descriptions of the history of the

construction of mental illness up to and including present legislation on the issue of mental illness and civil rights. As Janks (1997) recommends, the texts and the conditions of their production were read alongside each other in order to portray the ways in which existing social relations are reproduced or contested. This reading entails simultaneously description, interpretation and analysis. These activities do not proceed according to specific, step-by-step procedures but rather seek out the patterns of social relations that discourses construct. The strategic decision to juxtapose the concept of mental illness with the concept of civil rights allowed me to focus my study on the particular patterns of restrictive or respectful treatment and care of people with mental illness constructed in the discourse practices of society at large and of community clergy in particular. From a Foucauldian perspective, the task was a matter of identifying the ways in which available discourses are employed in a particular time and place, paying attention to the historical conditions that determine availability and use of the discourses under study.

Validity is a thorny issue in discourse analysis studies, for there are no "objective" data to which the research can refer. Every text and every statement is already an interpretation; they are already subsumed within and a product of discourse. In the famous statement attributed to Derrida, "There is nothing outside the text." There are no objective standards which can guarantee to the validity of the results of a discourse analysis. It must be admitted, as Kvale (cited in Oberg) points out, that validity itself is a social construction. What is crucial in postmodern inquiry is the production of an open text, which stimulates active interpretation on the part of the reader. Alvesson and Skoldeberg (cited in Oberg) advise postmodern researchers to

avoid giving an "authoritative" interpretation and thus "closing" their text. However, not any interpretation is acceptable. Denzin (cited in Oberg) points out that ultimately, the interpretation given must be believable, either in its coherence or in its continually disruptive and ongoing political analysis.

If there is nothing outside of discourse, then the researcher as well as the research is an effect of discourse. The conscious and unconscious motivations of the researcher are an acknowledged part of the research process and must be taken into account in a reader's interpretation of the study. As described above, my own awareness of my interpellation into discourses of psychiatric medicine was the origin of this study, my ongoing commitment and sensitivity to issues of civil rights of marginalized peoples was the source of the study design, and my desire for social transformation shaped my final reflections. The intertwining of researcher and research text produces both advantages and disadvantages that must be balanced. The researcher's relation to the discourse practices being analyzed locate her in various reading positions which Janks characterizes by the two binary terms, "engaged" and "estranged" (Janks, 1997, p. 330-331). The researcher assumes a position of estrangement when she disagrees with the meanings constituted by the discourses being studied. From such a position it is relatively easy to notice the effects of discursive practices and to identify the interests served and the oppressive relations created by them, in short, to assume the critical stance required by the project of discourse analysis. A position of engagement, on the other hand, makes these discernments more difficult. From such a position, the researcher is interpellated into the discourse and takes it as "natural." Both estrangement and engagement can

be forms of entrapment--the former, a confinement within the limits of one's own subjectivity and the latter a submission of one's subjectivity to the power of the discursive text. Janks (1997) argues that both positions are necessary to counterbalance each other. I believe I can claim to have achieved such a counterbalance, having begun in a position of engagement where I was coopted unawares into the discourse of psychiatric medicine in my own educational practice, and moving to a position of estrangement where I critique the effect of the discourse of psychiatric medicine and law on the civil rights of people with mental illness.

HISTORICAL DISCURSIVE CONTEXTS OF MENTAL ILLNESS

Historical construction of mental illness

Until the mid-20th century the insane were normally maintained in residential asylums which were physical places similar to prisons. People who worked in the asylums altered the conduct of inmates by means of psychiatric treatment. After World War II public health care systems throughout Europe and North America closed and radically downsized residential psychiatric hospitals, and the inmates moved into their communities to live and receive treatment.

Before the creation of the hospital and the authority of medicine and science to account for mental illness, people who exhibited irrational and unpredictable behavior were accounted for in various ways. At times they were described as possessed by demons, or their visions were heeded as divine; they were considered fools to be tolerated by the community or, like the lepers before them, they were perceived as dangerous or worthless and lived on the margins of the community.

Specialized knowledge and attendant language of professional medicine accompanied the construction of the hospital in the 17th century (Foucault, 1984). In conjunction with and as part of the political and moral establishment professional medicine created apparently reasonable laws for the involuntary incarceration of the mad, the sick and the dispossessed.

When asylums were later established for the protection and care of the insane as a separate pathological group, the medical profession had determined madness to be a physical illness in which the symptoms of disease included, as well as aberrant behavior, the loss of moral conscience. Psychiatric medical discourse created a specialized, authoritative knowledge that named and categorized various mental sicknesses. As subjects of knowledge insane individuals, devoid of personal and social responsibility, embodied the thing called mental sickness upon which the medical profession acquired the legal and moral right to research, experiment and control.

Because psychiatric and medical classifications produced specifications and categorizations of normal and abnormal/sick and well, the knowledge of psychiatric medical discourse constructed the organized management of the lives of socially and politically marginalized people--the addict, the retarded and the mentally ill. Psychiatric medical discourse systematically classified, treated and rehabilitated social anomalies, that is, it normalized by corrective or therapeutic procedures wrong behaviour. The power of psychiatric medical systems to take charge of life, to manage life, required continuous regulatory and corrective mechanisms to qualify, measure, appraise and hierarchize discrete pieces of information about behavior observed in the hospital as well as the community. In the normalization process this information of finely graded measurements of behavior created massive record keeping systems from which statistical analysis generated scientific proofs of sickness and decreased mental capacity (Foucault, 1984).

By the mid-20th century public insane asylums had become anathema to liberal beliefs about individual freedom and human rights. Photo exposes, films and autobiographies raised social awareness about the corruption of residential institutions whether residential schools, orphanages, juvenile detention homes, prisons or hospitals. Scholars and humanist researchers examined and deconstructed the meaning of insanity. Radical psychiatrists and anti-psychiatry activists challenged the authority of institutional psychiatry to explain psychological pain. Patient activists and their families advocated vigorously for community integration and better medical treatment. Not until medical and pharmaceutical research had developed and tested neuroleptic medication that could effectively restrain the behavior of people diagnosed with mental illness did residential hospitals relinquish their prerogative to manage and control psychiatric patients in institutional sites. Only the site changed, however, and in contemporary discourses on mental illness the necessary role of community care continues to be the necessary treatment and management of people with mental illness by mental health care systems dominated by psychiatric medicine.

The political position of people with mental illness as it is defined by laws, regulations and social policies continues to contradict liberal notions of identity and equality, personal choice, and protection from harm. Psychiatric medical diagnoses, which are inadequate descriptors for complex interactions amongst individuals and society, inform all contemporary mental health laws and regulations that establish policies for incarceration and management. By these policies, emergency response teams and police officers respond to behavior identified as mental illness; public hospitals accept, assess, treat and

detain voluntary and involuntary psychiatric patients; mental health care workers implement community treatment plans that are prescribed by psychiatrists and delivered by public health care facilities and community agencies. These services include, as well as psychiatric treatment and financial support, assertive case management to assure treatment compliance and illness management; life skills and recreation programs; particular employment and education counselling; supported independent living programs, group homes and managed apartment buildings (Cook and Hoffschmidt, 1995). The language of management and control is effected in the community then legitimated by law.

Contradictions between languages of civil rights and mental illness

The discourses and practices of psychiatric medicine and law intersect when the people who use labels of mental illness are able legally to dictate what a citizen must do. The use of mental illness concepts as signs of a person's capacity to make choices has profound effects on how people live their lives. The language and practice of civil rights is located in laws and systems which reconcile, arbitrate and dominate a person's freedom, protection from harm, and access to medical treatment.

Mental illness has always been associated discursively with danger, and a device that remains within the discourse of citizenship and civil rights is required so as to permit incarceration of potentially dangerous citizens. This device is mental health law. Mental health legislation is a set of rules for the apprehension, incarceration, and voluntary/ involuntary psychiatric treatment

of people who are identified as mentally disordered (Savage & McKague, 1987). These rules manage the behavior of individuals for whom a determination has been made that a psychological disorder deprives them of the ability to recognize that they are ill and therefore unable to comprehend effects of their actions. The stated intention of mental health law is to protect the individual and community from harm.

When is a person with mental illness behaving like a person without a mental illness? A young man who had previously covered his head with tin foil to block extra terrestrial voices impulsively stabs his mother as she is doing the dishes. Who has the authority to predict danger and report of harm? A terrified man holding an axe hides in his bathroom as heavily armed police officers break into his home. How does the community reconcile a person's right to choose treatment and his or her right to receive treatment? A woman known to be plagued by continuously demanding voices commits suicide.

The theme of civil rights in this study refers to the civil rights of citizens to participate equitably in the public services of the community in which they live. This study asks of the meaning of mental illness and the abrogation of the civil rights of psychiatric patients in the text of mental health law whose freedom is being safeguarded and from what? How does law define mental illness and the psychiatric patient? What are the limits to managing another person's life away from a closed institutional environment? Who, in what social system, has acquired the necessary authority to isolate and imprison a person as a subject of psychiatric treatment and research? What is meant by social harmony and the rights of citizens to protect

themselves and each other from the sanctioned harm of compulsory psychiatric treatment?

The introduction of The BC Mental Health Amendment Act (Bill 22) to the British Columbia legislature in 1998 raised considerable debate among those community groups and individuals who argued that it diminished the rights of people to choose treatment and those who claimed that it strengthened the rights of people to receive medical treatment. The debated issues included involuntary hospital admission and psychiatric treatment, compliance with psychiatric treatment plans as a condition of release from a psychiatric facility, and the individual's right to decline treatment or to seek alternative treatment ("Bill 22 here Nov. 15th, 1999"; Canadian Mental Health Association, 1998; Gutray, 1998). Two ideas in the debate show the role of psychiatric medical discourse in the construction of rules of civil conduct. First is the requirement that some patients under psychiatric management must comply with psychiatric treatment while living in the community or be institutionalized. Second is the requirement that the justice system must take into account a person's previous history of treatment compliance when considering involuntary admission and continuing incarceration.

The text of Bill 22 and Ministry of Health explanations of Bill 22 (British Columbia Ministry of Health, 1998) demonstrate the intersection of psychiatric and legal discourses and the interpellation of subjects into the external management and control of their own lives. The words and statements that define disorder, patient and treatment in Bill 22 function in

both involuntary psychiatric hospital admission criteria and the legal criteria that considers the individual's history of compliance with involuntary treatment outside the hospital.

Meanings for disorder, patient, and treatment which appear in a list of definitions in Bill 22 (British Columbia Ministry of Health and Minister Responsible for Seniors, 1998) and the meaning of patient as it is described in *Questions and answers on Bill 22* (British Columbia Ministry of Health, 1998) illustrate how the dominant discourse constructs language so as to make it appear less dividing or segregating. This is important because the interpellation of an individual's subjectivity into the dominant discourse requires language that appears normal and inclusive if the social effects it produces are to be construed as natural. Bill 22 eliminates the "mentally ill person" and the "mentally retarded person" and replaces these with the "mentally disordered person" which means a person who is "receiving care, treatment, maintenance or rehabilitation or is received, detained or taken charge of as a mentally disordered person or as an apparently mentally disordered person" (British Columbia Minister of Health and Minister Responsible for Seniors, 1998, p.1). An amendment to Bill 22 changed the wording in the definition to "persons with a mental disorder" from "mentally disordered persons" to emphasize the "personhood" of the individual with the illness (British Columbia Ministry of Health, 1998). *Questions and Answers on Bill 22* (British Columbia Ministry of Health, 1998) in an explanation for the use of the term "patient" in mental health law shows how language is used to construct the notion of neutrality in dominant discourse.

> Prior to admission to hospital, the person is referred to in the Mental Health Act and Bill 22 as a person. Once admitted, the person is referred as a 'patient'. There is nothing denigrating about the term 'patient'. We are all a patient to our optometrists, family physicians or upon admission to a hospital for a medical condition" (British Columbia Minister of Health, 1998, p.15).

"Treatment" means psychiatric treatment and includes any procedure necessarily related to the "safe and effective provision of psychiatric treatment" (British Columbia Minister of Health and Minister Responsible for Seniors, 1998, p.1). The adjectives, "safe and effective," were added by amendment to Bill 22. An explanation for reasons why a definition for psychiatric treatment has been added in Bill 22 illustrates how language that has powerful ramifications for peoples' lives may be presented so as to appear benign.

> The Act's current wording is somewhat confusing. Sometimes treatment is referred to as a medical treatment and sometimes as treatment. Bill 22 makes it clear that the only type of involuntary treatment which can be authorized is psychiatric treatment and not surgery or other medical treatments (British Columbia Ministry of Health, 1987, p. 4).

The following quote, which appears in *Questions and Answers*, was an answer to the question as to why there is a need for involuntary treatment and the Mental Health Act. It represents the common sense necessity for mental

health law and involuntary treatment, namely the protection of the individuals and the community from the harm that results from mental illness. The sense of this justification is important because it is repeated variously thoughout the texts of constructed conversations with community clergy which appear later in the study.

> There is sometimes a need for the involuntary treatment of people with a mental illness because illnesses of the brain, such as schizophrenia or manic depression, rob people of the ability to understand they are ill and need treatment to restore basic levels of functioning. Such people may have hallucinations, mood swings, delusions or thought disorder, which may cause them to refuse voluntary treatment, as well as harm themselves or others. Without involuntary treatment, such people suffer unnecessarily, sometimes become involved with the criminal justice system and lose their employment. With each successive breakdown, the possibility of returning to normal levels of functioning significantly diminishes. Left untreated, many people with serious mental illness are at risk of becoming sicker and being victimized because of eccentric behavior. The Mental Health Act provides access to treatment and legal protections for people who are unable or unwilling to seek voluntary treatment (British Columbia Minister of Health, 1998, p.1).

The discursive construction of mental illness in my own professional practice

Citizens participate in their own subjectivity when they actively take up as their own the discourses that shape them. As an employee in the mental health care system I too am interpellated into psychiatric medical discourse. My subject position in psychiatric medical discourse shows up in my practice when I agree with other mental health care workers that a client's dismissal of the efficacy of medications is a symptom of illness, a sign of paranoia, or when I agree with other mental health care workers that a student's understanding is in error when they characterize their inability to comprehend learning material as an effect of medications.

After residential psychiatric hospitals radically downsized and closed in the latter half of the twentieth century psychiatric patients moved into the community where they were expected to receive and comply with psychiatric treatment and at the same time to participate in socially complex community activities with people who may or may not be mentally ill. As a community-based adult educator working in a psychosocial rehabilitation program I facilitate this move. Specifically I assist people with mental illness to access and successfully achieve the educational services of their choice. I provide a range of educational services to a range of individuals who vary by age, experience, skills, goals and plans. Most people want information about courses, programs and funding relevant to their educational and occupational experiences. Together we evaluate educational goals and plans, discuss study skills and time management, strategize for the possibility of changing or

withdrawing from programs and courses, and prepare for the possibility of disability accommodation.

I have been taught in my job to notice signs of mental illness that are supposed to characterize the challenges people face when they participate in complex social environments. These signs are inappropriate and bizarre behavior and appearance, distractedness, disconnected talk, volatile and agitated emotions, and conversely flat and deadened emotions. From these lessons I have learned to speak unselfconsciously of clients and students in psychiatric medical language and consequently to focus on notions of diagnosis, symptoms, illness, medication and psychiatric history. I find it is easy to assume that mental illness is the primary interference in a person's capacity to learn or to adjust to an educational setting and not some other interference such as dyslexia or the normal increase of anxiety that accompanies an adult's return to school.

Labels that are constructed by notions of mental illness dramatically affect the lives of both people who are diagnosed and treated as mentally ill and those who are not so designated. Labels of mental illness can skew not only my respect for students' academic achievement but also the ways in which students characterize respect for their own achievements. For example, a post secondary student talked to me about the enormous stress she puts on herself to achieve A+ marks so she will be assured a place in graduate studies. She told me that through psychiatric care she had come to understand herself as obssessive compulsive with borderline personality disorder, and I nodded agreeably that this could be why she drove herself so hard, and why it was

that even when achieving the highest possible marks she felt inadequate and unhappy. In another context, however, she could be described perhaps as an exemplary student because she is achieving outstanding first class marks by taking responsibility for herself and her studies all the time.

I became curious about why it is that I would use the unfamiliar language of psychiatric medical diagnosis and treatment to address issues of education. I wondered how other working people use the language of mental illness to characterize behavior or physical difference and how this characterization has determining effects in regard to their responses to unpredictable or startling behaviour, behavior which might become the justification for curtailment of the person's civil rights.

STUDYING DISCURSIVE PRACTICES OF COMMUNITY CLERGY

In this section I describe the social conditions of the discursive production of pastoral care as observed during field visits to twelve Christian churches; the procedures used to select community clergy to participate in the study and a brief characterization of who these people were; the procedures and rationale for the construction of the interview protocol; and the strategies employed in the construction and analysis of the interview texts.

Social conditions of the discursive production of pastoral care

Foucault's (1972) analysis of cultural phenomena shifts attention from objects and ideas to the structure of organized bodies of knowledge and practice in their specific spatiotemporal articulations. Foucault identifies and classifies functions and relations rather than things. To put the interview text into a spatial and temporal context of community I visited the Sunday services of various Christian churches and took note of functions of space, ambience, music, spoken word, text and relations among the clergy, the congregation and myself as a visitor.

These observations served to identify the social conditions that affected the production of clergy discourse as subsequently reported in the interview text. As can be seen from the interpretations of fieldnotes that follow, the churches were particular public sites where people gathered who were representive of a wider community, including people who might have been

diagnosed with mental illness. However, in the churches, the norm seemed to be inclusivity instead of segregation. Behaviors that might have prompted various labels of abnormality or social deviance in other public gatherings, such as admission of drug addiction, bodily shaking and calling out, involuntary physical movements, extreme restlessness, or falling onto the ground, were received without comment or other show of concern. Available discourses of disapproval, embarrassment, furtiveness, or disregard were not in evidence. On the contrary, these behaviors were taken as falling within the range of acceptability and normalcy in this context of religious ritual and pastoral community. The degree of inclusivity witnessed in these churches created an oasis where people who would likely have been ostracized within the larger society found acceptance. This inclusivity was likely both effect and determiner of the character of pastoral care discourses evidenced by clergy who were interviewed.

I chose to visit Christian churches because as a Christian my misunderstanding of rituals would be minimized, and I would not be distracted by self-consciousness in an completely unfamiliar environment. The churches were referred to me, randomly chosen from the Saturday church directory in the local newspaper or had some personal significance. These visits were not in anyway related to the community clergy who were interviewed for the study; rather these visits were intended to portray general structural and institutional conditions for practices of pastoral care that are later discussed by the participants. Interpretations of my observations of the practice of pastoral care follow in italics.

The auditorium is filling quickly. People dressed in their very best greet each other warmly and there is a sense that something very exciting is about to happen. There is an atmosphere of confidence and cleanliness. People stand, raise their hands and sing. The lady front of me holds a little boy with Down's syndrome. He faces me directly over the woman's shoulder. He laughs at me as he bounces in her arms to the rhythm of the music and raises his little hands into the air. As I sing I watch him and my eyes fill with sudden and surprising tears. The woman looks at the child with pride and smiles at me.

The congregation is invited to come to the front and be led in prayer by an experienced and committed member of the church. I walk down the aisle, stand by the steps and wait. Presently a gentleman joins me, takes my hands and facing me quite closely asks me to pray. I bow my head and he begins to speak quietly in words that make no sense to me, but I relax my body and arms and let the words and circumstances flow over me. He continues to pray and soon lets go of my hands. I thank him and go back to my seat. Later we introduce ourselves and chat. He asks me about my occupation and the research I'm doing. I tell him that I am an education counsellor and my research has to do with community attitudes about mental illness. He tells me it is important that I protect myself from evil and invites me to meet with him and his wife after the service. I accept his invitation because, I tell him, I would like to understand more about the language he used in prayer.

As the service ends I meet with Keith, Elizabeth, his wife, and Ray another member of the congregation. In a small square room to the side of the

auditorium we sit in a close circle. Elizabeth holds my hand, and I feel her shaking. Keith and Ray answer my questions and ask me to read passages from the Bible. They explain utterances. Keith says they believe that although the intellect has its purposes when God speaks He speaks directly from the heart to the mouth. He tells me that when he prays publicly or privately he has no idea what sounds will come out of his mouth. This is prayer, he says, through the Holy Spirit and not conscious thought. I thank them and again we hold hands as they pray for me.

The day is warm for January and it is a pleasant walk through the quiet residential streets where massive trees and old gardens surround large Victorian homes converted for the most part into apartments which provide inexpensive family housing. The church, once closed and deteriorating, has been renovated. At the beginning of the service children are called to the front of the platform to renew their pledges to God and promise to live a clean life free from drugs and alcohol. When the short service ends an elderly lady introduces herself and invites me to coffee and cookies in the Sunday school room downstairs.

I am introduced to Kevin, a thin man in his late twenties, who talks to me about his wife, children and the church. He is an intravenous drug user, he says, and his wife, whom he introduces, is an alcoholic who has been sober for two years. They have four children under six. He tells me they have lost the children twice to social services and were told, he says, that if it happens again the kids will be put up for adoption. He tries hard, he says, to stay off heroin but has trouble when they get the GST cheque. He and his family

receive support through the church where friends don't judge and accept them for themselves. Kevin tells me their childhoods were characterized by drunken violence, and they want to give their children a better life. This isn't an excuse, he says, for his drug use and he's ashamed that his son has watched him inject.

The exceptionally beautiful little church is a plain white wooden building with black trim surrounded by mature hydrangeas and other shrubs. The small garden is well attended. Inside the sunlight is diffused by brilliant stained glass. The sanctuary holds roughly one hundred people. Over the years a thick coat of brown enamel paint has been layered onto the pews. The cushions are comfortable and kneeling rails fold down. The back of the pews hold prayer books and hymnals. The walls are paneled wainscoting and white plaster heavily decorated with military flags and commemorative plaques. At times the church is very quiet and the odd sounds of a baby's rattle and babble ring crystal clear. In front of me I say hello to two people with whom I'm acquainted. While the choir and congregation quietly sing, ten small children walk self-consciously to the front and sit on the steps to listen to a story. Jeffrey positions his wheelchair so he too becomes part of the small group of children, and Rod, rumpled and scrunched up in his big green parka, leans forward and smiles and grimaces from involuntary movements caused by medications.

Mike met with me after church. He is highly agitated, unkempt, and white foam flecks his dry mouth. He tells me he was upset last week and Doug took him for a shot. Mike says he has paranoid schizophrenia, but he doesn't hear

voices or hallucinate. "I'm not bad that way," he says. He says that he's reacting to the medication and his anxiety level is high. He's extremely restless. He is comfortable pacing while we talk. He picks up his coffee and has a sip as he goes by the table then sits down to smoke a cigarette. I ask him what the restlessness feels like. Does it feel like an ache or a pain? "No," he says, "It feels like lust."

The bright, white room, the cedar arch and paneling, the simple cross, the pulpit, the reading stand and stunning tapestry, the organ and piano, the ornately carved and polished table that serves as the altar, the blonde wooden pews with scarlet cushions, the smell and feel of the books; the atmosphere is exactly as I remember and I am emotionally overwhelmed by sensuous memory. For a few moments my heart speeds up, my hands shake, I am light headed and disoriented. A lady behind me finds the song in the hymnal for me and I sing to keep from weeping.

I'm a little late today and I can hear the music a block away. It is a well lit room, rows of clean, comfortable chairs face a low stage. At the end of the centre aisle a wooden lectern is flanked by pots of large white Easter lilies. I say hello to a woman I have known for a number of years. She touches my arm to welcome me to her church. She is physically vulnerable and psychiatric issues often cause her difficulties. One day when we met on the bus she told me that she had committed herself to her faith.

Two musicians with an acoustic guitar and tambourine lead the congregation as we sing the words of the liturgy projected onto the overhead screen. I have

been moved to tears by church choirs singing fabulous old hymns and have swelled and sung from pure joy to the music of electric blues and acoustic guitars, small combos, professional pianists and pipe organists, but I have not felt so much a part of the music as I do at this little street church. I feel I am contributing to the pleasure of all of us. My body is smiling and I am filled with the desire to sing and clap my hands and move all over to the rhythm. I recognize the prayers of the ancient liturgy in the continuous singing. I am absorbed in the music. A man in a neat secondhand suit whose face has been carved by a hard life sings as tears stream down his cheeks. He sits down and wipes his face with a large white handkerchief, then he stands and continues to sing the beautiful melodies and words.

I recognize a man who comes in the door and quietly takes a seat just behind me to the right. I turn and smile hello. He looks surprised and pleased to see me. He has a soft voice and soft movements. Even when he is very drunk, he is gentle and quiet. After the service we talk outside. He asks me what I'm doing here. I tell him I'm visiting. He tells me he likes to visit other churches too and that he has been attending this particular church since 1979.

For the first hour the congregation of about 120 people sing and clap and dance to lovely long riffs of an electric blues sound lead by a young man with dreadlocks. The lyrics are simple and repetitive. Children run excitedly about the room dancing, singing and playing games. Outside children climb the rocks and trees opposite the parking lot. Parents hold babies, and teenagers lounge on the sofas and each other at the back of the room. There are some middle aged and a few elderly people but the congregation is

predominately young men and women with babies and children. They are comfortably dressed in long skirts and dresses, blue jeans and overalls.

During coffee break I stand in line with Dave. We talk about various churches we know. I tell him how active I find this congregation. He tells me that 40% of the congregation are children and teenagers and that it is important for kids to be free to enjoy themselves. When I comment on how much I enjoy the music, Dave suggests that if I want good music to come to the blues jam.

After coffee break the children go off to separate activities. Prayers are said for the people of Kosovo and to remove insanity and sickness. A man speaks softly into a microphone while a guitar plays quietly behind him. He interacts with the congregation in a thoughtful discussion about the meaning of worship. The teenagers continue to lounge and talk quietly amongst themselves. Across the room from me a woman stands with her arms at her sides, her body vibrates and her head compulsively shakes. She is unrestrained. She radiates energy and her wide eyes gaze internally. When she comes out of her trance she is calm and radiant. Other people stand and their bodies sway, their arms outstretched and palms up, their eyes are closed. People who may fall are gently surrounded, hands reach out to them but they are not directly touched. Some kneel on the floor. Prayer continues as the children return and people prepare to leave. Space opens up in front of the stage where a group moves to pray with those who wish to receive healing and physical renewal. People form circles around individuals who

convulsively shake and at times fall to the floor. They wave their hands over the person as though they are brushing away flies.

Characterization and selection of community clergy

Community clergy were invited to participate in this study because they live where they work and in their occupations directly serve the community including people with mental illness and not particularly people with mental illness. Their work includes study and writing, conducting public religious services, the management of staff and volunteers, service on committees, teaching and individual counselling to members of the church as well as members of the general public who seek them out. Because religious services are inclusive public events, clergy may serve a wide demographic cross-section of the community. They have post secondary education and training, and they work within policy they do not directly create and with which they may or may not agree. They rely upon their discretion, experience and training to assess particular situations and make independent decisions. Their relations with the public are often emotionally intimate because they have to do with material and spiritual reality.

The participants in this study selected themselves for the project, and in so doing demonstrated a particular interest in issues of mental illness and civil rights. An invitation to participate (see Appendix B) was send to each organization listed under Churches & Other Places Of Worship in the yellow pages of the local telephone book. I did not want to select the participants by religion or culture, but rather by their availability to the community. The

telephone book was useful because it is a common reference of community services and allowed me to blindly contact prospective participants. I attempted to contact each organization by telephone for the name, title and full address of a clergy representative to whom I could mail an invitation to participate. When I was unable to make contact by telephone I mailed the letter and invitation to the address that was listed. Fifteen clergy responded and twelve agreed to participate in not more than two, one-and-a-half to two-hour, interviews.

The short contextual observations below introduce the research project as it was presented to the participants and are interspersed with my reflexive account in italics as counter-point to the formality of the research process. (See consent form in Appendix C) The presentation of this section suggests both the personalities of the participants and the atmosphere of the offices where they work and the interviews were held. The atmosphere of the participants' offices is a factor in the how they talked about their experiences and ideas in that their work sites reflect their interpretations of their practice as clergy. That is, the space in which they practice is an accessible and private place where people enter and leave by choice. The significance of order and safety, cleanliness, warmth and refreshment in clergy offices reappears in their talk about mental illness and civil rights.

Soft morning air and the dusty, sweet smell of the garden drifts through an open window.

Researcher: Before we begin I would like to review with you the intentions of my research and ask you to read and sign a consent form for participation.

Bright cotton carpets and primitive artifacts glow in the warm dim room as the cool summer rain beats on the window.

Researcher: The study is an exploration your experiences, beliefs and opinions about mental illness and civil rights. I am interested to know how you recognize severe mental illness and what meanings you attach to it in the normal course of your occupation.

Friday afternoon, it's hot, and we've been talking for almost two hours. I'm feeling cramped in the small room. I listen and gaze through the open window opposite me that frames a deep green chestnut tree against a blue sky. Fifteen minutes and one more answer.

Researcher: I am interested to hear your reflections upon the meaning of civil rights in general and the civil rights of people with severe mental illness as they have to do with involuntary treatment.

The room is shady and cool. I recognize journals, references, biographies, histories and novels. Large maps of the city and the province are pinned on the wall behind the desk. The desk is piled with binders and loose papers, and the computer has been left on.

Researcher: The research will contribute to two fundamental questions: How does the community recognize mental illness? How does the community value the civil rights of people with mental illness?

For several minutes we sit without speaking, I am absorbed in the stunning panorama of a sundrenched ocean. She has more to say to make sense of complexity and ambivalence. I watch her face. She speaks intently stumbling around with uncertain language. We're almost finished and I'm concerned about the tape. I shift my gaze. She loses her place.

Researcher: In the data you will be reported only as community clergy without identification of name, personal characteristics, religion, denomination or sect.

Construction of the interview protocol

At first I thought I would do two one-hour interviews, but I realized early in the project that the concentration the participants gave to the interview could be comfortably sustained for an hour and a half to two hours. Also their responses were spontaneous in that first interview and a second interview would have been a different experience. Except for one participant who asked for three questions in advance as examples, the questions were not known before the interviews. At the end of each interview I invited the participants to contact me if they wanted to discuss the project, any of the issues that were raised in the interviews, or if they wanted to extend the interview. None did.

The interviews were structured by a series of questions (Appendix D), constructed before I did the interviews, that were intended to reveal intersections of mental illness and civil rights in the language of the participants' answers. The questions were designed to focus specifically on clergy interpretations of contradictory and complex notions contained within the particular words "mental illness" and "civil rights" when these words are put together to represent a third notion--"mental illness and civil rights." In other words the questions were structured to answer the question: How do community clergy talk about one, mental illness as they see it in their jobs and two, what do they do about mental illness in relation to issues of civil rights? To find answers to this question I then reworded it as a topic of research: How do community clergy construct various meanings of mental illness and how do they interpret their responses to issues of mental illness and civil rights?

When I was thinking about how to structure a study that would perhaps answer this question I began by asking: What do I specifically want to find out in the interviews? I decided that I wanted to know how clergy talk about mental illness and civil rights by hearing, in their language, how they experience mental illness; how they interpret relations between clergy and the church, and people with mental illness; how they understand hallucinations and delusions; how they define mental illness; how they understand civil rights; and how they understand civil rights and involuntary psychiatric treatment. Because I wanted to encourage the participants to address, as directly as possible, these six themes in the interviews I designed a series of

twelve questions that synthesized the the ideas contained within the themes. These questions required thoughtful answers as to how the participants:

1. Experienced people with mental illness in their jobs. By listening to work stories I hoped to be able to hear in their language the participants' social construction of people with mental illness.

2. Interpreted relations between clergy and the church on the one hand and people with mental illness on the other hand. Interpretations of experience construct social meaning and practice. Therefore, the clergys' interpretations of what it meant for them to be clergy and what the church meant to them and their interpretations of what they and the church meant to the people they serve, particularly people with mental illness, were intended to show how they construct in language who they are as clergy, where they practice and what they do as they practice their occupation.

3. Understood hallucinations and delusions. Interpretations of what people see in others are constructed in discourses that are available to them. Therefore I specifically asked in this study about hallucinations and delusions as symptoms of mental illness because these have been historically connected to some understanding of spirituality or interpretation of God.

4. Defined mental illness. I knew from my own experience that the language of my work, adult education, did not have language that helped me define what I meant when I talked about mental illness as a thing that

someone acquires. Therefore I wanted to know what clergy thought they might mean when they used the word "mental illness" to describe an object.

5. Understood civil rights. Because I was not interested in studying discourse that structures civil rights except in its relation to mental illness, the notion of civil rights is not clearly defined in the thesis. Therefore I was not interested in definitive meanings about civil rights but rather how clergy interpreted in a broad, vague and theoretical way their understanding of the notion of civil rights.

6. Understood civil rights in terms of involuntary psychiatric treatment. It is in language that society constructs its knowledge of what is right and wrong and what should be done about the difference. Therefore, I wanted to know how the clergy used language to justify the abrogation of civil rights for people diagnosed as mentally ill.

To categorize these themes efficiently as they appeared in the interview text, each participant was asked the same questions in roughly the same sequence. I deliberately adhered to the script of the questions during the interviews because I did not want to bias the participants' answers, although I acknowledge my subjectivity is implicit in the questions.

Construction and analysis of interview text

While listening to the tapes as I transcribed them I came to appreciate the complexity of the questions I had asked the participants to answer. The audio tapes of each of the twelve interviews were first transcribed into a verbatim text which comprised everything the participants said as well as their mannerisms, rhythms and metaphors. I edited the verbatim text several times to remove stutters, pauses and ticks and to restructure and punctuate the sentences while respecting the intent as well as content of the discourse. I tried to maintain the distinctive cadences and rhythm, metaphors and personality of individual voices. For example some participants were robustly confident about their understanding of mental illness and their interpretations of experiences with people they identified as mentally ill, while others avoided talking about their experiences of particular individuals and referred to mental illness as a philosophical idea, a physical illness or a function in civil rights. At some point, however, each participant referred to mental illness as an abstract construct embodied concretely by individuals they had experienced.

Each of the interviews was then edited with consideration for anonymity. In editing for anonymity I also removed language that I thought was irrelevant to the six themes contained in the questions such as personal asides and passionate language of religious belief. Language that could identify people and particular religions in the community, as well as language of religious belief that did not directly relate to issues of mental illness and civil rights was altered or removed. In the thesis therefore "church" means

the same as house of worship, house of God, Lord's house, tabernacle, chapel, temple, cathedral, basilica, mosque, synagogue, meeting place; the participants' work place or where their offices are located; religious service, service, divine worship, devotions, religion, denomination, faith, affiliation, persuasion, belief, sect and cult. "God" denotes supreme being, divine power, a divinity, the Supreme Being, Jehovah, the eternal Spirit, the Creator, and the Sovereign of the universe (Thatcher, 1984).

I now had a binder that contained each of the twelve interviews in readable and anonymous text that dealt specifically with the six themes. Knowing with immense relief that the participants had indeed addressed the six themes I was then faced with two questions: How do I analyze the text, that is, the participants' answers to the questions, to see how they addressed the six themes that were used to construct the twelve questions that were used to construct the themes? And how do I present this analysis in a thesis? I decided to take the text of the twelve interviews apart and reconstruct them as conversations amongst twelve community clergy. These conversations were e structured so as to address each of the six themes. Presentation of analysis of interview text as conversation was constrained by the amount of space that would be acceptable to readers of the thesis.

The decision that about forty pages would be appropriate meant that I would have to choose for analytical representation about one third of the original edited interview text in which the participants addressed the six themes. I could not condense the text of individual interviews any further without damaging the integrity of the language of the participants' answers.

So I decided that if I could not condense the text I could choose those passages I thought best represented the themes and use those as broad representations of the ways in which the twelve participants talked about mental illness and civil rights.

The next question was how to take the interviews apart and reconstruct them as conversations that represented the various range of answers to the questions. In editing the interview texts I had given each participant a code name therefore I saw that it was possible for individual passages of each interview to be coded and paginated for reference. For example LIII/3 or SVII/5 means I am referring to participant LIII page 3 or SVII page 5. I decided to begin by making two forms that divided the text into overarching themes--mental illness and civil rights.

I began the process of combining the interview texts as conversations by dividing passages from the text into two overarching themes--mental illness and civil rights--and then recording the participant, page number and a temporary passage title onto two forms entitled "Themes: mental illness" and "Themes: civil rights". The form, "Themes: mental illness," contained three sections -- recognition of mental illness; the job and people with mental illness, that is, being clergy; beliefs about mental illness. Early in the analysis I dropped the section 'beliefs about mental illness' because I realized I had strayed from analysis of language and into the murky world of ideological analysis. The other form, "Themes: civil rights," is different in that it contains six sections without subsections. These sections are one, meaning of civil rights; two, civil rights of people with mental illness in particular; three,

feelings about need for treatment; four, consideration of involuntary admission and treatment; five, threat people with mental illlness present to themselves and the community; and six, possibility for people with mental illness to participate as equitable citizens. The last section was later dropped because it seemed to warrant conclusions on a theme that had not been addressed by the questions.

Using these forms I categorized most, if not all, passages found in the interview text into the two overarching themes. Below are two examples of how these forms worked at the beginning of the study to draw out the language of mental illness and civil rights from the interview text. Long passages were broken apart and given temporary titles so I could later keep track of the language they contained by using participant codes and page numbers that indicated where they appeared in the text. These passage indicators are shown in italics in the examples below.

The first example indicates the pages and language in which participant SVII describes experiences of mental illness, relationships between mental illness and the participant's occupation, and the participant's beliefs about mental illness. The second example indicates the pages and language in which participant DVI describes an understanding of civil rights in general and the civil rights of people with mental illness particularly in regard to need for treatment, involuntary treatment and the presumption of threat presented by mental illness.

Theme: Mental illness

Participant: SVII

1. Recognition of mental illness

    a. Description of experiences of mental illness in the work place

        we are a loving congregation, p.1

        don't do exorcism, p. 2/3

        how patronizing/ personal judgement, p.8

    b. Defintion of mental illness

        chemical imbalance, p. 3

        too bloody sensitive, p. 4

    c. Understanding of symptoms

        imagination, p.14

        demon possession, p.14

2. The job and mental illness - being clergy

    a. Influence of the job upon understanding people with mental illness

        time with prayer and scripture, p. 8

        credibility with people, p. 9

    b. Relations between church, clergy and people with mental illness

        sensitive souls, p. 4/5

        church offers acceptance and love, p, 5

        people cry, p.6

3. Beliefs about mental illness

    a. Stereotypes of mental illness

        sex crazed society, p. 10

    b. Changing beliefs about mental illness

        (not addressed)

In this next example I have noted for myself some general notions this participant, DVI, had presented with regard to civil rights.

Theme: Civil rights

Participant: DVI

Understanding of civil rights generally as the balance of individual rights and rights of the community. Right of the community to intervene on behalf of the individual. Freedom of expression.

a. Meaning of civil rights

power, p. 7

over-zealousness, p. 5

b. The civil rights of people with mental illness in particular

mental health laws, p. 2

changes in law - improvement, p.5

right to citizenship, p.4

need to protect the individual and the group, p.5

"for their own good," based on fear p.5

marks of a fearful society, p. 6/7

c. Feelings about need for treatment

major part of the problem was need for treatment, p. 1

sarks and soma, p. 10

d. Considerations of involuntary admission and treatment

fearful responsibility, p. 1

eccentric, wealthy professor, nature of the system, p. 3

according to behavior rather than diagnosis, p. 4

e. Threat people with mental illness present to themselves and the community

range - psychopathic killer to a silly ques at the bus stop, p. 4

propensity for violence - a very small proportion, p. 4

f. Possibility for people with mental illness to participate as equitable citizens

provide a community that is welcoming, p. 10

comfort of science, p. 9

prejudice, p. 9

The next step in the construction of the interviews as conversations was to take the interviews out of their individual sets and combine them so that they addressed the particular themes raised by the questions. These themes include experiences of mental illness, interpretations of the relationship between clergy and the church and people with mental illness, understanding hallucinations and delusions, definitions of mental illness, understanding civil rights, and finally understanding civil rights and involuntary psychiatric treatment.

I used the data sheet in Appendix D to guide the construction of the interview texts as conversations. It followed the outline of the two previous forms beginning with the section "recognition of mental illness" and in so doing created a means by which I was able to combine the language of the entire interview text into themes and still maintain the structure of the language produced by the participants in the interviews. I then had a complete overview of places in the interviews the participants challenged and

concurred not only with each other but also with the dominant discourses of psychiatric medicine and law. These data forms were reworked several times with constant reference to the interview text binder to make sure I maintained the integrity of the interview language.

The interview text that follows is one of several drafts that were developed from the complete text of the interviews. Because I wanted to reduce repetition and create a dramatic effect I arbitrarily decided to present the interviews in such a way that the themes in which the participants were most confident and which they articulated most clearly would be highlighted. Because the clergy are identified by code I thought it might be possible to follow their experiences and explanations throughout the conversations. In the presentation and analysis of the interview text which follows each theme is first introduced by my continuing characterization of clients and students in my own professional practice and my observations of the language clergy used to respond to the questions. A question in italics then introduces the topic that the following conversation, also in italics, responds to.

As researcher I make no claim to objectivity in the study. On the contrary I had a specific interest with which I constructed the interviews. Although I did not lead clergy answers, the questions I constructed focused their responses on my particular interests. Even though I focused clergy on my interest, I am confident their descriptions of their experiences and their opinions and considerations were not biased by my behavior. The range of responses received from the participants supports this.

CONVERSATIONS WITH COMMUNITY CLERGY

This chapter portrays language practices that community clergy employed to construct mental illness and to rationalize the abrogation of civil rights of psychiatric patients. It demonstrates both the participants' use of the language of mental illness and their resistance to and concurrence with the construction of mental illness effected by psychiatric medicine and law.

Experiences of mental illness

When I asked one clergy person to tell me about his experiences of mental illness he asked himself, "How do I know when I'm truly experiencing mental illness in another person?" I thought about particular students and clients, what they have told me and what I have observed. I realized that like the clergy I experience mental illness through conclusions I draw from my observations of other people with the awareness I am not experiencing mental illness as existing in my own body. In other words I assume my sanity when I describe what I consider to be insanity in others.

With matter of fact directness the participants describe people behaving in unpredictable and startling ways. Their stories are humanistic; they pay attention to feelings, leave room for errors of judgement and misunderstanding and, generally, have hopeful endings.

How do you experience mental illness in your job?

RXI: People have mental breakdowns in any stream of society and for different reasons. A church community includes the members of the church, the people in the community, visitors, staff. The church is a people place, so you are bound to get people just the way they are, not the way you wish they would be. We have the desire for where we want them to be, but we live in a real world where we're facing real struggles. I think we run into everything from emotional breakdowns to paranoid schizophrenia.

BV: I was never directly involved in any severe mental illness, apart from one woman who was in severe postnatal depression and who was convinced that she was dead, and she, in fact, went through electroshock therapy which completely sorted her out, which amazed me. When I heard that this was what her doctor was going to do to her, I was horrified and tried to intervene and got nowhere; she had the treatment, and she has lived a perfectly normal life ever since. I pulled in my horns at that point, thinking I was a great campaigner for civil rights for this woman, and they called the shot right. I was happy in her case. At any rate she's done very well ever since.

GVII: I did six weeks in a psychiatric ward in a hospital in London as part of my seminary training, and the purpose was to expose me to every type of mental illness there is. So I spent a week with people who were catatonic and a week with people who were the opposite. They were walking around, starting fights and saying they were God, that kind of thing. So I did that for six weeks, and I was shell shocked from that experience. I have probably not

even thought through all the experiences I had there; they were so vast, and they were so extreme.

RX: Occasionally somebody comes to visit me and I sit down and chat with them. I acknowledge them and try to get to know them, and sometimes it becomes clear they are not well in the sense that they can't cope with their lives. Some people are very open and say this is my condition while others are very resistant to talking about it. They don't necessarily see it as something wrong with them but rather that the world is not fair and they do not have a quality of life they should have. They have reasons as to why this is happening, but do not identify that they are not coping or that something is happening to them that they cannot handle. I believe faith helps, but it's not everything, and just handing them money usually isn't helpful.

GVII: I didn't mention one fellow in our church. A fifty-four year old guy, and he drools, and he can be real self-centered. He wants to be the center of attention and he's very brilliant and he's corrected some of my theological points at times. For a few years I fought the urge just to avoid him until finally I realized that what he needed was honesty and directness. He needed to be treated like a person so I began saying, "OK. Let's sit down and talk. Now I'm finished talking, I need to do other things." He taught me to assert myself, and it's a lesson I've used in every relationship. It's all relational, everything. As soon as we get systematic about things the spirit isn't there. I was at the library the other day and this woman in the library square began telling me about how her neighbors were killing her. She had these incredible stories about how they were trying to accomplish this. So I

decided in my spirit not to make a judgment on whether that was true or not because I couldn't. I was just getting it from her. I was suspicious, but look at where she was at; she was living in fear. Her delusions were working out negatively in her life.

RX: I can only talk personally, and I'm thinking of about four or five people that I've met over the years. One woman who was manic depressive arrived at church in a manic phase and wanted to be healed, and she had decided to be off her medication because she felt awful, and she also felt that if she had faith that she would be healed. But more importantly she wanted to be listened to and understood and loved and respected. But the belief that "I don't need medications; I'm well," got in the way and so that was that. Another woman was looking for normalcy, and coming to church is in some sense a normal thing to do. She was diagnosed with schizophrenia and has past experiences. She doesn't want to scare people because she's aware of how people react when she talks about it, so she tries to be a little closed around it. She comes to church I think because she has this desire to be in something, to be considered normal and again to have a relationship with God and community. She's not looking for healing, and when we offer support groups she is able to talk about it. She shares her experiences and what it's like to carry this burden as a way of life. Here at least there is a desire to be accepting, not to judge, to be able to tell your story.

DVI: We have people who walk in here to the church on a regular basis who have problems in living. A number of them are just people whose grasp of reality is somewhat different and they are not a threat. They come to have a

cookie and a cup of tea. Perhaps, if they don't wish to leave and we need to lock up a section of the church, I'll have to be rather firm with them.

XII: I would say that my experiences have not been extensive but where they have arisen it has always been very sad because the person involved has always been a person with their own identity, a person whom we would describe as a good person. In most cases it's not their own fault they arrived in a bad situation. A lovely lady here eventually had a breakdown. She would stay for hours in the church. I knew that she was very much on the road and life was very, very difficult and I asked her to get involved in helping to prepare for services. One time as we sat down for the scripture reading there she was behind the rubber tree in the corner peeking through the branches at the congregation. I felt that I couldn't go over and take her hand and take her away. I just ignored her, but people were saying afterwards, "What was she doing there." Well it wasn't long before she left and we didn't see her for awhile and then she would come back and wanted to stay for hours in the church. Well there was a question of her lighting candles and burning the church down. And there were problems such as lifting these very heavy silver candlesticks and either breaking them or falling and hurting herself. You couldn't just lock the church up and say well she'll be all right. I had a student with me at the time and on two occasions we literally took her by the arm and took her outside, but he realized before I did that really wasn't the solution. So we phoned the police and they came and took her to the hospital. When I visited the hospital I wasn't surprised that she refused to see me although we had been very good friends.

SVII: I'd like to tell you one story if I may about a very difficult situation I found myself in. In my first year a young woman started coming to church. A wonderful person. And I knew that she had come from a difficult and abusive marriage that hadn't lasted very long. This kind of thing. One night she called me at home and said, "I need you to come do an exorcism." I said, "Well I can come to you, but I don't do exorcisms." It was very clear that she was really, really becoming a danger to herself. She was lighting candles to take the devils away and all this kind of stuff. I was looking up mental health in the yellow pages and going back and forth to see what was happening with her. It was really clear that there were voices and things that nobody else could hear or see. I called an emergency team because it was more than I could handle and they came. They were wonderful. They took her to hospital where they got her back on medications. This was probably my most intimate experience with someone whom I really loved, a marvelous person, but if she's not on her medication she's in trouble. So that's one story and I got involved in it because I was her minister.

RXI: There's a schizophrenic lady here who gets angry. Anger is an incredible tool in this society and especially around churches. So we had to speak to this issue. "You can't talk like that. You can't threaten people, this isn't right and we can't have that." Now it's still up to her. It has to do with helping her come to terms with herself, but also saving the peace of the environment. That's important. But we make more room than the wider community. For instance this angry lady. One day we had a guest musician, a singer-songwriter who had a tape and CD table at the back where you could purchase tapes. She asked him for a free one and he said, "I can't give

you a free one now, but if you give me your name and address, I'll mail you one." Well, that wasn't good enough for her so she cleared the table. She just took her arm and knocked off every tape and CD in a very crowded vestibule and then walked out. That kind of thing puts a bit of a damper on the morning; it doesn't destroy the morning, but it's destructive enough behavior that it needs to be challenged. Maybe challenge is too strong a word, but that person needs to be held accountable as in, "Look you can't do that, that's inappropriate." Usually what happens is the person comes back, "Oh well, I'm sorry about that," and I say, "Well I appreciate your apology but you understand that that can never happen again. We can't have that happen again." Inevitably it does in some other capacity; some other way, like throwing stones or meeting somebody in the parking lot with some strange concept. Anyway those are some of the things that take place around here.

VI: I know that there are people in the congregation who have been diagnosed as manic depressive, clinically depressed and schizophrenic. I don't know how many. Some families in the congregation have children who are schizophrenic. Others who are active members of the congregation have significant struggles with depression or manic depression, but they have a tendency not to over play that. Most of the time they keep it as a non-issue. Sometimes people in the congregation who are manic depressive go off their medication. You can almost always tell by their acting out when you're trying to do things in small groups or committees. This person is just, you know, out of bounds. It's like you don't know who's going to show up and that gets

difficult I think for families who say, "You know I love you and I care, but God, you know, this is hard to live with for months or years at a time."

RXI: I know people who struggle with schizophrenia and have a very clear understanding of themselves and their illness, of the burden it is to them and the shortcomings it leaves them with. They tell me how hard it is to keep their job and why; what feelings they have in situations that seem to be straight forward. Social settings for them are very complicated and difficult. I try to deal with them as people. As much as I can I deal with them in the context of normalcy. As much as I can, when they struggle, when they get paranoid, when they get anxious, I speak to those issues in the context of reality.

For instance,

"The RCMP are after me."

"No."

"They've been following me."

"No they haven't."

"Yes they have. I know they have. I know these things."

"Well I'm telling you the RCMP don't have a clue where you are. They couldn't care less. Just try and relax about it."

DIV: We had a woman who is not coming to church anymore who was a manic depressive. She was in the choir. In her manic phase she would get up out of the choir and go down to get water, to go to the bathroom, to do a hundred other things off and on throughout the service. She has social skills and social graces and stuff like that, but she was all over the map. In her depressed state we hardly ever see her and the problem is that nobody misses

her too much because she takes a lot of energy. An interesting woman and very kind, but people don't say, "Gosh we'd love to have Mary back in the choir." She has a lovely voice, but the energy expended to keep her going was too much for us. As an older congregation we have people who are just beginning to have Alzheimer's and are aggressive. We have a guy who makes announcements every Sunday. He tells us he's going on his holidays to the Maritimes or just coming back or brings greetings from some church or other. He's had a life of church involvement and he's just kind of going over the edge now and his behavior is getting quite difficult to manage, so we're all struggling with how to contain him while keeping him in the congregation.

DIV: I have worked with a man for about five years. He first came to see me and asked me to pray with him because the devil was inside him and he was bleeding. His head was bleeding because he had been trying to beat the devil out of himself and so I prayed with him and laid hands on him and he seemed to be calm when he left my home. Of course within a few hours he was in the hospital because of his behavior.

DVI: We have the pleasure of a janitor here who would probably not work in a regular place. He is a very large man, six and half feet, three hundred pounds and he is bi-polar, among other things. Some days he isn't feeling that well so his face kind of glowers, but we know here that doesn't mean he's angry at you or me. He's an extremely peaceful man and he's come a long way since he started working here two years ago. We include him in staff get-togethers, and he participates in most. Again this is my perception, but he needs just a little different amount of space in life to be a really good

productive person. Sometimes he likes to sit in the sanctuary and I guess maybe that recharges his batteries. We have a good mix and this is a good mix and match for us. And it's a good reminder for people like myself to be very careful about the judgment I pass on others and not to rely completely on my initial reaction to people.

Interpretions of relations between clergy and the church, and mental illness

How I see my myself as an adult educator shapes my interactions with the students and clients I serve. As well as referring to the discourse of mental health care that is the system in which I work I also respond to clients' and students' questions and requests in the context of adult education and training. Therefore, when I work with people who identify themselves as mentally ill, I assist them to obtain services that address their psychiatric disability while they are engaged in study. The participants in this study work within a theological framework in which they identify themselves as spiritual counsellors whose job it is to listen sympathetically to emotional vulnerability, to assist people to experience God and to demonstrate love.

When I think about people with mental illness I often identify them by psychiatric diagnosis and treatment and place them socially within the mental health care system. In a religious context inclusion is bounded only by the public's choice to experience religious practices. "What you're going to hear when you come here is religion." The participants interpret the role of churches as providing space for a kind of inclusive privacy in which it is possible to participate individualistically within a community where there are

boundaries in space and time as well as expectations of appropriate behavior. Church is a particular place for particular time set aside to contemplate the meaning of spirituality by offering orderliness, sanctuary and acceptance of differences.

What is your understanding of relations between clergy and church, and people with mental illness?

XII: I hope being clergy would make us more sensitive to others because we perhaps have more intimate insights into people's lives than many other people. It's a privilege shared by doctors and some social workers, but because of the confidence that people have in us we are required to be more insightful, sensitive and very, very sympathetic to the condition of people. There is a genuine desire to help and one of the indications of the competence of the clergy is to know where the line is that we need the psychiatrist.

XII: Church has a warm sense of welcome, the atmosphere is generally relaxed, the music is beautiful and there's a good balance between encouraging people to be involved and at the same time respecting their privacy. Anyone can sit in a church and the service goes on, and, when the service is over, they can stay or go and there's no one saying you should be standing up or you should be singing, where's your book. There's a sense that I can go there, I can get away from the confusion of the outside world, and find some peace. Sanctuary.

LIII: My experience with mentally ill people is that they are incredibly sensitive to others, to the tone of relationships and can pick up a phony at a hundred yards. That kind of sensitivity to other's reactions and whether or not they are accepting is an incredible gift, honed on their experience of rejection. If someone is talking about church or religious experience a lot, then very likely it's because religious communities have given them a kind of unconditional acceptance which they perceive very clearly as real. People can be disordered in their moods and thoughts and the whole area of religion can be a fertile ground for all kinds of interesting and wonderful delusional material. Often a religious experience is so important that it becomes the focus of delusions and some of those delusions are incorporated into an understanding of life. And we all have our delusions. Some are a little less obviously delusional than others, that's all.

RX: A hundred years ago, two hundred years ago the issues and questions raised by mentally ill people would have been addressed by the church as spiritual issues. And in the end they would have been both healed and mistreated. I firmly believe that the core issues of mental illness, from the church's perspective, are religious issues because they have to do with quality of life, issues of being spiritually created, how we live in our community and how we care for one another. These are the real issues that we have to deal with. It's not sufficient to label somebody else when we're all the same as human beings. We all have gifts and the mentally ill have gifts for us that we would be poorer without. It's hard to say to people, "We don't want the gifts you bring us which are who you are. Your perspective of life

and your experience of life is challenging, but it is really important for us to hear that."

DVI: Perhaps in the search for meaning people with mental illness appreciate the spiritual dimension more so than perhaps some folks who have had a little easier time getting along in life. Searching for inner peace is usually identified with finding one's spiritual roots and working from there. The church has historically played a role in providing succor for a variety of people with what we now describe as challenges or mental illness.

BKIX: Anyone who is interested in religion has an internal reflection about themselves and the purpose to life. Those who wrestle with mental illness are asking the same questions in a powerful way. They wrestle with finding meaning in their day or finding connectedness to other people. We automatically look inside and ask, is it me, what's wrong with me, what am I suppose to be getting out of life? Or asking the existential questions, how do I find meaning in my existence? And those are the same questions we ask in religion. Why am I here, where am I going, where did I come from? There is, in some sense, an internal or spiritual life going on. When we have a condition that we can't solve we are certainly hopeful that there exists someone more powerful and more able to help us. It is in the realm of spirituality to believe and hope that God is there to bind our wounds and solve and protect and heal the things we can't do for ourselves.

KII: My job is to help people find meaning in whatever they're going through, not to tell them what that meaning is. I hope that we are once again

moving toward a time when we will use our own theological tools, our own symbol system, our own theological framework to make sense of these things rather than relying so heavily on other systems which ultimately have just as many holes or unexplainable things in them as our own. This search for legitimacy is kind of a wasted one. We have a market place of discourse. I need to know my own story and allow that to shape me and allow it to give me the integrity that I need to make sense of whatever it is that I am encountering.

BKIX: I hope churches can offer companionship. I think mental illness is very isolating and it takes some conscious effort for anyone, but especially those who struggle with mental illness, to come out of their comfort zone. There is also a sense for many people that people with mental illness are more demanding, dependent and intractable, and very draining. It's more difficult to involve them, but I do see it as a role for the religious community to be there for them, to support them in any way we can.

RX: In my job there are people who are mentally ill who have drawn me to them because of their experience of life. The church has a responsibility to tend to and care for these people. We are an inclusive community, we value all people, and we don't distinguish in a hierarchical manner or value one person over another. People with mental illness feel different. Whether they say they are mentally ill or not doesn't usually happen right away, but over time, as a trusting relationship comes forward you begin to hear and talk. The church needs to be a safe place for the mentally ill to be present and counted, and the church has a responsibility to be patient and hopeful and

deeply passionate. I don't know whether or not we can bring healing but maybe, at least, a deep level of compassion.

SVII: I don't think being clergy has made me any different from who I was before I was clergy, but I suppose as clergy I do spend a lot of my time with prayer and scripture and that sort of thing. I take the injunction to do onto others, to love one another and all that stuff probably more seriously than some people do because I'm working with it all the time. The other thing is that it gives me a credibility with people, like the woman who called and wanted me to do an exorcism. There's no way I would ever attempt to do such a thing, but she saw me as a person with spiritual authority. I find that people open up to me about things that are deep inside them more readily than they would to other people, so I am a lot more aware of the inner struggles of people. I hear it way more than somebody in some other line of work.

Understanding hallucinations and delusions

Mental illness is identified in Bill 22 as a disorder of the mind that causes the individual to act inappropriately. Common symptoms of mental illness that cause inappropriate behavior include hallucinations, delusions and extreme feelings. Psychiatric medical treatment promises to mitigate these symptoms so that the person may function in the community. At work I acknowledge the psychological distress of perceptual confusion and rapid/cyclical thinking as well as my powerlessness to fix it. My job is to find ways to engage the person educationally in spite of symptoms.

William occasionally attends the drop in on Wednesday. He comes to talk about mathematics and science, and his plans to study at university. He moves very rapidly amongst concepts and does not seem to hear logical presentations. His questions and comments are out of context to the presentation although he appears to be listening intently. A colleague who works in William's home told me that delusions of grandeur prevent him from experiencing failure.

The participants are as wary of bizarre perceptions of reality as they are wary of the authority of psychiatry and medical science to define the meaning of visions, and they contend that a theological model for making sense of these things would be different from the medical model. Historically the discourse of religion has attributed demon possession as well as mystical prophecy to hallucinations and delusions, and these notions, like psychiatric medicine, have classified, separated and excluded people for special treatment. When one participant says that society is both attracted and repelled by the idea of schizophrenia, he summarizes the general consensus of the participants that social effects which accompany visions (the physical reality of auditory/visual hallucinations and delusional thinking) exist within the context of social abstractions such as culture, tradition and history of mental illness.

How do you understand hallucinations and delusions?

RX: It's true we listen to voices all the time. We listen to our own thoughts, our own voice within ourselves engaging in dialogue, but hearing voices while trying to accomplish tasks and the effect that would have...I can get just a glimpse of what that must be like, to have dissonant voices. It's one thing if you're cueing voices, but if the voices are different, telling you to do things while you're trying to do something else, you wouldn't be able to function.

KII: I know how I experience my world and that's not the same way you experience the phenomena that are going on around us, and yet presumably we are well within the boundaries of normalcy. Hallucinations and delusions seem to fall outside those boundaries. I have no doubt that they are real for the people who experience them which is why as a caregiver I need to take that as seriously as I would take my own reality. But at the same time to support people you need to always be aware of the destructiveness that may be involved in allowing these things to continue. Sometimes people don't get the help they need unless someone says, "You need help." Pretending that everything is OK and walking away from it is always a serious judgement call.

DVI: How do you deal with the realm of the so-called ecstatic experience in religious history? Divine madness as it were, insights. It's a complicated field and I think in someways we have less tolerance as we begin the 21st century than we did fifty or a hundred years ago. We are a people who are

reassured and solaced by scientific evidence whether it's the coliform count in a lake outside of town or the Stanford-Benet test I run on your child. We love measurement and we love to be able to measure things.

LIII: It's always fascinating that it seems the most important pieces of a person's experience get incorporated into mental illness symptoms, and religious faith is the most important experience that one has. We, all of us, live by delusions and not always religious delusions but things like the world is getting better and better all the time. I'm not sure it is, but we live with that kind of delusion. A delusion of our present society is that all people with mental illness can be one hundred percent participants and members of this society at the same time they are subjected to the prejudices we have.

KII: I could certainly offer a theological framework, model, paradigm for understanding hallucinations based on the tradition of visions over centuries. That model and the way it made sense of those sorts of things would be different from the medical model. Each would use different kinds of language and concepts to try to explain the same phenomena. Today we would say that science is right and theology is just someone's opinion, but I think that theology is perhaps every bit as good an explanation or attempt to explain this kind of unknown behavior, unknown phenomena as a medical model would be. Maybe there's a third way to try to explain this. For instance Karl Marx would probably try some kind of economic deterministic methodology or paradigm to try to explain this phenomenon.

RX: People have visions and voices, hallucinations, and I understand them as being their own. So my attitude is generally, that's fine, and I don't get into them. I don't consider them to be reality, particularly, and an individual may even find them to be helpful. I take seriously a person's perception of the world and their experience, so I try to understand the world as they experience and recognize it. I try to hear what they have to say, so I take that part of it seriously. Whether I put weight or value on what they describe as visions and hallucinations, I don't know. I say, "This is what you're describing, it's interesting and I'll listen, but I may not put a lot of value on it, in the sense that you are revealing something to me. You're describing another world that exists and you are imparting it to me." The truth is I have dreams and visions and perceptions and imagination and what is the difference? Historically there are stories of wild women, the witches, people in scripture, as well as stories about demonic filled people that are spooky. Where do these voices come from? Does a person believe it's God speaking? Historically schizophrenia has been understood as people with visions, and the community isn't quite sure what to do with them. We are both attracted and repelled and there's a sense of the divine and demonic wrapped up in it.

Definitions of mental illness

The following psychiatric medical case study is typical in form and content. In a recycling bin at a typical psychiatric conference I found this printed text of a power point presentation on the treatment of mental illness. It demonstrates one way in which psychiatric medical discourse defines the human being it treats and manages:

> 21yr female with 7yr h/o multiple admissions for self harm and numerous therapists. Diagnoses including depression dysthmia, borderline PD, adjustment disorder, alcohol & cannabis abuse. Treated with Prozac, Fluanxol, Epival, Manerix, Rivotril, Imovane, Choral, Stelazine, Desyrel, Trilafon. Comorbid obesity, IBS, tubal ligation after ectopic at 16yr. Galactorrhoea and amenorrhea on Nozinan. Wt gain with OLZ ? endocrine disorder. MRI show pituitary microadenoma. Noncompliant with psych follow-up but recurrent ER contact for CNS/endocrine investigations.

The various ways in which the participants define mental illness resonates with the ways the power point presentation characterizes a particular young woman. Mental illness is defined by both the presentation and the participants as abnormal and unacceptable behavior, an inability to get along with people; as psychiatric diagnoses and neurological disorders; as a function of treatment in that mental illness is identified as something which responds to medications and other psychiatric treatment; as trauma and life experience; and as caused by organic/chemical change.

In the dominant discourse mental illness is not presented as socially constructed language and practice. Clergy differ from the psychiatric medical construction of mental illness in that they consider other abstract definitions such as an imbalance of the mind, demon possession, or a physical experience within a spiritual dimension. The participants also describe mental illness as

labels applied to behavior that determines a person's identity, behavior that raises questions and challenges our assumptions about what behavior means and for whom, assumptions that remain the same over time even though the language which defines them changes.

How would you define mental illness?

KII: Where the line falls between the normal and pathological is always a kind of political decision, a decision of experts. Mental illness as a category never existed a thousand years ago. What we define as mental illness and competency and non-competency is probably going to change in the future as we as a society change the way that we understand what is normal behavior and what is not normal behavior. These categories are ultimately historically, socially constructed categories which help define the boundaries of normal and not normal for all sorts of different reasons. Ultimately those boundaries are political boundaries. Ideology in the interest of power. I don't hand everything over to experts in medicine and law. In my job grace always take precedence over any sort of political boundary, drawn lines, definitions or categories.

DVI: I'm not sure that anyone has properly defined mental illness. It's something that we as a society continue to struggle with from decade to decade. What is mental illness in one period of time, or even in one country, changes and is different. As soon as one definition has been accepted there is another. In more general terms I suppose it is behavior which deviates or

which is perceived as deviating from the norm. What is mental illness? What is the meaning of life?

BV: Terms such as well balanced, the lack of obsessive behavior, would perhaps be a starting point to define mental illness; well adjusted in terms of relationships with those you come in contact with. The person suffering from mental imbalance in one form or another would be the person who is having difficulty coping with their surroundings, with people they come in contact with. There are chemical and genetic triggers to mental illness. That's pretty well recognized. But there are also cultural triggers. Personal mental hygiene is about one's own personal decisions about one's own life, the way you behave, the choices you make, the situations you allow yourself to get into and thereby damage yourself mentally and spiritually. But don't get me wrong, I'm not saying that a person with schizophrenia chooses that.

BKIX: Severe mental illness is where a person's thoughts, feelings and beliefs are confused. They have a hard time finding happiness and a hard time achieving the goals that they desire in daily life. I think chunks of it are organically based so it is a medical condition. I think that there are other contributing factors, traumas, history, events in people's lives that contribute toward and exacerbate physical problems. I think it is a lonely situation, and it's hard to get relief from.

RXI: Mental illness is a sickness of the mental faculties; it's a short circuiting of the system. It can be caused by a chemical imbalance, so it can be physical. Or it can be the result of emotional or sociological

repercussions. But I would say it is an imbalance of the mental faculty. I also measure mental illness on the level of social interaction. How do they deal with crisis? How do they deal with daily life skills? How do they interact with people? That's the first sign I guess. Are they able to participate easily within the work a day world? If problems arise I wonder is it some kind of illness that's getting in the way. Sometimes it isn't; sometimes it is something else. I think we measure it in accordance with what we understand as normalcy or a semblance of normalcy. Nobody is normal really, but we have this standard for the way people act and if they step over the line more than once or if they step over the line in an exceptional manner they get my attention and I start processing it. What's the problem and it may be mental illness. It's almost a common sensible thing. You know what the norm is in terms of society's expectations, you know what the norm is in terms of a classroom environment, and when that norm shifts through the expression and actions of one individual then you start thinking. What's going on? What's the problem? And problems may be varied but as you examine behavior and activities and words you start to make assumptions. Our world is based upon assumptive thinking and as long as our assumptions are right, we get along pretty well. Maybe there's times when the person is all right and maybe we've got the problems. I've always left that open to my assumptive world.

SVIII: For me, a person I would call mentally ill is somebody who has a chemical imbalance and you know I mean we all get a little crazy sometimes, it's part of the human condition. When we're not mentally ill we come out of it. We get pissed off or depressed or whatever and then we come out of it.

When a person is mentally ill they don't have the inner resources to come out of it without some kind of help. My understanding, totally as a lay person, is that treatment for many people, if not most, who are truly mentally ill is chemical intervention. That's my understanding of what mental illness is and the difference between somebody who is just kind of having a blah day or a blah week or a blah month and somebody who's mentally ill. The other thing is that the behavior becomes really erratic and they do things that are bizarre.

RX: I don' think I have ever defined mental illness, particularly. I guess there's issues of depression which are always present in people in churches. I guess what I perceive around mental illness is a sadness and a sense of not fitting in. People carry a sense that there is something wrong within them, that they're broken people. All people are broken, but they're broken in a particular way. They have trouble coping and they can't make it, so the world is not safe. And I don't see what they're going through as being very happy. It's not so much punishment, but in some sense they feel punished.

VI: I would define mental illness as the inability to relate within the community in a manner that's expected of people in that community, but our judgment is very subjective. I mean you could not be mentally ill but be alcoholic, drug addicted or just hanging out in poverty, and so the average person isn't necessarily going to be able to say, "Oh this one's this and this one's this and this one's this."

KII: The line between the imagination and the world out there is blurred. I think I'm a very intuitive person and tend to pick up on things like that before I can cognitively put a finger on it. There's a kind of aura. There is something that you feel. The things I always look for is the person able to care for themselves, care for others. Are they a danger to themselves? Are they neglectful of themselves? Eccentrics tend to be like that too but there is a different level of competency and psychological state to it. If I was looking for words one is a character thing and the other is more a psychological thing.

RXI: We're so intricate. We are such delicate beings. I don't know where short-circuiting takes place on a physical level. You and I do know that if we don't eat enough and don't get to drink, we'll hallucinate, or if we don't get enough sleep we'll hallucinate. To me that is a physical experience that affects us mentally. I also believe that there is a spiritual dimension and there is a spiritual working out of that which is destructive. I believe that there are spiritual realities that come into individuals' lives that can interfere with an individual's life. Where you draw the line, I'm not sure.

SVIII: I'm glad that this is anonymous because when I think of someone wanting me to do an exorcism, I don't know for sure that people are not sometimes demon possessed. I don't know for sure that there isn't something out there that's tormenting them. There may be. And again, maybe, because of their sensitivity, mentally ill people realize this and know that most of us are oblivious to it, so it doesn't have a way of getting hold of us. I don't know...Certainly scripture has lots of stuff about demon possession, and

healings were frequently about driving out the demon, so is that just cultural understanding of epilepsy, maybe, or maybe it was an understanding of something else that's real...I don't know what the ways are. I say I don't know, but another part of me does know. Whether that is what's happening when people are into a psychotic break down of some sort, I don't know. Sometimes, maybe, yes; sometimes, maybe, no, but, yeah, I think there are bad spirits, and just as I can't tell you what God is and what God looks like, and how God functions exactly, I can't tell you where these bad spirits live and how they function and what they do, but it's an element in it, in someway. As I say I feel like I'm on dicey ground trying to say this, but I believe it's true.

GVII: I'm not able for a minute to say that that person has a spiritual problem or that person has a mental problem. I do believe that spiritual entities can speak into your mind, can tell you to kill yourself, but the voice of temptation can also be inaudible and not necessarily a mental problem. In my role I deal with people as whole persons not just the part of them we call mental illness. I don't always know what the problem is, and I don't think that medical people know sometimes. They give the physical explanation, and I think they feel they know, but they clump a lot of stuff together as mental illness, and it may not be that. Most of the time people have their struggles and are struggling mentally and it's affecting them as whole persons.

Understanding civil rights

The participants talk about social tensions that exist between the rights of the individual and rights of the community in terms of the individual's capacity to conform to standards of appropriate behavior, to make decisions in their own best interests and in the interests of others. These tensions show up in the contradictions between the ideology of individual choice and freedom and the actions of persons in authority that deprive an individual of the excercise of choice. Two short uninterpreted anecdotes which follow show how I have experienced these tensions in my occupation and how serious and complex the implications of ideology in practice can be.

I met with an eighteen year old First Nations man at the psychiatric hospital where we talked about school, and I asked him if he would like to do a math assessment. I asked him how he could answer the questions correctly when he had not completed grade eight. He looked at me contemptuously and said that it was not that hard to figure out. A friend who shared a hospital room with him told me later that the young man had committed suicide within a day of his release. Bill said he had asked a nurse why the hospital was allowing the boy to leave when he was clearly distraught and depressed because his girlfriend had just ended their relationship. The nurse told him that they could not keep him because he had voluntarily committed himself. Bill told me that that did not make sense because the police had brought the boy to the hospital after he had barricaded himself in a social services office, and other psychiatric patients, including himself, were being treated in the hospital involuntarily.

A friend has enormous barriers to communication. He is profoundly deaf and signs old fashioned English rather than American sign language. He does not read and cerebral palsy makes it difficult for him to write. He walks with a pronounced gait and has trouble with his balance. He is sensitive to air quality and what he eats because he has severe allergies. When he moved into his own apartment he became extremely distressed and was admitted to hospital. He was transferred from the psychiatric hospital to jail because he assaulted hospital staff when he felt he was being forced to take medications. His sister told me later that she was appalled when an inmate pushed him in a wheelchair into the visiting room until he told her he hurt his foot playing volleyball and that he actually preferred jail to the hospital.

The participants express their understanding of basic civil rights in a liberal democracy in terms of laws which address notions of balance, protection, equality, safety, harm and threat. They recognize that contradictions exist between the ideals of equality, opportunity and choice on the one hand and, on the other hand, ideals that protect the individual and the community from the threat of harm. When the participants experience behaviour they perceive as harmful or dangerous they accept the authority of psychiatric medicine to diagnose and treat the person who is mentally ill. At the same time they question psychiatry's right to manage the individual's life when an individual's behavior is startling or unpredictable but not harmful. The participants reflect upon their responses to another's behaviour and question if they have at some time unnecessarily interfered with a person's right not to be incarcerated and involuntarily treated.

What is your understanding of civil rights?

SVIII: Equal opportunity, equal responsibility, equal privileges that's what civil rights are. The law that applies to me, however, is different from the law that applies to a five year old because the five year old needs more protection, but there is the same set of laws for everyone. Everybody would have the same opportunities if we took civil rights seriously. The way it is in reality is that if you're rich it's different from if you're poor, different if you're male or female or not white. If we took civil rights seriously opportunities would be equal.

RX: Basic rights are the right to be heard and to have a voice. Because I live in a democracy I have a vote and I am able to seek justice. People with mental illness are entitled to have a voice, to be listened to. All human beings have a right to a quality of life consistent with the quality of life in the community and culture in which they live. That means equal rights.

DIV: Civil rights is what each of us has in this democracy. We have the freedom to live our lives as we want to as long as we fit within the parameters of our democracy. Everybody has inalienable rights to freedom of speech and freedom of action and life, as long as their rights don't impinge on other people's freedoms.

DVI: What we are talking about is the rights of citizenship and citizenship has to be fully enforced. We have to protect the individual at the same time

we protect the larger group, and sometimes the protection of the group takes precedence. We know from history, however, that we should be extremely careful when we remove certain nominal rights from individuals for their own good, quote, unquote, because the track record of our society has been to err on the side of over-zealousness in depriving the individual of their rights.

BKIX: Basic civil rights include the right to be properly housed, clothed and fed. To have a choice around beliefs and to be allowed to live according to the dictates of our own conscience to the extent that they don't interfere with other people's rights. The challenge is to strike a balance. Civil rights begin with common basic human rights that we all have: the right to respect, to self-actualization and personal growth, and the right to be treated with respect and decency. And then we look at how we do this within the context of other people, so I respect their rights and they respect mine and we negotiate what we are going to settle as our common interest.

RXI: Civil rights means the right to feel safe within the context of the collective society, the right to pursue freedoms of expression and life style. There's a balance. Your right to pursue individual freedom is balanced with the rights of others. We're talking about an individual within the context of the whole community and civil rights affects the whole community as well as the individual. The rights of mentally ill people, aboriginal rights, homosexual rights, single parent rights are social issues addressed by the social contract. We are always dealing with issues of welfare and citizenship so the freedom of expression is about being able to pursue a particular lifestyle within the context of its effect upon the whole community.

GVII: The American constitution was one of the first instances of a liberal democracy trying to define civil rights, the right of every person to have liberty and justice. I guess my definition of civil rights then is that people of a country are free to pursue their interests and goals, and they are able to vote and participate in the structures of the government.

XII: Civil rights are the right of each individual to be born, to live with a reasonable amount of what this world has to offer, the freedom of choice in marriage, the right to bear children and to have the opportunity to work to provide for their needs and if we have done everything we reasonably can do to provide that and they still can't manage then the community has an obligation to support us and we call that social welfare. Rights include reasonable medical help, opportunities for recreation, freedom to practice religion according to the dictates of our conscience, but not to the extent of violating somebody else's rights. And then retire with dignity and be buried with dignity. People in the world today opt for a democratic form of government, and if the people we choose are competent then every effort will be made to assure these freedoms to the individual.

LIII: Civil rights are limited, just as freedoms are limited, and the primary limitation in our modern society is to not harm another person. One can do better than that and say the responsibility of a human being in our society is to be helpful, to respond positively to the needs of other people, to help them to facilitate their survival and their well-being, and I would prefer to have

that as an understanding of rights rather than just the bare minimum to do no harm.

Understanding civil rights and involuntary psychiatric treatment

The interview text demonstrates recurring tensions and ambiguities about the determining social effects of mental illness as the clergy attempt to reconcile the limits that notions of mental illness place on the exercise of civil rights. Concerns for public safety and individual self harm bump against ideals of civil liberty. Beliefs in the value of liberty and choice are limited by fear and love, self-protection and the impulse to do the right thing. The possibility for causing harm while attempting to prevent harm is a serious consideration in a practice of caring for peoples' psychological and physical welfare. A shifting and morally uneasy space in the clergy's talk sustains the individual's right to choose and consent to psychiatric treatment while accommodating the conflicting right of the individual to care who is too ill to voluntarily choose psychiatric treatment.

I was sitting in the reception area of a ward of the psychiatric hospital waiting to speak to a client. Two police officers were talking to a couple of people behind the tall desk. From where I sat I was able to see the corridor that leads to patients' rooms. A skinny man with a long grey hair sat in a chair along the corridor wall. He was wearing blue hospital pyjamas. The police officers put on white latex gloves, walked over to the man, picked him up and out of his chair and carried him down the hall and around a corner. He shouted, "Let me go you bastards." His voice was the only sound I heard. I

watched his blue pyjamas sail into the corridor. And I imagined him naked in an isolated observation room. Maybe he wasn't. I really hoped not. An earnest hospital employee came over and spoke to me. He said, "It isn't always like this around here." He seemed embarrassed, so I said I understood. I had no idea what the man did or did not say or do. The image of those pyjamas lying crumbled in the halls still scares me. At some point in my childhood I became aware that if we have bad laws, I could be locked naked in an observation cell.

Tensions and ambivalence about the role of psychiatry in the construction of civil rights is revealed in the clergy's answers to questions regarding the meaning of civil rights in a democracy and a necessary balance between when and what is reasonable. The participants consider how the rights and accompanying responsibility of individuals to live as they choose is limited by their capacity to make decisions in their own interest. They express their ambivalence about the limitations of equality when these are balanced by perceived threats to community safety. The clergy describe their general understanding of civil rights as an abstract idea that cannot always accommodate an individual's psychological pain and his or her resistance to voluntary psychiatric treatment to relieve that pain. The participants support the idea of civil rights on a theoretical level but acknowledge they respond to behavior on a practical level. They reluctantly accept incarceration for non-criminal behavior and caution that involuntary psychiatric treatment and involuntary admission is a traditional response that could be based on ignorance and fear of people who talk, act and think in startling and unpredictable ways. They acknowledge that they might misjudge or

misinterpret difference, and question the ability of psychiatry to judge what is normal and not normal.

How do you understand civil rights and the right to/the need for involuntary psychiatric treatment?

LIII: If a person is slashing himself, his civil rights need to be curtailed. Even against the person's will, some attempt should be made to prevent him from continuing that kind of self-destructive behavior. Because he's different and seems to have strange thoughts or act in peculiar ways doesn't mean that he should have any restriction of his rights. It is only when there's an imminent danger to himself and to other people that one would consider curtailment appropriate.

VI: When the state makes a decision to confine someone involuntarily or says this person could be a danger to themselves, to their family, to someone else, I see the civil rights of the individual being held in some sort of tension with the civil rights of the rest of the members in society. Of course the psychiatrist has to find a balance between a person's ability to cooperate to get help and the fact that they need help even against their will. Treatment even without consent is going to ultimately work to the person's advantage and that balances off the extent we do, in a sense, temporarily violate their will. It's obviously a very difficult decision to make.

RX: A person who's physically ill will go to a doctor, will go to a hospital and seek treatment. A mentally ill person may think that they're not ill, but

that the world has turned bad. I find it difficult to respond because I care for them and I'm frustrated. I'll say, "I believe, if you went to see a doctor you could receive some psychiatric assessment at the very least, if not treatment. There needs to be some understanding of what's going on here and perhaps you could be treated for this." And people will say, "I'm not gonna' go." And then they can't cope, they can't look after themselves, and they go deeper and deeper, and they make poor decisions. And then I find my self thinking that I don't know if I can continue. I don't know how much more money I can give to an individual when they can't cope. So I sit down with them and say, "I can't help you. I have to draw a line." And they get angry and upset and feel betrayed and feel awful about themselves and their situation. And that kind of helplessness is part of the frustration, and it's a human frustration. It may not be my role to play, so I walk away from it, but there is that desire, "I can take you somewhere."

SVIII: I think I compromised the civil rights of the young woman who wanted to continue with her automatic writing and light fires all over the house to ward off evil spirits, but there were other people who lived in the apartment below her and it was essential that her civil rights be compromised at that point. There is no question that she would have burnt the house down. Well of course she might not have, but chances were good, and even if she hadn't she would have just gotten worse and worse and worse and she would have done something else as drastic. So there are times when you have to protect someone from what they are doing against themselves, but it's not easy to know when to do that and when not to do that.

DVI: We're talking about the requirement for involuntary treatment on two levels, there's the philosophical level and the practical level. On the kind of theological, philosophical level the burden of proof is always on those who claim to tell others how they should live and what they need to do that successfully. On the practical level, if people are not able to care for themselves, if they are a danger to themselves or to others, then we have a responsibility to support them and tend to them in the most gentle, loving way that we can. We need to be always weighing all the factors.

KII: When you talk about people who may not be able to make an informed or rational choice, and these are big words - rational, reasonable, choice - you have to ask: Does society have a responsibility or right, depending on how you look at it, to intervene in another person's life, to incarcerate them because we don't agree with the way they want to live? And what gives me the right to tell you that you can't make a choice that I do not agree with? With illness though there is a question as to whether people are actually able to make choices. If they're not really able to make choices what you may be really doing is neglecting them, and that's a destructive thing to do.

RX: But isn't that forcing someone to go into treatment which they resist and are fearful about because I'm frustrated and want things to be fixed so we can get on with it? It's hard to deal with things which are so private. Although it's very difficult it comes back to me and back to the church. What is our response to mental illness as a label that separates people? If we take that label off we can see the human being's experience in life and we can

hear God speaking to us through these voices. They are important to us as they are, so our responsibility is to try to live in a way that includes them. We try to help them with their symptoms and try to provide an environment where they can live without necessarily being institutionalized. On the other hand some people go into treatment and are made better and get proper medication and live much happier and self-fulfilling lives. So there's always that possibility and this is the tension. But I have to ask what is my concern for them, and what is my self-interest?

DVI: The group I'm most familiar with in terms of loss of rights is seniors because I see more of them. We have situations of understaffing in lodges and retirement homes and so drugging facilitates the staff getting through x amount of work in a day and a sleepy patient is an easy patient. It's quite widely accepted and I am bothered by it. You know I see bright, bright people who are sitting there nodding in front of the Road Runner cartoon show.

SVIII: Drugs are handed out too easily, but sometimes they are necessary. Although I don't think we should force drugs down somebody's throat, we may have to interfere with their civil rights somewhere along the line, maybe when their behavior becomes so erratic or out of control that they are standing in the middle of the street going back and forth not knowing what they're suppose to do next. That's when infringing on civil rights is intervention.

RXI: Let's relieve the pain, and sometimes medication will take care of it for the time being. What's three days in the life of a person? If we don't know where things are going let's find a link and I'm happy with that. Even when people who fall into deep depressions and just can't help themselves, I say, "Well let's go to the doctor, let's get something that'll help you, that'll calm you; it doesn't have to be long term; you don't have to be on this for the rest of your life; let's just see if it helps and then let's address the issues again." In that there's a collective, cooperative investment in trying to lead people back to wholeness.

DIV: Hopefully a person is evaluated on an individual basis and there's an appeal process. If a group of professionals feel that this is the best treatment for a person and the person doesn't follow the treatment...well I've seen people who didn't do that and they went berserk. However, there's gotta be an appeal. If the person feels they have a good reason for not following treatment, they've gotta be heard.

BKIX: It is reasonable in an emergency situation, in the moment of crisis, to compromise the civil rights of people but after that it's not reasonable. After a crisis passes the courts ought to be working as hard as they can to restore the individual's rights. We tend to do that in three month, six month and one year chunks because the beliefs from the medical model say that in the event of mental illness you've got it for life although it can be treated and go into remission.

BKIX: In wrestling with this big question of people not wanting to go to hospital and being forced to go and how to balance respect for people's choice not be to treated, I think it gets into a question of safety and harm to self and others. But I think it goes deeper than that. For the individual there must be some partnering so trust can exist, some kind of belief that others have their interest at heart and are there for their benefit not just to run their life and stick them off in a corner so they're not a problem in the neighborhood. Civil rights can best be identified when there's a plan, when people understand that they have no choice but to be taken to the hospital, that it's temporary and that resources are being put in place to try to solve the problems and get them as independent as possible. I don't think we go nearly far enough in help people understand that. We act out of fear and act on a quick solution rather than the best interests of the individual.

DVI: Certainly in the last century we have used terminology such as "for their good," and "for their protection." Most of this probably stems from fears held by the general society and the magistracy. Because the profession of psychiatry is a very recent study, these women and men are under pressure, if they err, to err on the side of what fits with society's perception of what we should be doing, and partly so the politician can say, "My ministry is doing a good job because we're protecting you, and we're doing the best we can for Jeannie or Joe or whoever this prisoner is."

BV: Because of their lack of judgment and their mental situation, if they're liable to kill somebody then the community becomes a victim of their mental illness and has to provide protection for itself. It might involve incarceration

for the individual psychiatric patient simply because the right to freedom is overridden by the right of the larger community to avoid the danger of being murdered.

DVI: I find myself thinking that we might discover those possibilities within us which could be considered violent. The issues of violence and damaging behavior won't go away if you just took all the mentally ill and disabled people and got rid of them. They may not actually pose a threat, but they do provoke a fear in our lives. The other person who is radically different can provoke fear and the mentally ill point to images of our shadow side.

BKIX: Those who spend much of their time in a paranoid state and in a self protective mechanism of belief that they are under attack and therefore must strike back present some risk of violence to innocent people, so they need some assistance to solve that paranoia. They need protection, the public needs protection, and the individual needs some protection from retaliation if they are behaving in threatening or outrageous ways. That is an extreme situation, however.

LIII: The instances of violence and endangerment from psychiatric patients is as low if not lower than the nonpsychiatric population. The incidents where they do cause harm are blown out of all proportion and I don't think it is a fair representation of the situation. The thing about mental illness is that more often than not it encourages the individual to withdraw rather than anything else. Any harm that comes is usually harm that's inflicted on themselves either by not eating, not sleeping, not doing the normal things in

life. In extremely rare situations, sure, people can have a thought disorder that is sufficiently powerful that it will encourage them to act in the mistaken belief that they're threatened or endangered, and they may respond with aggression or violence in some form, but I think there are no more incidences of violence amongst the mentally ill than amongst the regular population.

BV: If you're talking about harm in the community and that's really where I'm coming from, I think many people find persons with mental disorders to be a little odd, a little peculiar and they take a little more time to deal with, and they can't always be dealt with in the regular kind of way so, yeah, they're inconvenient. I mean they get in the way sometimes because their thought patterns and their affect may not be synchronized and that is something that one is not used to, essentially it's different so sometimes it throws people for a loop. You can't relate to them directly as you would to a person without a mental disorder. What is the community's responsibility to treat people and what is the community's responsibility to embrace people as they are?

BKIX: Mental illness is not a big scary thing. When I see and hear of behavior of people with illness I see it in the context of having seen that a hundred times before and know it has boundaries and limitations to it, and we don't have to get all worried that it's going to become this big when it's only small.

LIII: I think that those who are truly at some risk of harm to themselves or to the community are a very small percentage. You know we're talking about

half of one percent in the literature, so if you see someone struggling there's less than one percent chance that they are going to create problems and yet our common response is that one hundred percent are going to create problems.

KII: Those on the margin are the most vulnerable. The greater society has all of the inertia on its side so it's pretty easy to crush anything that raises discomfort. Many people don't see mental illness as an illness and tend to moralize these different things. The intersection between morals and medicine is a long one. There's a long history of using medical metaphors to talk about morality. If I have a heart condition people understand in a morally neutral way. If I have a mental illness there's a moral judgment that somehow comes across in that labeling.

RX: The label of mental illness separates people, but remove that label and we may see a human being who was created by God speaking to us. Human beings are important for the way they are, so we try to live in a way that includes everyone. We try to help them with their symptoms and try to provide an environment where they can be without necessarily being institutionalized. On the other hand some people go into treatment and are better because they receive proper medication. There's always this possibility and this creates a tension. I have to ask my myself what is my concern for them. What is my self-interest, what's the community's responsibility to treat people and what is the community's responsibility to embrace people as they are? One of the realities is that a lot of mentally ill

people are homeless people who cannot make decisions in their own interest. They are fearful at the same time they don't have safe places to be.

RXI: I have confidence in the medical profession because they are partners with us. When we run out of ways or ideas to deal with people we need to go to the medical people for help. I've taken suicidal schizophrenics to the hospital because I knew I couldn't do anymore and maybe they just needed something to calm them; maybe they needed something to give them a little time so that whatever they're feeling right now would go away and maybe they could get through it or maybe they just needed a place to lay down that feels safe to them. It's quite interesting the responses I get from people who are agitated and are really having difficulty out here in the normal environment. I fight with them to get them to go to the hospital, but once they get there they calm down and are actually happy they made that decision. A mark of illness is that when the treatment comes they relax, they fight it and find it's not so bad. What happens within the process of treatment I'm not sure. Does a person have a right to check themselves out if they're not a threat to society?

DVI: Did you ever read Dostoevsky's The Grand Inquisitor? I think it speaks to what you are attempting to find out in your interviews. We have to be very careful with the rights of the individual and we also, for the good of society, have to be very careful how much power we give to any one individual and the history of both the church and secular society reflect that. We don't go far enough to see the need for understanding the power we have over each other. Do you know, it's like I can do anything I want because I

am responsible, but I'm not going to let you do what you want because I don't trust that you are responsible. This is rather a sad comment. I think we downplay the social control aspect. It's incredibly powerful and incredibly all pervasive, but we don't like to think about it because we believe we act in the best interest of the other.

BKIX: In democracy the kind of freedoms we claim and the kind of government we have is based totally on education. The more we know the freer we are; the more we know the better we can vote; the more we know the better we can use the system. So education is really the core of democracy; it's the core of our society. Yes, certainly, to advocacy. If there is a mechanism to be in place it is that every citizen needs education about their personal rights because it's their life; it's their stewardship to manage as best they can within the world around them. And we can best do that when we have the information which says, "Oh by the way when you get sick you have a right to go to the emergency room and get a prescription, and oh by the way if you are mentally ill you have the right to have an attorney or an advocate who can lay that out for you so that you have some sense of being able to act on your rights."

DVI: Involuntary commitment is fearful; it is a fearful responsibility, particularly when we say this person needs to be institutionalized for their own good, but I think what we really mean to do is assuage society's fear of some particular group. As I understand it people who are perceived to be mentally ill have a good deal of protection, but as with most things within the law, this will be affected by their social and economic status, their friends

and their colleagues. I can be an eccentric professor and get away with amazingly wierd behavior so long as I conform to a certain image and retain a circle of friends who will support me in that image. But do the same things as an unemployed mechanic who lives in a walkup flat down here and you would be run in on a pretty regular basis. I don't mean to be a cynic but it's the nature of the system in which we live that there's justice for all depending on how much money you have.

KII: Michel Foucault would argue that pathologies are constructed in order to show us where the boundary of normalcy is, and out of our great discomfort we have deemed certain behavior to be pathological. Its unpredictability and volatility fall outside the safe little universe we try to construct around us. People with mental illness make us uncomfortable because they don't take up the role in society we have deemed acceptable. I think we live and breathe and move and have our being in corrosive structures and we are shaped by that. History teaches that we need to define the other in order to deal with the fears of our shadow side. We define certain kinds of behavior as pathological and set up a whole system of knowledge around that in an attempt to control it. It's a scapegoat that we are creating rather than letting someone who challenges us just to do that and live and move freely through our society. By challenging us the other person puts the onus on us to examine why we feel threatened and insecure. It's easier to have a scapegoat than to deal with our own stuff. This person is ill so we need to lock them up. We focus our energies there, which is really oppression, rather than focus our energy on ourselves. Everything is political I guess is what I'm saying. And if police officers have to come in to

transport a person from one place to another that's an ethical or moral judgement that is being expressed in that event. Sheer brute force to protect us from what we fear.

DVI: Cultural stereotypes are a product of the ether. Although I think it's improving there is a fear of the other. Some element of tribalism drives that one out. Why do we fear the other, the different, so often. Unless we are taught and taught often I think it is easy for us to fall into a comfort zone that depends on the homogeneous group around us. I think it is the mark of a fearful society that demands more and more conformity. One of the marks of some of our nastiest societies of the twentieth century has been in the treatment of the most vulnerable including people suffering from mental illness.

CONCLUDING REFLECTIONS

The language of clergy both reproduced and contested the dominant discourses that determine the meaning of mental illness. In the end they were willing to tolerate their admitted ambivalence, and their responses thus illustrated the most important point of this study, that is, continually to question our own implicatedness in the production and reproduction of categories of difference especially with respect to people with mental illness.

Language is used to label and reinforce specific norms of behavior. It is not always clear where these norms come from although they are usually taken to be existing facts of life. Their status as social facts tends to render invisible the social power relations which have produced them. That the relation between mental illness and civil rights is problematic is not a new observation. What mental illness is officially, medically and legally, and what it is in the experience of people who are diagnosed with it, and what it is in the experience of people who are not diagnosed with it is largely, although not entirely, determined by discourse. The problem of mental illness and civil rights is about freedom and protection and specifically whose freedom and whose protection from what. Analysis of the problem of mental illness and civil rights as it is represented in various social discourses challenges the community to question whose discourse creates the values, law and systems that reconcile, arbitrate and dominate a person's freedom, protection from harm and right to psychiatric medical treatment. And it specifically challenges the community to talk about what is meant by social harmony and the right of citizens to protect themselves and each other from the harm of

compulsory psychiatric treatment. Given that mental illness has always been associated in social and historical contexts with unpredictable violence it is not surprising that the language of ordinary people, as well as contemporary mental health laws, is driven by combinations of fear and genuine desire to help another person's distress.

Mental health law and government policies justify and legitimize the systematic separation and management of particular individuals for their own good and the good of the community. Clergy justifications for differential respect of civil rights are also present in government policy and law. That is, a person's right to determine the quality of their lives and to make decisions regarding hospital admission and psychiatric treatment are contingent upon assessment of their capacity to cause harm and to know their own best interests.

The language of the clergy challenges the authority of psychiatric medical discourse to define mental illness, to know what is normal, not normal, pathological, a chemical imbalance or cognitive short circuiting. They acknowledge that social behavior is shaped by expectations of appropriate behavior specific to worksites, school, churches and other public places. The discourse of psychiatric medicine that resonates throughout the interview text and that so powerfully determines a person's legal rights and medical treatment in mental health law is absent in the practices of pastoral care in religious rituals. Here room is made for anyone, members of congregations and visitors, to participate. There are no assessments and no hierarchy with power to exclude, confine or fail the other human being.

The community resists change and perpetuates the construction of identity by ideology. The strength of discourses can be seen in my own rationalization of my own acceptance of psychiatric medical discourse to dominate my professional practice. Community care and integration have been financially expedited by intensive drug therapy that reduces symptoms but does not address society's ingrained policy habits of neglect and coercion. Increased social control of people with mental illness supplants the problems of reductions to social services, high unemployment, deep seated prejudice and discrimination, ignorance about responsible citizenship and enforced institutional dependency. Choices about medical treatment, relationships, housing, education, culture and recreation are circumscribed for people with mental illness, not because these things are not available to them, but because the acquisition and maintenance of these things require time and information and knowledge that is less accessible to emotionally vulnerable people than it is to people who determine the status quo. As Weedon says,

> "Whereas, in principle the individual is open to all forms of subjectivity, in reality individual access to subjectivity is governed by historically specific social factors and the forms of power at work in a particular society" (Weedon, 1987, p. 95).

Clergy acknowledge a role for police services and critical involuntary psychiatric treatment management when a person presents a very clear and present danger to themselves and the community. Some participants question the authority of psychiatric medicine to dominate the lives of psychiatric

patients after a crisis has passed while others easily rationalize the abrogation of civil rights if a person appears to need continuous non-emergency involuntary psychiatric medical treatment.

> The fixing of meaning in society and the realization of the implications of particular versions of meaning in forms of social organization and the distribution of social power rely on the discursive constitution of subject positions from which individuals actively interpret the world and by which they are themselves governed. It is the structures of discourses which determine the discursive constitution of individuals as subject. Yet discourses, located as they are in social institutions and processes, are continually competing with each other for the allegiance of individual agents. The political interests and social implications of any discourse will not be realized without the agency of individuals who are subjectively motivated to reproduce or transform social practices and the social power which underpins them (Weedon, 1987, p. 97).

Clergy characterize mental illness simultaneously as both something wrong in the body that causes bizarre language and action and as an abstract, socially constructed notion. These contradictory characterizations destabilize the meaning of mental illness and provide for the possibility of treating people with mental illness firstly as people and secondly as people with an affliction. Clergy recognize through their practice that pharmaceutical interventions can provide opportunities for some individuals to live more

self-directed lives. At the same time they resist the idea the medications are a panacea for all psychological pain. They are concerned that other explanations, such as physical sickness, poverty or personality, that could account for unusual behavior are not addressed by psychiatric medical practice. The identification of a person as other than mentally ill, as first a citizen, an employee, a student or spiritual being, provides space for considerations of alternative human expression of complex identities within complex social systems and institutions.

> Social relations, which are always relations of power and powerlessness between different subject positions, will determine the range of forms of subjectivity immediately open to any individual on the basis of gender, race, class, age and cultural background. Where other positions exist but are exclusive to a particular class, race or gender, the excluded individual will have to fight for access by transforming existing power relations (Weedon, 1987, p. 95).

People who work with the public have something to say about how mental illness is identified and valued in day to day community structures and relations. Further research into how we live together in the community could explore the meaning of mental illness in other discursive contexts such as the language and practices of education, recreation and occupation and, perhaps, thereby extend the multiplicity of individual identities and roles through which society and culture is both constructed and constructing of itself. If power resides in diffuse networks of institutional systems as Young (1990)

posits, then it may be through examination of the language of people who work directly with the public in these systems that issues of power in regard to rights, opportunities and self-respect may be addressed and relations of oppression and domination changed.

The participants' stories reflect my own uncertainty and ambivalence about mental illness and involuntary incarceration and treatment. They share with me language that challenges and questions institutional beliefs that present themselves as politically neutral. The clergy who participated in the research don't always trust experts and at the same time trust experts to know. There are doubts and hesitancies and questions about how they understand their experiences of mental illness, how they define mental illness and how they understand the civil rights of human beings who have been classified as mentally ill. They recognize the power of knowledge and social structures to own the necessary language with which to create a scapegoat stripped of identity beyond that of mental illness.

The research experience has contributed enormously to my practice. As a professional outsider in the mental health care system I was presented with an opportunity to critique language practices that structure community understanding of mental illness and the civil rights of psychiatric patients. Critical designations, such as mental illness will always rob a person of a life worth living, are attended by beliefs that the side effects of medication are always preferable to symptoms of illness that cause unusual and unpredictable behavior, and that social exclusion, condescending tolerance or pharmaceutical interventions are society's only choices with which to respond

to behavior we fear because we cannot classify it within our own and society's constructions of knowledge, logic and reason. Like the clergy I don't pretend to understand how some behaviors may be connected to brain disorder or understand the benefits or harmfulness of medications in the relief of pain, and I'm not so sure that where in the body need arises matters all that much to education. What matters is that the language and structures of adult education celebrate and accommodate difference so that individuals will be afforded opportunities to bring to learning and work their unique perspectives and contributions.

Within the mental care system where my colleagues and I provide educational and employment assistance to people with mental illness, we have learned to acknowledge clients and students firstly as human beings with individual personalities, experiences and life goals and secondly as students and employees. We have learned to accept people as they present themselves with behaviors that are different from the norm and to respect that individuals have their own ideas about a life worth living and so may on occasion choose not to participate socially as students and employees. Like the clergy whose jobs are to help people to recognize themselves as spiritual beings, our jobs are to assist people who choose to participate as students and employees to understand that there are boundaries to behavior and expectations of accountability in the work place and in educational settings. More importantly our jobs are to assist people to advocate for reasonable accommodations within education and employment that make it possible for them to exercise their right to participate socially as students and employees. It is at the sites of the school, the work place and the church that the dominant

language of mental illness could be set aside in favour of other social language and practices that are inclusive and accommodate the individual regardless of our construction of the social meaning of symptoms of psychiatric illness or the effects of psychiatric treatment.

It is easy to say a patient is also a person, and more difficult to act upon the idea that patients are first citizens with a civil right to participate in community however they may present themselves. Civil rights are fragile because its language is easily manipulated so as to legitimize the political violence of the state when it is exercised through systems and institutions that reform behavior in the name of community virtue and safety.

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APPENDIX A

University of Victoria - Human Research Ethics Committee

Two Certificates of Approval

University of Victoria
Human Research Ethics Committee

CERTIFICATE OF APPROVAL

Principal Investigators		Department/School	Supervisor
Bernice Montgomery		**CMFD**	**Dr. A. Oberg**
Graduate Student			

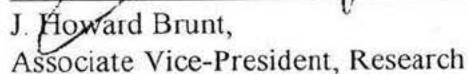
Co-investigator(s):
N/A

Title: Civil Rights & Psychiatric Patents: Attitudes of Community Clergy

Project No.	Start Date	End Date	Approval Date
105-99	**23 Mar 99**	**30 Jun 99**	**23 Mar 1999**

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and Other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.



J. Howard Brunt,
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions/minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

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Office of the
Vice-President,
Research

University of Victoria - Human Research Ethics Committee

Certificate of Approval

Principal Investigator	Department/School	Supervisor
Bernice Montgomery **Graduate Student**	**EDCD**	**Dr. Antoniette Oberg**

Co-Investigator(s):

Title: **The discursive construction of mental illness: Conversations with community clergy.**

NOTE Dr Oberg confirmed that the student B Montgomery at the time of her request for title change was just analyzing the data she had collected earlier

Project No.	Approval Date	Start Date	End Date
401-02	**22-Nov-02**	**23-Mar-99**	**30-Jun-99**

Certification

This is to certify that the University of Victoria Ethics Review Committee on Research and other Activities Involving Human Subjects has examined the research proposal and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

J. Howard Brunt
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions/minor amendments may be granted upon receipt of "Request for Continuing Review or Amendment of an Approved Project" form.

401-02 Montgomery, Bernice

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APPENDIX B

Letter of invitation

Enclosed is the description of a research project that may be of interest to you.

If you or another clergy would like to respond to my request regarding participation in this project, I may be contacted by telephone 389-1410 (W) or 389-1748 (H) or e-mail bernice@islandnet.com.

Sincerely

Bernice Montgomery
1005 Gosper Crescent
Victoria BC V9A 4J2

I am a graduate student in the Faculty of Education at the University of Victoria currently engaged in a research project to discover and describe personal attitudes and meaning community clergy attach to the civil rights of people with severe psychiatric disorders. The purpose of the research is to contribute to the knowledge of a community's understanding and attitudes about severe mental illness and the civil rights of psychiatric patients.

I am writing to request a half-hour appointment with you to discuss the details of the project in order that you may decide whether or not to be a research participant.

If you decide to be a participant, you will be asked to consent to two, one-hour interviews which will be audio taped or recorded in written notes. You will be asked to respond to a series of open-ended questions about the meaning and recognition of severe mental illness, the place of psychiatric patients in the community and the complex balance between individual civil rights and public rights. You may also be asked some general demographic information (gender, age, socioeconomic status, etc.).

Your participation will be completely voluntary and you are invited to withdraw from the study at any time, without explanation. Your anonymity and confidentiality will be protected throughout the research and after the project has been completed. Interview results will be kept in a locked filing cabinet. Your name will not be recorded on data sheets, published results or other documentation. The signed consent form will be stored separately from

any data. You will not be identified by religion or any other distinguishing characteristic in the final research report.

If you wish an appointment at your work place to discuss this project, whether or not you choose to be a participant, please telephone me at 389-1748 or e-mail **bernice@islandnet.com**.

Sincerely

Bernice Montgomery

APPENDIX C

Consent form for participation in the study entitled,

"Civil rights and psychiatric patients: Attitudes of community clergy"

The objective of this study is to discover and describe the personal attitudes and meaning community clergy attach to the civil rights of people with psychiatric disorders. The purpose of the research is to contribute to knowledge about a community's understanding of and attitudes toward mental illness and the civil rights of psychiatric patients.

If you decide to be a participant in this study you will be asked to consent to two, one-hour interviews which will be audio taped. You will be asked to respond to a series of open-ended questions about the meaning and recognition of severe mental illness, the place for psychiatric patients in the community and the complex balance between individual rights and public rights. You may be asked some general demographic information (gender, age, socioeconomic status, etc.).

Your participation is completely voluntary and you can withdraw from the study at any time, without explanation. You have the right to refuse to answer any question you do not wish to answer.

Any data collected in the study will remain confidential; interview results will be kept in a locked filing cabinet in a locked office. Only the researcher and Faculty Supervisor, Dr. Antoinette Oberg of the Faculty of

Education at the University of Victoria (phone 250-721-7807) will have access to the data. Your name will not be attached to any published results or other documentation, your name will not be recorded on the data sheets, and the signed consent form will be stored separately from any data.

Your interviews will audiotaped and the tape will be erased within 5 years after your responses are coded in written form. You may decline to be audiotaped at any time and the interview may be recorded as written notes. Your additional permission will be sought before the recordings or transcriptions of recordings are used in any public exhibition or publication. If you withdraw from the study your interview tapes, notes and transcriptions of recordings will be immediately destroyed.

Whether you participate or choose not to participate will have no bearing on your employment status, academic standing, job or the services you receive; your employer will not have access to any of the information collected in this study.

If you consent to participate in this research project please sign and date below.

Signature of participant:

Date:

Thank you.

Bernice Montgomery

Graduate researcher

Phone: 250-389-1748 or 389-1410 Email: bernice@islandnet.com

APPENDIX D

Interview Questions

1. What have been your experiences of mental illness in your job?
2. How would you define mental illness?
3. What is your understanding of hallucinations, delusions and extreme anxiety?
4. What do you think church offers people with psychiatric disabilities?
5. What is your understanding of civil rights, in a general way?
6. What are the basic civil rights of citizens in a liberal democracy?
7. What is your understanding of the civil rights of people with mental illness?
8. Do you think being clergy influences your understanding of mental illness and civil rights?
9. How could a balance be created between a person's civil rights and their requirement for involuntary psychiatric treatment?
10. On a continuum of extremes from dangerousness to inconvenience, what is your understanding of harm that people with mental illness present to the community?
11. To what extent is it reasonable to compromise the civil rights of psychiatric patients for their own protection?
12. To what extent is it reasonable to compromise the civil rights of people with mental illness to protect the public?

APPENDIX E

Construction and analysis of interview text

Data sheet

Themes

1. Recognition of mental illness: Subjective judgment - normalcy - cultural differences - view in context.

a. Work Stories : Experiences of mental illness in the work place

i.. a person with their own identity,

ii a lovely lady here, eventually had a breakdown

iii I don't do exorcisms

iv a cookie and a cup of tea

v the church is a people place

vi she was all over the map

vii taught me to be assertive

viii sometimes I will sound just as irritated as I feel

ix trying to do things in small groups or committees

x me as being a Christ figure/looking for normalcy

xi loving congregation/looking for the bathroom

xii want a sounding board

xiii so she cleared the table

xiv his face kind of glowers

xv the frustration I feel

xvi they know these drugs

xvii the RCMP are after me

xviii married for a long time

xx an older congregation

SVII *we are a very loving congregation p1; don't do exorcism p 2/3 how patronizing p8 Judgment call*

DIV *small component* This idea occurred several times that there was no one in their experience who is mentally ill *p1; she was in the choir p4; an older person p5; head was bleeding p8*

RX *Christ figure p2; satanic abuse p2; it's not everything...acknowledge them p5*

BKIX General descriptions of people with mental illness. Demonstrates and understanding of people with mental illness and problems they present to clergy. How? *hard time finding happiness; p l lonely situation; demanding, dependent intractable and very draining.*

KII Reoccurring theme--the distinction between normal and not normal behavior

wounded people tend to collect p 1; visit care homes p2; a kind of aura p2; an intuitive person

BV Hesitancy *I haven't a lot of experience p1; wasn't their normal environment p2; couldn't function p10.*

VI Hesitancy *not talked about very much p1*

GVII *he drools p2*

XII *medieval nun* Focus of interview participant framed thought about civil rights around his experience with this particular woman

DVI *a cookie and a cup of tea p1; his face kind of glowers p8* Respond to behavior and demeanor of individual. Why they thought what they saw was mental illness - maybe answer in 1/b

b. Definition of mental illness

LII *no one definition p1; a little piece of their experience p9*

SVII *chemical imbalance p3; too bloody sensitive p4*

DIV *behavior that is not acceptable p6*

RX *sadness displayed p4.* See others use the same metaphors aura/sadness/excluded

BKIX Factors which contribute to mental illness are organically based so it is a medical condition related to trauma, history, events. Paraphrased.

KII Philosophical understanding of mental illness

VI *don't know...experts don't know p1; if you're broke p7; people get labeled mentally ill p 11*

GVII *not right in the mind; then we are all mentally ill p1*

XII *mental illness caused by life experiences and born with defects p1;...inability to relate p3; judgment subjective p4/5*

DVI *what is mental illness? changes from time to time p1; subjective judgments p 8.*

c. Understanding symptoms

LIII *the impact of symptoms p7; a pyromaniac p10; we all live by delusions...things are getting better and better p14; schizophrenia screening days p15*

SVII *imagination p14; demon possessed*

RX Social/economic disparity? *Some say this is what I have p5; homeless people p8; people have visions and voice p 14/15/16*

DVI *ecstatic experience p5; reassured and solaced b scientific experiences, measure things.*

KII *judgment call ; behind the symptom p.3*

GVII *woman in the library square; six weeks in a psych ward p1; fruit of those things...*see KII for the same idea

XII *religious...carried to extremes...sign of mental illness p6; symptoms triggered by circumstances p1*

Being clergy: The job and mental illness

RX *religious stuff p1, p8*

a. My job is religion: Influence of job upon understanding people with mental illness

LIII Background working with the mentally ill p 1

SVII *time with prayer and scripture p8 credibility with people p9*

RX *in my job p1; it comes back to me...p8*

DVI *trained to know types and signs of mental illness* (think about in relation to naming particular illnesses)*; hope and compassion ... attuned p3.*

VI *sensitive to the complexity p3; support to people p4*

GVII *a matter of faith p4*

XII *sensitive...intimate insights; sympathy for condition of people; know limits of ability to help p8*

b. It's a people place: Relationships between churches/clergy and people with mental illness

LII *a greater level of acceptance p12; religious questions around direction...p12; fertile ground for imagination...p13*

SVII *sensitive souls p 4/5 church offers acceptance and love p5 people cry express feeling*

DIV *community of people p1; haywire p2; hard to fit in p 2/3*

RX *training p1; church community p1; deep level of compassion p2; strong interest in religion p3; desire to be in something...normalcy p3/4; eastern and western theology p9*

DVI *church ambivalent in respect to people....p2*

BKIX *finding meaning in life; companionship...support p 1*. How participants viewed the role of church in the lives of emotionally vulnerable people.

KII *mystery; God is not just a big illusion; theological framework p4; unknown behavior...medical model; chronological tradition p5*

BV *sense of guilt p4*

VI *difference between what people present in public and what they tell me in private p12*

GVII *attracted to spirituality; offer relationships p2; society without a soul p5; people in relationships p7*

XII *warm welcome; music; encourage involvement; respect privacy; find some people p5*

3. Beliefs about mental illness ????? Not looking at beliefs. Take care here.

a. Stereotypes of mental illness.

LII *scared at the thought p4*

SVII *sex crazed society p10*

DVI *subjective judgment...scary face p8 careful about judgement I pass...we fear the other p.9*

BKIX Mental illness as a scary thing. Exaggeration of danger from people with mental illness. See harm/danger p 2. Also discussed by DVI and RXI .

VI *this umbrella of mental illness is huge*

XII *fear based upon ignorance; scary...fear...as a child p 9*

RX *the public is both attracted and repelled p3; shadow side p 4.*

b. Changing beliefs about mental illness

LII and treatment *treat mentally ill people in the community p5*

DIV *small town in Manitoba p13* Community *people without support systems p1*

BKIX Belief systems p 4.

GVII *capable of the same kinds of things p8* Making a judgment *handling it with humility p2; looking for a way p3; best not to judge p6.*

XII *changes in treatment p 9*

Civil Rights

Balance rights of the individual and rights of the community. Right of the community to intervene on behalf of the individual. Freedom of expression. Subjective judgment - normalcy - cultural differences-view in context. Strike a balance.

a. Meaning of civil rights

BKIX Basic Civil Rights in a democracy *Civil rights begin with common basic human rights. Right to respect, self-actualization, personal growth, treated with respect and decency. Right to be properly housed, clothed and fed. Rights to choice of beliefs and to live according to conscience. p.2*

XII *Doesn't give you the right to control other peoples' lives p. 1*
This is my option and my privilege. p. 5
List of civil rights. p.6

DVI *matter of power.... p.7*
overzealousness... p. 5

KII *freedom of choice..p.6*
rights and responsibilities
economic relationship
right to chose and with that responsibility...

RX *a voice p.6*

LIII *civil rights is a balance between rights and responsibility p. 1,2*

DIV *freedom of action and life p. 6*

democracy

freedom of speech - ambivalence

establish parameters p. 7

VI *basic legal rights p. 2*

GVII *American constitution p. 3*

definition of civil rights p. 4

laws are tools p.6

SVII equal opportunity p. 6

RXI Responds with clear directness. See separate notes Notes RXI

treat the individual within the context of the community p. 11

American definition of civil rights p. 5

balance between the rights of collective society and the individual accountability

<u>b. The civil rights of people with mental illness in particular.</u>

BKIX *People feel railroaded and sometimes are because they don't have information.* *Every citizen needs education...p.5*

XII *Balance their rights with the rights of the community p. 3*

Psychiatric patients share exactly the same rights as others. p.7

Education and responsibility of the community p.10

Balance their rights p.3, p.7

DVI *changes in the law show improvement p.5*

marks of a fearful society p.6/7

mental health laws. p.2

need to protect the individual and the group p.5

"for their own good" is based on fear p.5

KII *Just lock them up and that's that p.9*

RX *a voice p. 6*

LII *the same civil rights p.2/3*

agents of social control p. 11

socially controlled reality p. 11

we don't like to think about it p. 12

VI *tension p.3*

GVII *in a democracy p.4*

laws are a tool p. 9

SVII *civil rights of a criminal*

burn the house down p. 11

do you really know what you are doing p. 11

GVII *involved in decision making p. 3*

c. Feelings about need for treatment

DVI *major part of their problem was the need for treatment p.1*

sarks and soma p. 10

KII *philosophical and practical treatment p.8*

RX *they don't think they're ill p. 6/7*

third option p. 13

BV *a lady...electro shock treatment p. 3*

the alternative is catastrophic p. 6

DIV *the devil inisde him p. 12*

self harm and harm to others p.13

VI *real quick response p. 14*

underfunded p. 5/6

GVII *person's best interests p.7*

an interest p. 8

lines drawn in a different way p. 8

the doctors were the power houses p. 5

SVII *meds p. 4/ 15*

group home p.7

lack of support and sensitivity p. 11

intervention p. 12/13

needs more than treatment p. 13

<u>d. Considerations of involuntary admission and treatment</u>

BKIX *Questions of safety and harm to self and others. p.3*

How we should respond to people who do not want to go? Ask what is reasonable on in a crisis. p4.

XII *We did in a sense temporarily violate her rights. p.3*

Certain treatments worked to her advantage. p.3

DVI *fearful responsibility p. 1*

the eccentric wealthy professor and the unemployed mechanic living in a flat down town

nature of the system p. 3

according to behavior rather than diagnosis p.4

RX *forcing someone...p. 8*

LII *emphasizes pathology p. 6*

needs to be a professional decision p. 7/8

do not regard themselves as in need of treatment p. 9

IV *real quick response p.4*

underfunded p. 5/6

VI *outside my area of knowledge and experience p.8*

if done from a reasonable basis p. 8/9

take context into account p. 10

misread, judgments, knowing what is on the slate p. 11

GVII *a terrible role p. 6*

they've gotta be heard p. 7

an appeal process 5/6

SVII *danger to themselves p.7*

RXI *what's three days in the life of a person p. 10*

group decision...dictating rights p. 5

help towards wholeness p. 6

medication..no opinion..don't know...without meds life is complicated.

Speaks freely about drugs.

need to go to medical people p. 7

connection between illness and treatment

right to refuse treatment but not the right to cause damage

act for good of someone else..compare to broken arm p. 6

help people towards wholeness..is it a bad thing?

creative manipulation

e. Threat people with mental illness present to themselves & the community

Harm/inconvenience/danger

BKIX *protection...risk of harm/danger to self or others is minimal*

XII *Relatively small number of people attempt to cause harm p.9*

Exceptions to the rule p9

...fear and ignorance....p.9

DVI *Range...psychopathic killer and a silly question at the bus stop. p.4*

a very small proportion have propensity for violence p.4

KII *unpredictability and volubility p. 9*

discomfort p.9

scapegoat p.0/9

the use of sheer brute force p.12

RX *you hear about murders p. 13*

they do provoke fear p. 14

BV *more danger to themselves p.8*

LII *low if not lower than the general population*

DIV *self harm and harm to others p. 13*

VI *may or may not be more inclined p. 6*

economic harm p. 7

GVII *harm presented p.4/5*

best not to judge

SVII *dangerousness occurs when people go off medications* p. 9

RXI *people may act and look scarier than the are p. 7*

impact upon community and responsibility of the community to care

capable of doing hurtful things p. 8

kind of scary

f. Possibility for people with mental illness to participate as equitable citizens.

The community and people and mental illness.

BKIX Some thoughts about how to protect the rights of the individual within the context of the greater society. Very strong section. p.3

DVI *provide a community that is welcoming. p. 10*

BV *the community for me...p.5*

LII *delusion of our present society p. 1/4*

GVII *society that dares for it marginalized people p. 3*
people in relationships

RXI *people with mental illness respond to differences between right and wrong p. 8*

g. Balance between individual rights and rights of the community.

BKIX Interest in the project arises from occupation with an agency which serves the needs of people with mental illness. Thoughts on civil rights of the individual in relation to the need to be treated beyond work as clergy.

GVII *live in relationship p. 6*

<u>VITA</u>

Surname: Montgomery Given names: Glenis Bernice

Place of Birth: Winnipeg, Manitoba

<u>Educational Institutions Attended:</u>

University of Victoria	1965 to 1976
	1976 to 1977

<u>Degrees Awarded</u>

B.A.	University of Victoria 1976
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Title of Thesis:

The Discursive Construction of Mental Illness: Conversations with Community Clergy.

Author

Glenis Bernice Montgomery

January 27, 2003