Conclusion

There is growing pressure in North America and Australia from interest groups supporting the medical model to bring the various schizophrenia controversies to closure. The mental health industry is currently undergoing an expansive phase and new mental disorders are being progressively added to psychiatric diagnostic manuals. In conjunction with this general expansion there is also a growing tendency to use coercion in psychiatric practice. These trends give rise to concerns about an exacerbation of human rights problems that arise from routine psychiatric practices.

A principal objective of this thesis is to demonstrate the depth of confusion that prevails within the psychiatric profession about the cause of the symptoms of schizophrenia. Chapter 3 laid the foundation for achieving this objective with a discussion about the philosophical problems of medicalising a condition that has no apparent physical cause. Various tests were applied to determine whether the symptoms of schizophrenia conform with generally conceived notions of disease. It was concluded that these symptoms are similar to the phenomena of baldness and homosexuality in that it is impossible to make sound arguments supporting a pathological interpretation. The descriptive psychopathology for schizophrenia was found to have a long and confused history and the contemporary psychiatric consensus about symptomatology, founded on the work of Kraepelin and Bleuler, was shown to be largely contrived.

Chapter 4 probed the aetiological confusion by examining the dichotomy between psychiatric theories postulating biological causes and theories which argue for environmental/experiential causes. The proliferation of sub-models attached to each side of this dichotomy was described and analysed. The wide variation of these aetiological theories was tendered as primary evidence that the psychiatric consensus about diagnostic and treatment techniques for schizophrenia is not supported by scientific knowledge about the underlying cause of the condition.

Another objective of the thesis is to cast doubt on the wisdom of extending psychiatric coercion so that more people can be treated involuntarily with neuroleptic drugs. This objective was achieved by demonstrating that the medical model is only one of three meta-models for explaining the symptoms. Chapters 6 and 8 described and analysed competing explanatory models — a mystical model and a myth-of-mental-illness model — which were both shown to be at least as rational and plausible as the medical model. Of the three models only the medical model supports arguments for drug treatment. The normal neuroleptic drug treatment is only a crude management tool, not a cure, and frequently does more harm than good. Treatment often results in a variety of seriously debilitating neuroleptic-induced diseases. An underlying argument of the thesis is that there is no

medical justification for treating people with these drugs against their will and that to do so violates a number of basic human rights.

Chapters 5, 7 and 9 demonstrated that each of the three meta-models is supported by competing interest groups. Partisan interest groups were found to be driving the aetiological controversy by raising conflicting human rights imperatives associated with their separate perspectives. An objective of the thesis is to demonstrate that the human rights entitlements of people diagnosed with schizophrenia largely depend on the model through which the cause of the symptoms is viewed. Most psychiatrists seem unaware they are routinely violating human rights imperatives that arise from non-medical perspectives. It seems inconceivable to psychiatrists that normal medical treatment, given in good faith, could be rationally construed as torture or a violation of the freedom of thought and belief. Yet the thesis clearly demonstrates this to be the case.

Chapter 10 on early psychosis demonstrates that psychiatrists are expanding the diagnostic net for schizophrenia into areas that appear to be outside the boundaries of their medical expertise. This chapter described and analysed current psychiatric research which is extending the definition of schizophrenia to include a pre-psychotic phase. When this research was analysed it became apparent that it is largely founded on false premises and utilises arbitrary criteria to provide a superficial appearance of scientific rigour.

Ostensibly the psychiatric intention of early psychosis research is to provide the basis for a preventive medicine campaign against schizophrenia. However, it is apparent that research funding from drug companies is helping to drive this extension of schizophrenia and it seems likely an underlying motivation is to expand the market for the new generation of schizophrenia drugs. The implementation of a preventive medicine campaign, involving pre-psychotic detection and treatment, will further exacerbate the many human rights problems surrounding the treatment of people diagnosed with schizophrenia.

The tentative status of pre-psychotic symptomatology, and the large number of seemingly normal people who fit the criteria, could quite conceivably bring the whole medical model for schizophrenia into disrepute. A preventive medicine campaign based on the current pre-psychotic diagnostic criteria may prove to be one of the many watersheds that psychiatric practice passes through from time to time.

In a 1977 article published in the journal Science George Engel, a US based professor of psychiatry and medicine, observed that psychiatric practice had then reached one of these watersheds:

> At a recent conference on psychiatric education, many psychiatrists seemed to be saying to medicine, “Please take us back and we will never again deviate from the medical

> model." For, as one critical psychiatrist put it, "Psychiatry has become a hodgepodge of unscientific opinions, assorted philosophies and 'schools of thought', mixed metaphors, role diffusion, propaganda, and politicking for 'mental health' and other esoteric goals". In contrast the rest of medicine appears neat and tidy. It has a firm base in the biological sciences, enormous technological resources at its command, and a record of astonishing achievement in elucidating mechanisms of disease and devising new treatments. It would seem that psychiatry would do well to emulate its sister medical disciplines by finally embracing once and for all the medical model of disease.[1]

Engel himself, however, did not agree with this position and he went on in the article to analyse the crisis that psychiatry was then undergoing. He began by observing that the essential characteristic of the crisis was a split within the profession about its future direction. One camp was advocating a return to strict observance of the medical model based on assumptions of brain dysfunction as the cause of behavioural deviations. The other, "exemplified in the writings of Thomas Szasz and others who advance the position that 'mental illness is a myth'," [2] was urging the foundation of a new discipline based on the behavioural sciences which would supersede psychiatry and "be concerned with the reeducation of people with problems of living".[3]

The purpose of Engel's article was to caution psychiatrists not to be too impatient for a resolution because the crisis that was then afflicting psychiatry could also be found in other branches of medicine. He believed that the root cause of the problem lay with the over-extended usage of the biomedical model, which underpinned all of medicine. The biomedical model, he argued, was originally conceived for scientific research purposes. Although it served well in this role Engel claimed it had been extended too far into popular culture:

> The historical fact we have to face is that in modern Western society biomedicine not only has provided a basis for the scientific study of disease, it has also become our own culturally specific perspective about disease, that is, our folk model. Indeed the biomedical model is now the dominant folk model of disease in the Western world.[4]

According to Engel the unsuitability of biomedicine as a folk model lies with its inability to integrate psychological and social factors into the understanding and treatment of disease.[5]

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[1] George L. Engel, 'The Need for a New Medical Model: A Challenge for Biomedicine', Science, Vol. 196, No. 4286, 8 April, 1977, p. 129.
[2] Ibid.
[3] Ibid.
[4] Ibid., p. 130.
[5] Ibid., pp. 129-136.

Engel proposed a new model to replace the biomedical model. He called the new model a biopsychosocial model and he thought it would be particularly well-suited for psychiatry: "Medicine's unrest derives from a growing awareness among many physicians of the contradiction between the excellence of their biomedical background on the one hand and the weakness of their qualifications in certain attributes essential for good patient care on the other".[6] The "attributes" Engel was referring to involved recognising the psychological and social needs of patients, and the contributions these needs can make to the presentation of disease. They also involved a knowledge of how and where to refer a patient on for non-medical expert advice when the application of biomedical expertise was inappropriate. Engel recommended this biopsychosocial approach to disease be included in the educational curricula of physicians and psychiatrists.

However, as psychiatric practice has unfolded since the late 1970s it is apparent the psychiatric profession has not followed Engel's advice. Although the terminology of 'biopsychosocial' is now widely used, it is usually only as a rhetorical device. Mainstream psychiatric practice has clearly followed the course that Engel warned against. From the early 1980s onward there has been an ever-strengthening commitment by psychiatrists to a strategy which positions their profession firmly within the scientific community. An important part of this strategy has been to give precedence to biomedical approaches in aetiological research and treatment techniques.

This renewed commitment to the biomedical approach is particularly evident in research into the aetiology of schizophrenia. There is very little contemporary research in this area that is founded on psychological or social premises. Interestingly though, the rhetoric, if not the substance, of a biopsychosocial approach is sometimes used to support biomedical theories about the aetiology of schizophrenia. This is apparently done to make the renewed commitment to biomedical assumptions more acceptable to non-medical mental health professionals.

Examples of this rhetorical use can be found where individuals with a hypothetical biological indicator for schizophrenia are tested for their psychological and social adaptation skills. This psychosocial testing is done to test the validity of the biological theory. The combination of a biological theory and psychosocial testing is then called a 'biopsychosocial' approach to aetiology.

In one recent study, for instance, 42 schizophrenics were divided into two groups on the basis of their brain ventricle size.[7] One group had enlarged ventricles while the other group had normal ventricles. The psychological and social functioning of the two groups were compared by testing

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[6] Ibid., p. 134.

[7] Rosemary L. Farmer and Anand K. Pandurangi, 'Diversity in Schizophrenia: Toward a Richer Biopsychosocial Understanding For Social Work Practice', Health & Social Work, Vol. 22, No. 2, May, 1997, pp. 109-117.

them with a battery of measurement techniques. The objective was to determine whether ventricle size had any bearing on psychosocial functioning levels.

On this occasion enlarged ventricles were found to have no bearing on the psychosocial functioning levels of schizophrenics. However, the researchers did make an incidental discovery. It appears that the gender and race of schizophrenics does affect their level of their psychosocial functioning — women and Afro-Americans faring better than males and whites.[8]

Closure of the controversy over the cause of the symptoms of schizophrenia appears to be remote at this stage. This is despite the confident assertions by many proponents of the medical model that a breakthrough in the biological area is imminent. When the various lines of biological research are closely examined it is not difficult to discern that all of them are returning equivocal results. But it is not only the quality of the results that makes an early closure unlikely. The sheer quantity of conflicting psychiatric theories also has to be considered. There are so many divergent threads currently being pursued that it is quite evident that psychiatric researchers are a long way from reaching consensus.

Nevertheless, powerful interest groups supporting the medical model are ignoring the poor quality and scattered variety of this biological evidence. They are also tending to ignore the severity of adverse effects produced by schizophrenia drug treatments. These interest groups are currently demonstrating considerable political skills in campaigns to extend both the definition of schizophrenia into a pre-psychotic phase and also to extend the reach of psychiatric coercion.

The high confidence levels expressed by psychiatrists in their professional, philosophical and ethical capacity to deliver a just outcome from this situation often seems to be misplaced. The history of medical treatment for schizophrenia over the past century features a succession of cruel and ineffective therapies that appear to have been devised more to inspire fear and aversion in patients than to provide comfort and amelioration of the symptoms. There is a clear pattern of one cruel and ineffective treatment being replaced by another as public disclosure catches up with psychiatric practice. This pattern is currently being repeated as atypical neuroleptic medications are phased in to replace conventional neuroleptics. The new atypicals only appeared on the scene after there was extensive public disclosure about the epidemic of tardive dyskinesia and other severe negative effects which conventional neuroleptics have routinely caused in patients over the past 40 years.

A central question arising from this situation is whether the extension of the definition of schizophrenia, and the extension of coercive powers to apply psychiatric treatments, should be

[8] Ibid.

allowed to proceed without first properly reconsidering the basic premises on which the medical model for schizophrenia is founded.

The mystical model and the myth-of-mental-illness model both provide plausible alternative explanations for schizophrenia. These alternative models are often more attractive to people who have themselves been labelled with schizophrenia. This is particularly true of people who have been made involuntary psychiatric patients. When preventive medicine campaigns using prodromal symptoms for schizophrenia are analysed in relation to the three different models it is apparent that the medical model is in many ways the least plausible of the three.

Perhaps the reason why three divergent models can all be shown to provide reasonable explanations for schizophrenia is because the various categories of symptoms for schizophrenia are themselves so divergent. A range of positive mental symptoms — like delusions and hallucinations — are said to be reflected in outward forms of irrational behaviour. But at the same time there is also a range of negative mental symptoms that can manifest as behavioural inactivity. On top of these positive/negative and mental/behavioural dichotomies there are also various forms of social and occupational dysfunction that are used as symptoms for schizophrenia.

If three entirely different models can suitably explain the cause of schizophrenia then it is not entirely implausible to assume that the diagnostic net might be so wide that it is ensnaring three entirely different and unrelated classes of people. That is, while the three models might all serve to give reasonable explanations for schizophrenia in general, if the models were to be tested separately on individual cases, it might be found that each separate case of schizophrenia is only plausibly explained by one particular model. Perhaps this is what is happening when recovered schizophrenics review their own personal experience and select for themselves the explanatory model they think is most appropriate.

It is not a difficult task to develop a hypothesis which refines the explanation of schizophrenic symptoms by separating schizophrenics into three classes of people and attaching individuals to the particular model that is most appropriate. Such a distribution would appear to be most rational along the lines of the bio/psycho/social framework. However, in order to make this adjustment it is necessary to make a correction to a long-standing anomaly in the medical model.

Although the enviro/experiential theories have been traditionally incorporated within the medical model they are increasingly ignored by practising psychiatrists. Many psychiatrists have found that it is illogical for them to assume a psychological cause for the symptoms of schizophrenia when their medical training does not properly prepare them to either understand psychological problems, or to treat them. The medical training of psychiatrists logically inclines them to prefer assumptions of a biological aetiology and the application of drug-based treatments.

This anomaly, whereby psychological theories have been falsely associated with medical expertise, can be easily corrected by combining the enviro/experiential theories with the mystical/religious theories under the heading of Psycho/Mystical Model. This adjustment leaves the biological theories under a revised heading of Biomedical Model. In this way three alternative explanatory models can still be used — Biomedical, Psycho/Mystical and Myth-of Mental Illness (i.e. social problems) — which conform with the bio/psycho/social framework.

Model	**Biomedical**	**Psycho/Mystical**	**Myth-of-Mental-Illness**
Type of Symptom	bio	psycho	social
Focus of Research	brain	mind	behaviour
Treatment	medical	psychotherapy meditation	social skills living skills
Human Rights	right to treatment informed consent	freedom of thought and belief	right to liberty protection against torture

Using this plan people who are diagnosed with schizophrenia could be attached to one of the three models in the following way:

(1) People who manifest any of the positive or negative mental symptoms, which can be traced to a physical cause — like substance taking, infection, brain damage or adverse reaction to neuroleptic treatment — would belong with the Biomedical Model.

(2) People who manifest mental symptoms, like delusions and hallucinations, which have no discernible evidence of a physical cause, would belong with the Psycho/Mystical Model.

(3) People who have experienced some kind of social or occupational dysfunction, without any positive mental symptoms, would belong with the Myth-of-Mental-Illness Model. (Although diagnosticians may claim to have observed mental symptoms in people belonging to this class these may simply be manifestations of role-play, rebellion, disappointment or social rejection).

Of course, this sort of pattern is already partly incorporated in normal psychiatric perceptions. People who would be directed to the myth-of-mental-illness model in the above plan, because mental symptoms have been mistakenly attributed to them, are now called false/positives by psychiatrists. That is, these people are said to have been falsely given a positive diagnosis of

schizophrenia. Psychiatrists already recognise that such people theoretically exist and that in their particular cases the mental illness attributed to them is indeed a myth. But very little psychiatric research has been conducted in this area. Rosenhan's experiment with pseudo patients, discussed in Chapter 8, indicated that the incidence of false positive diagnosis for people presenting at hospital emergency rooms may be very high.

The problem for people who fall into this category is that once a label of schizophrenia has been attached to them it is virtually impossible to have the diagnosis removed. This is because there are no laboratory tests that will overturn a diagnosis and there is no way for a person to refute a diagnosis by demonstrating sanity. Indeed, the more a diagnosed person denies the illness the more convinced psychiatrists are likely to become of the severity of their disorder. This is because psychiatrists argue that such people lack insight, or self-recognition of their mental disease, and therefore have less self-control and are more vulnerable to irrational impulses.

While psychiatrists are willing to concede that false/positives theoretically exist they seem incapable of taking any steps to identify them and to rectify the impossible situation in which false/positives find themselves. This causes many psychiatric survivors with false/positive diagnoses to adopt the myth-of-mental-illness model as a way of explaining their situation. They come to believe that not only is mental illness a myth in their own particular cases but that the whole mental health structure, and the psychiatric profession in particular, is built on fraudulence.

But if psychiatrists currently give only twisted recognition to a class of schizophrenics that fit the myth-of-mental-illness model, the irony caused by that twist is overshadowed by an even greater irony in the psychiatric convolutions over the significance of physical causes for schizophrenic symptoms. It is the identification of physical causes that would separate the people belonging to the psycho/mystical model from those belonging to the biomedical model in the above plan.

In current psychiatric practice DSM-IV requires a diagnostician to differentiate between people who have identifiable physical causes for their schizophrenic symptoms, and those who do not. Only those people with no physical causes for the symptoms are supposed to be diagnosed with schizophrenia. Under the heading of Differential Diagnosis DSM-IV offers the following advice to diagnosticians:

> A wide variety of general medical conditions can present with psychotic symptoms. **Psychotic Disorder Due to a General Medical Condition, delirium**, or **dementia** is diagnosed when there is evidence from the history, physical examination, or laboratory tests that indicates that the delusions or hallucinations are the direct physiological consequence of a general medical condition (e.g., Cushing's syndrome, brain tumor). **Substance-Induced Psychotic Disorder, Substance-Induced Delirium**, and

> **Substance-Induced Persisting Dementia** are distinguished from Schizophrenia by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the delusions or hallucinations. Many different types of **Substance-Related Disorders** may produce symptoms similar to those of Schizophrenia (e.g., sustained amphetamine or cocaine use may produce delusions or hallucinations; phencyclidine may produce a mixture of positive and negative symptoms). Based on a variety of features that characterise the course of Schizophrenia and Substance-Related Disorders, the clinician must determine whether the psychotic symptoms have been initiated and maintained by the substance use. Ideally, the clinician should attempt to observe the individual during a sustained period (e.g., 4 weeks) of abstinence. However, because such long periods of abstinence are often difficult to achieve, the clinician may need to consider other evidence, such as whether the psychotic symptoms appear to be exacerbated by the substance and diminish when it has been discontinued, the relative severity of psychotic symptoms in relation to the amount and duration of substance use, and knowledge of the characteristic symptoms produced by a particular substance (e.g., amphetamines typically produce delusions and stereotypies, but not affective blunting or prominent negative symptoms).[9]

The intention is obviously to exclude anyone from a diagnosis of schizophrenia who has symptoms that can be traced to a physical cause. If a specific physical cause can be blamed for schizophrenic symptoms then there will be a more appropriate medical diagnosis that is associated with that physical cause. So, according to correct psychiatric practice only people who have no detectable physical cause for their symptoms are to be given a diagnosis of schizophrenia.

However, after first determining that a person with schizophrenic symptoms has no known medical (i.e. physical) cause for the symptoms the convoluted practice most psychiatrists then follow is to still proceed with medical treatment as if there were a physical cause. After first taking care to eliminate all possible physical causes by ensuring the store of knowledge about medical conditions which give rise to distorted mental states has been thoroughly sifted, strangely, they not only assume there must still be a physical cause, despite the lack of evidence, but they proceed with treatment as if they fully comprehend its exact nature. This assumption of a physical cause is made in the absence of any evidence whatsoever. We can be certain of this absence of evidence because if there were any evidence then a diagnosis other than schizophrenia should be given.

All of the current psychiatric rationale for the diagnosis and treatment of schizophrenia would seem to hinge on this practice of first eliminating known physical causes of distorted mental states and

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[9] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth edition, American Psychiatric Association, Washington, 1994, p. 283.

then assuming an unknown physical cause. If a biomedical theory like the dopamine hypothesis were ever to be proven correct then schizophrenia would probably cease to exist as a 'mental' disease. Henceforth it would be a dopamine-associated brain disease, and perhaps a medical speciality other than psychiatry would be given responsibility for treating it. It would seem that the current psychiatric monopoly of treatment for schizophrenia relies very strongly on the maintenance of ignorance about the true aetiology of the symptoms and an unsubstantiated belief in an unknown physical cause.

If it is generally agreed that medically-trained professionals should not extend their range beyond the proven area of their expertise then a serious re-evaluation of the concept of schizophrenia might now be appropriate. It seems apparent that there might be three entirely different classes of people who are wrapped up in the package of schizophrenia. One of these classes comprises people who have nothing either mentally or physically wrong with them. Another class has serious psychological/mystical problems but these problems have no biological basis and their treatment therefore is well outside the province of medical expertise. A third class might have physical problems that give rise to mental distortions and are therefore clearly within the range of medical expertise but, if this is the case, then a diagnosis of schizophrenia for these people would be either incorrect or inappropriate.[10]

An approach to the aetiology of schizophrenic symptoms which divides the people who experience them into three types could be truly called a 'biopsychosocial' approach: 'bio' to represent those whose symptoms have a physical cause, and who should be re-diagnosed with the disease that is correctly associated with that physical cause; 'psycho' for those in the midst of a psycho/mystical crisis, for whom the application of a medical diagnosis and treatment is inappropriate; and 'social' to represent those who only have social/occupational problems, whose supposed mental illness is a myth.

If the medically-trained psychiatric profession were to adopt a truly biopsychosocial approach to the aetiology of schizophrenia they would be free to make a radical shift in the perception of their professional role in regard to this condition. People they henceforth encountered with schizophrenic symptoms would be divided into the three types. Only those with an identifiable physical cause would be given medical treatment. Individuals belonging to the other two groups would be referred on to appropriately trained non-medical experts. There is already a wide range of experts who deal with problems associated with psychological, social and occupational dysfunctions.

[10] Gwynneth Hemmings, 'Calamitous Systems of Diagnosis For Schizophrenia', Journal of Nutritional Medicine, Vol. 4, No. 2, 1994, pp. 251-259.

It is perhaps true that there are no existing professional services available to provide guidance for people undergoing a mystical crisis. However, if this is the case the reason might simply be a lack of demand caused by the current biomedically-dominated mental health system forcibly aborting all detectable mystical experience by imposing drug treatment on involuntary patients.

Perhaps one reason why psychiatrists continue to believe that people diagnosed with schizophrenia are a homogeneous class, despite the implausibility of this position, is due to the effect of neuroleptic drugs. Prescription of neuroleptic medication normally swiftly follows a diagnosis of schizophrenia. The effect of these drugs is to suppress the schizophrenic symptoms, for which the person was diagnosed, and supplant them with the relatively homogeneous symptoms of neuroleptic intoxication and neuroleptic-induced movement disorders. These drug-induced disorders not only provide the common denominators of pathology, which apparently help to reassure psychiatrists they are treating a discrete disease entity, but they also induce many of the bizarre forms of behaviour and mannerisms that convince relatives and friends that the person is indeed seriously mad. A person who enters into psychiatric care with only a psycho/mystical or social problem will soon develop serious medical problems once neuroleptic treatment has commenced.

This point brings us finally to the question of the human rights of people who are diagnosed and treated for schizophrenia: Do these diagnostic and treatment procedures violate basic human rights? The unequivocal answer is that they most certainly do. It is clear that members of the psychiatric profession are not properly trained to understand the underlying nature of either social/occupational problems or psycho/mystical problems. Medical treatment for these problems is simply inappropriate. When people accept medical treatment for these problems voluntarily it is likely that they do so without the appropriate level of informed consent. When treatment is forced on them against their will various basic human rights — like the freedom of thought and belief, the right to liberty and the right to protection against torture and cruel treatment — are violated.

The central human rights defence that is routinely mounted to support current psychiatric practices argues that people who are in the midst of a psychotic crisis are incapable of understanding their urgent need for treatment. The psychiatric logic is that, since they have a human right to be treated, the decision to treat has to be made for them. But this human right is an imperative to treat people with medical problems. If the underlying nature of the condition is not a medical problem then this human right does not apply. For instance, there is obviously no human rights imperative to treat a transparently non-medical problem like illiteracy with medication. To argue that there is would be quite bizarre. Yet this is the type of argument that is routinely mounted in defence of current psychiatric practices.

Even when a person's schizophrenic symptoms are caused by a physical problem, and the person therefore has a right to medical treatment, a diagnosis of schizophrenia, and neuroleptic drug

treatment, are clearly inappropriate. So even this class of people seem to have their human rights abused as well.

But these observations merely beg a question: If all the many millions of people in the world who have been diagnosed and treated for schizophrenia are victims of human rights abuse, why are the victims not complaining? The answer is that they do complain, but that few people hear them. In a powerful critique of the mental health system McCubbin and Cohen have detailed some of the reasons why this happens. They argue that a range of factors come into play including systematic power disadvantages, stigma, distress, and "treatment-induced intellectual and social dysfunctions".[11]

But the essential problem is that it is almost impossible for victims to raise the issue of psychiatric abuse without expressing the social identity of being a 'schizophrenic'. And people who have been labelled as 'schizophrenics' are rarely taken seriously. Once a person has been diagnosed with mental illness by a medical expert there is little hope for them of publicly (or even privately) challenging that determination. Any attempted challenge of this kind is generally viewed as a laughable manifestation of the person's madness.

It is largely because of this lack of public credibility of people who have actually experienced schizophrenic symptoms that interest group activity remains disproportionately weighted in favour of the existing medical model. So long as this situation prevails it is likely the human rights violations, that are intrinsic to the current psychiatric diagnostic and treatment practices for schizophrenia, will go unrecognised.

[11] Michael McCubbin and David Cohen, 'Extremely Unbalanced: Interest Divergence and Power Disparities Between Clients and Psychiatry', International Journal of Law and Psychiatry, Vol. 19, No. 1, 1996, pp. 1-25.