

Hearing Voices: Mental Illness and Cultural Recognition

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Abstract Popular misconceptions about the danger of madness have undermined mentally ill people's struggle for social inclusion. Consequently, efforts to think through how we might belong together must take account of mental patients' right to a public voice. However, the article takes issue with an excessively cognitive and rationalistic conception of the public citizen. It suggests, instead, that 'alternative' forums can be constructed which counters the dominant cultural image of the "mad, crazy, nutter". It concludes by discussing one innovative TV series (*Video Diaries*) in which 'mentally ill' participants' reveal their capacity to speak for themselves.

Keywords mental illness, marginalization, culture, recognition, public voice

Introduction

On New Year's Eve 1992, visitors to the lion enclosure in London Zoo were alarmed to see a young man climb over the safety barrier*. Despite urgent appeals for him to return to the safety of the viewing area he walked calmly towards the lions, knelt, and was then attacked. The man, Ben Silcock, survived though surgery to repair the damage took many hours. The drama of his mauling, captured on video by an amateur camcorder enthusiast, was later aired by all the main British TV news organizations. The newsworthiness of the incident was added to when it transpired that Silcock was a diagnosed schizophrenic and the previous day had asked for, but been denied, admission to hospital. He had apparently recognised that his psychotic symptoms were worsening and had sought emergency treatment. However, rather like the character Yossarian in Joseph Heller's *Catch 22*, medical staff at the hospital felt that

* I am grateful to Graham Murdock for comments on earlier versions of this article.

Silcock's request was itself evidence that he was not a suitable case for urgent treatment.

The footage of Silcock's mauling was deeply disturbing and in Britain quickly came to symbolise the violence associated with closing traditional asylums. But in the aftermath of recriminations and explanations it was never made clear why he chose to enter the lion's den (aside from popular explanations that "he must be mad"). In a television interview sometime after the event, he spoke of how he often visited the zoo because he felt a particular communion with the caged lions. His father, Brian, commented that living as a mental patient in the community was akin to being an unwelcome guest at a party to which he was not invited and suggested that his son felt more at home in the company of wild animals than people.

Nearly a decade later, the symbolism of Silcock's mauling continues to carry two meanings. It remains a *cause celebre* for those who maintain that the care in the community policy is not working. But it also suggests the immense difficulty that the mentally ill encounter in forging a sense of belonging in a world that wishes they were elsewhere.

Inclusion and Exclusion

The notion that the mentally ill do not 'belong' is embedded in the popular lexicon of mental disorder: "barmy", "batty", "crazy", "demented", "loony", "mad", "nutter", "psycho", "wacky", "zany". This insistent vocabulary of difference marks out the vast gulf between 'us' and 'them'. It drives home the strangeness, the remoteness, above all the 'otherness' of mental disorder. The inclusive vision of community care policy

therefore has to contend with deeply ingrained notions that the mentally ill are *not* normal, that they *are* different. As one British mental health service user recently put it, 'It is easier to live in society with a prison record than a psychiatric record' (Mind, 1999: 6).

Barham and Hayward (1991: 137) interviewed mentally ill people living in Britain to explore their experiences of life after the asylum. Speaking about the social impact of his particular psychiatric diagnosis, Henry, observes that 'with schizophrenia you're not living, you're just existing... I think that schizophrenia will always make me a second-class citizen'. His assertion is based on an experience of boredom and demoralisation following release from hospital. His situation is such that he feels he does not belong in the world of 'normal' people. This sense of exclusion is frequently reinforced by local hostility to having mental health facilities located in residential neighbourhoods (Sayce, 1995).

The tension generated by the encounter between 'rational' and 'non-rational' individuals illustrates how far communal solidarity with the mentally ill is vulnerable to moral judgements about 'the responsible self'. This tension governs our policy goal to fashion the mentally ill as people like ourselves, equal members of our political community, whilst at the same time ensuring that their apparent difference from 'us' - their irrationality - is dealt with at the *pharmacological* level¹. In other words, if mentally ill people are given civil rights then we can expect certain responsibilities from them; they must act responsibly and take prescribed medication.

¹ A proposed new Mental Health Act for England and Wales will construct non-compliance with a drug regime in the community as an offence. At present compulsory treatment requires hospitalization.

The Silence of Madness

Foucault (1987) has argued that the literal ‘shutting up’ of the insane in institutions has silenced madness. This has led to an extraordinary deafness towards the communications of the disturbed, and in particular a discounting of the reactions to, and complaints against, the treatment meted out to them. Inmates were all too aware of how the power dynamic inside the asylum obscured their point of view - a fact wryly noted by the Restoration playwright Nathaniel Lee, following his committal to Bethlem Hospital in the late sixteenth century: ‘They called me mad, I called them mad, and damn them they outvoted me’ (Quoted in Porter, 1991: 1).

What the asylum system produced, then, was not merely confinement for large numbers of people but a whole way of seeing and understanding irrationality at the individual level. Foucault shows how the ‘great confinement’ of the mad gathering pace since the Seventeenth Century resulted in a modern system of social exclusion in which the voice of the mental patient is ignored as rank nonsense. In Britain, for example, this has historically meant that some patients detained in mental hospitals have been denied the right to vote in elections.

Institutional segregation has been replaced by care in the community. Yet the official medico-psychiatric language for managing the mad continues to decide ‘where and how they can participate in the lives of those deemed to be of full mental health’ (Adam Phillips, 2001: 36). In considering the recovery of the mental patient’s ‘place’ in the community, Glass writes that ‘the medical language that exercises such a powerful hold over the patient’s sense of identity and liberty, reinforces the self’s

knowledge of its own separateness, its essential and abiding alienation from the species, from community' (Quoted in Barham, 1997: 170).

Expanding citizenship's vocabulary in order to communicate with the mad (Hickman, 1996) is vital if we are to find a way of belonging together. However, mental patients' struggle for inclusion has not figured in recent 'recognition' work promoting a revised ethos of citizenship grounded in the deconstruction of 'otherness' and recognising difference (see, for instance, the recent special edition on 'recognition and difference' in *Theory, Culture and Society*, April, 2001). While mental patients are the archetypal 'other - representatives *par excellence* of the non-normal – their marginalization is mirrored in the current politics of recognition which prefers to elevate racial, ethnic, and gender marginalization over the cultural politics of mental health.

Madness and Cultural Recognition

With the closure of Britain's Victorian-built asylums, mental patients have reappeared as familiar figures on our streets and in other public spaces. However, the cultural image of the mentally ill as "mad, bad and dangerous to know" has simultaneously reinforced their 'otherness' and grounded it in everyday experience. As Anne Phillips (1999: 81) puts it, in the context of arguments about equal human worth, 'it is proximity to those different from ourselves that resurrects long-buried ideas about social superiority and social inferiority, and that it is easy to conceive of others as your equals when you are not exposed to the details of their lives'. Recognizing mentally ill people's humanity easily dissolves in the face of recalcitrant experience.

Perhaps we should not be surprised. As Barham (1984: 178) reminds us, ‘we err if we suppose that administrative changes in the form of the transfer of those people from one category of sites to another necessarily indicate a deeper social change in the terms on which such people are to be regarded and permitted to participate in social life’. Barham’s caution derives from a concern that the blunt reality of care in the community falls some way short of the rhetorical promises.

This is not a uniquely British problem. Knowles (2000) has shown how, in the absence of welfare provision, homeless schizophrenics in Montreal pass through city spaces in which by definition, they can never anchor their lives. Her interviews with schizophrenics also reveal how, cut loose from the asylum and the hospital, they encounter misconceptions about their condition (that they have a split personality, are dangerous, and so on) which are worked into both their own understandings and their relations with others: ‘Schizophrenics’ conceptions of madness form a part of the public regimes for disposal of private terror. It forms a part of the ways in which they walk the streets of the city’ (Knowles, *ibid.*: 101). In short, madness remains a fixed cultural reference point within the political economy of local urban mythology.

Though writing from different geographical and cultural perspectives, Knowles and Barham share the view that the mentally ill are denied full inclusion in the social community, and pose the challenge of reconstructing social bonds with the mentally ill. The extent of the challenge is neatly summed up by Knowles: ‘The mad clearly occupy a strategic place in popular public concerns about safety and danger. This entails overhauling the existing relationship between the mad and not so mad and

rethinking the terms of our mutual existence, something that requires a major shift in the ways in which we think about madness' (Knowles, *ibid.*: 160).

However, the ways in which we think about madness carry historical weight. Gilman (1982) has shown how visual representations in our own era continually draw upon conceptualizations of madness from past times. Such continuity of representation, he suggests, overrides the banality of real mental illness and helps maintain a symbolic barrier between 'us' and 'them'. Following Gilman, a leading mental health advocate, Otto Wahl (1995: 114), argues that the 'creative professionals of today's media are, in some ways, just carrying on traditional depictions of the past. Many of today's images are repetitions or residuals of long-standing popular beliefs'. In his discussion of US films involving the mentally ill, for example, he notes how the portrayal of the "mad murderer" as looking distinctively different activates artistic conventions that have evolved over centuries.

Images of madness are also entrenched in the popular British imagination. In this historical and symbolic context, a complex relationship between madness and culture has evolved (Porter, 1987; Busfield, 1994; Showalter, 1987) in which representations and images of madness are found across a range of legal, medical and literary texts, as well as in the visual arts such as painting, film and photography. Over the years, as madness gave way to modern notions of 'mental illness', psychiatry has been unable to distance itself from cultural narratives concerning violent insanity (Wearing, 1993).

For instance, concern about unsupervised mental patients abroad in the community has figured prominently in popular UK newspaper accounts of mental illness and

crime (Muijen, 1995; Sayce, 1995; Baker and McPherson, 2000). Similarly, public fear about mental patients has provided British TV soap writers with a wealth of dramatic material (Philo, 1996; Henderson, 1996; Rose, 1998). Major soaps like *East Enders*, *Coronation Street* and *Brookside* have each introduced storylines exploring the dangerous consequences of caring for mental patients in the community.

Mental Illness and Cultural Rights

The mythology of violence that underpins popular assumptions about mental illness in the community suggests we must confront the cultural legacy of misrecognition in the public sphere. The social consequences of misrecognition, as Nancy Fraser (2000: 113) makes clear, are that people are ‘denied the status of a full partner in social interaction, as a consequence of institutionalized patterns of cultural value that constitute one as comparatively unworthy of respect or esteem’. In the case of the mentally ill, cultural representations which reinforce their marginal status are not only antithetical to changed social relations between the mad and not so mad, but also undermine their claim to the cultural rights of citizenship.

The concept of cultural rights has evolved as an extension of citizenship rights; that is as the most recent set of rights to enable the citizen to be a fully participating member of the political community (Turner, 2001; cf. Murdock, 1999). Cultural rights, in this sense, offer the prospect of inclusion in the community regardless of cultural identity or life style. Recent reassessments of the cultural conditions for citizenship often begin with T.H. Marshall’s seminal essay on ‘Citizenship and Social Class’ (first published in 1950), which took for granted ‘that cultural rights were implicit in civil and social rights’ (Roche, 2001: 76). However, such a view overlooks the role of

media in constructing (and delineating) membership of the political community. Consequently, the concept of cultural rights points to the *symbolic mechanisms* by which cultural belonging and recognition are facilitated.

Cultural rights, according to Pakulski (1997: 80), herald a ‘new set of citizenship claims that involve the right to unhindered and legitimate representation, and propagation of identities and lifestyles through the information systems’. The framing of cultural rights in terms of rights of cultural citizenship points not only to the recognition of difference, but the further universalizing of citizenship. In other words, cultural rights provide a bridge to a second aspect of recognition demands; ‘that is for recognition of the *common* humanity of different groups and the equal worth of each citizen, which flows from that’ (Lister, 2001: 100; emphasis in the original).

Pakulski’s notion of cultural rights involves three sub-elements: ‘the right to symbolic presence and visibility (vs marginalization); the right to dignifying representation (vs stigmatisation); and the right to propagation of identity and maintenance of lifestyles (vs assimilation)’ (Pakulski, 1997: 80). These rights centre upon the role of cultural institutions in strengthening (or undermining) symbolic ties of citizenship. As Stevenson (1999: 59) puts it: ‘To talk of cultural citizenship... is to be concerned with the various ways in which membership is both determined and constructed. Are you an insider or an outsider, accepted or rejected, embraced or shunned by contemporary society?’ These questions are not simply academic; in the context of shifting politics of mental health care they pose substantial practical difficulties for the mentally ill.

The reorganisation of mental health services from asylum to care in the community challenges prevailing attitudes toward the mentally ill in two ways. Firstly, it acknowledges the cultural rights of the stigmatised. In the case of the mentally ill, this involves rights of access to a public voice. Secondly, and related to the latter point, the deconstruction of the mentally ill ‘other’ is essential to re-valuing their lives, helping them forge empathetic relations with others. This is valuable in helping members of the community understand that the ‘otherness’ of mental illness does not belong ‘elsewhere’, nor does it entail irretrievable differences of identity between ‘us’ and ‘them’. Indeed, given that mental health problems affect one in four people in Britain (and 450 million people worldwide), it underscores that ‘they’ are also ‘us’.

Mental Patients and the Public Sphere

The advent of community care appears as a particularly helpful context in which to promote mentally ill people’s emergence into the public sphere. Free of the asylum, so the argument goes, they can participate in public discourse on *equal terms* with others in order to offer alternative accounts of their condition. But this ideal speech situation borrows heavily from a Habermas-inspired view of public discourse. It presupposes that the mentally ill will encounter no difficulties in entering a discursive space predicated on *rational* debate. Here, the point is that Habermas’s emphasis upon the rational character of communication compounds mentally ill people’s difficulties in taking up rights of participation in the public sphere.

Feminist critiques of Habermas’s classic public sphere model argue that his masculine dissociation from the feminine reproduces a public world devoid of emotion and affect (e.g. Fraser, 1987). This criticism points to the way in which prevailing

relations between reason and emotion structure rights of participation in the public sphere. Other critics have questioned the dominance of the rationalist voice on the grounds that '[t]he Enlightenment, in promoting the hope of universal reason, silenced those whose voices were considered unreasonably emotional, superstitious or old-fashioned' (Billig, 1996: 12). Post-modern celebrations of 'Otherness' have helped reinstate these maligned voices. It would be a mistake however, to think that every voice suppressed by the dominant voice of western rationalism has been rescued.

Despite the apparent multivocality of post-modernism, certain subjects (and subjectivities) remain marginalized and subject to censure by 'rational' society. One group for whom this is a continuing problem are voice hearers. As Blackman (2000: 57) makes clear: 'The hearing of voices is a signifier of deficit, disease, pathology, and lack, indicating that a person has lost certain psychological propensities and is unable to function as a responsible citizen'. At the very least, one can imagine how people who hear voices might be wary of drawing attention to their experiences.

The Politics of Voice Hearing

However, the decline in the pre-eminent position of the asylum has seen a shift in the discursive field around mental health. Thus, for example, the Hearing Voices Network (HVN), a growing international network of self-help groups for voice hearers, argue that voice hearing is misunderstood by psychiatry which denies the *reality* of their hearing experiences (see Coleman, 1999). Consequently, the HVN offer an counter-space in which hearers 'can adopt different relations to their voices producing very different ways of being, thinking and acting' (Blackman, 2001: 189).

The HVN places particular emphasis on hearers retrieving the personal meaning their voices may have. The approach is one of challenging orthodox psychiatry by working with hearers to listen to, contextualise, and then integrate the significance of their hearing experiences within the tapestry of their own lives. As the authors of the network's self-help manual, *Working With Voices*, put it: 'It is important to see yourself as an individual rooted in society and not as a patient rooted in psychiatry' (Coleman and Smith, quoted in Blackman, 2001: 200).

At the heart of the HVN enterprise is an opportunity for voice hearers to understand their experiences *on their own terms*. In doing so, the network encourages hearers to vocalise ways in which psychiatry has misrecognised their hearing experiences and concomitantly helped reinforced the cultural image of the "mad, crazy nutter".

However, while the self-help organization of the network means that voice hearers are able to share their hearing experiences between each other, the question remains as to how voice hearers can add their experiences to the stock of available reality?

Recognition and Representation

This is a deceptively simple question. Within the paternalistic ethos of British public-service broadcasting, for example, people who hear voices have been constructed as one more 'social problem'. From an early point in its history in Britain, radio and later television opened itself to a range of popular voices but this did not include the mad. The locked doors of the asylum marked the symbolic boundary between rationality and derangement, intelligible speech and sensible utterance. Mental illness, if it was spoken about at all, was debated by experts and addressed by government policies.

However, the shift from asylums to community care has coincided, in Britain, with major changes in the television system. The emergence of a ‘new populism’ in documentary and current affairs programmes in the 1990s has led to a decentring of expertise and an emphasis on common sense and grounded experience (Livingstone and Lunt, 1994). The arrival of populist TV means that marginalized voices have been granted more extensive access opportunities to speak about their experiences than in varieties of paternalism associated with the ethos of public service (Corner, 1994).

The breakdown of the paternalist tradition has resulted in accusations that the public sphere is collapsing under the weight of emotionality and affect (see Dahlgren, 1995). However, this need not be the case if we imagine forms of arrational public discourse that do not assume an excessively cognitive and rationalistic conception of the ‘public citizen’. Indeed, affect and emotionality, far from denigrating the public sphere, might contribute to understanding as to why we should actually care about others. This leads us to consider one documentary series which marries interest in ‘others’ with recognition of the other’s right to speak for themselves in public.

Video Diaries: ‘Mad, Bad or Sad?’

In the BBC series *Video Diaries*, individuals with a story to tell are first selected and then issued with a camcorder to record events in their own lives. Diarists then edit the tapes in consultation with BBC professionals. The resulting programmes are then broadcast on the national network. The series aims (in theory) to empower the diarist by mobilising their experientially based vision of the world within a format that supports their capacity to speak for themselves (Dinsmore, 1996; cf. Dovey, 2000).

The series' format allows viewers a privileged and unique mode of access to a degree of subjectivity unimaginable in traditional documentary modes of expression.

'Mad, Bad or Sad?'² is Sharon's video diary about being a black schizophrenic woman living in Manchester, England. A key figure in her diary is Mickey, Sharon's husband, also a schizophrenic. Together, they offer a deeply personal perspective on the experience of hearing voices and being labelled 'schizophrenic'. Consider, for example, Sharon's opening address to viewers:

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

This perfectly illustrates the remit of *Video Diaries*: to allow ordinary people to tell their own stories in a way that gives us insights into the 'reality' of their situation. Sharon's story is one of being permanently marked by the label 'schizophrenic'. Watching her 'diary' however, we are not asked to distance ourselves from her but to identify. We are offered a sense of intimate engagement with the otherness being portrayed. Sharon's narration draws us into her personal world of 'Mickey, my two

² Broadcast, 25th April 1995.

cats and my voices'. The subjective camera and first-person voice-over, allow us to view the world entirely through Sharon's eyes. This process may have been 'hard', but it enables her to explain the 'root' of her madness from within her own life-world perspective.

The argument, alluded to earlier, that the mentally ill are *in* the community but are not part *of* the community, lies at the heart of Sharon and Mickey's story. In the following testimony, Mickey speaks both authoritatively and emotionally about his experience of living and coping with a mental illness diagnosis:

Some people would say you live the life of bloody Riley because you get that little bit extra, cos you're on the sick, rather than just being unemployed. But there's a price to pay. I mean, if you end up in the loony bin you know somewhere in your head that you're being talked about, 'cos you know that when you were out there before you got that label, well you were one of them. You'd be talking about people. You'd be saying, "oh, such and such is in the loony bin", you know, "a right nutter". I mean if you were to mention it to your shrink he'd probably say you were paranoid! But I know. I know what we used to say about people and I know the jokes that were made. And consequently, I know the jokes that are made about me and Sharon.

Here, Mickey expresses his dislike for the mental illness label based on his pre-illness experience of judging people according to their status as a mental patient. His candid testimony draws on the popular terminology used to marginalize and exclude the mentally ill. Instead of avoiding derogatory words such as "nutter" and "loony bin" however, he deliberately appropriates them in order to contest the validity of such (mis)representations. Moreover, by playing with the 'shrink/paranoid' joke he signals

how his own pre-illness attitude towards the mentally ill impacts on his present schizophrenic identity. He is talking to viewers as a ‘schizophrenic’, but also as someone ingrained within a culture that sees schizophrenics as different. The deficiency of the schizophrenic (“a right nutter...”) is turned on its head and becomes the deficiency of society; one that fails to recognise their *humanity*. As his testimony concludes, the image track cuts to a shot of Sharon asleep. The image of normality this conveys adds to the poignancy of Mickey’s acknowledgement that others see them as a joke. The message appears to be: “There but for the grace of God go I”.

Making Madness Visible

The marginalization of the mentally ill seems likely to become one of the main issues for recognition politics over the next few years. In Britain, some psychiatric service users are adopting tactics of past civil rights movements. For example, the Chair of a user-led campaign group, Survivors Speak Out, signs his letters Glad to be Mad – just as gays reclaimed the word ‘queer’. He has also set about organizing a Mad Pride Rally, modelled on Gay Pride. ‘All this happened while the rest of us have been stuck in the old thinking about nutters and weirdoes. The lunatics have not yet taken over the asylum – but they are raising their voice’ (Freedland, 1998: 28).

The anger of service users is driving demands for an end to the discrimination of the mentally ill. However, the notion that mental patients are incapable of giving a valid viewpoint is often enough to ensure their marginalization from more ‘rational’ forms of public discourse. Their vulnerability to the image of the “mad, crazy, nutter” is a form of censorship and silencing. This means that participation in the community for

those currently constituted as mentally ill must be guaranteed through the provision of cultural rights of citizenship, including rights to a public voice.

But as the argument above suggests, the terms on which the mentally ill should be given a public voice raise particularly awkward issues. With the advent of the care in the community policy, there is a blurred distinction as to the criteria we might adopt in taking mental patients' views seriously. In the case of voice hearers, for example, their right to speak about their hearing experiences can easily be countered with the claim that what they are saying is evidence they are "unwell". This reproduction of a medicalized way of seeing and understanding 'the mad' under a new set of conditions may well turn out to be psychiatry's most potent legacy.

Final Remark

In Britain, the mental health field is currently experiencing winds of change. Various interest groups are gathering in order to stake out their vision of future psychiatric policy. Between incarceration in 'secure' environments and the relative 'freedom' of community care, a repertoire of professional and lay voices are engaging in a struggle to be seen and heard. Without closing the cultural gap between 'us' and 'them', mentally ill people's mode of belonging is provisional and subject to the machinations of those who would (re-)impose citizenship's exclusivity. It remains an open question as to whether the grainy video images of Ben Silcock's fateful visit to London Zoo will be a lasting memorial to our failure to find a way to belong together.

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