

A STATE OF MIND: DOMINATION, COERCION AND ABUSE IN THE SOUTH AFRICAN MENTAL HEALTH CARE ACT

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Abstract.

This paper examines the South African Mental Health Care Act, focussing on its ideological and theoretical underpinnings. It argues that the Act is flawed not only through clear textual inconsistencies, but further, as a consequence of its view of mental illness resting on contestable psychiatric dogma. Specifically, the disease model of mental illness reproduced in the policy allows the desires, thoughts and behaviours of psychiatric patients to be entirely delegitimised, and replaced with the arbitrary system favoured by the psychiatric institution. It will further be argued that it is the very power of the legislative-psychiatric complex that allows the codes of conduct prescribed by the discipline of psychiatry to be accepted as an objectively normative way of being, further masking the tenuous nature of the truth claims psychiatry makes about human cognition and behaviour.

The purpose of this paper will be to examine the discourses that inform the South African Mental Health Care Act of 2002 (hereafter, MHCA). Taking a critical perspective on psychopathology and challenging the assumptions that are passed from the **Diagnostic and Statistical Manual of Mental Disorders** onto the MHCA reveals the policy to be little more than a rubber stamping of the psychiatric orthodoxy. In a discipline where research is inconclusive and disagreement both within and between paradigms is common, giving legislative approval to one of these competing paradigms creates a situation where psychiatry can undertake legally, ethically and scientifically valid interventions that appear benevolent, but remain a gross abuse of human rights.

Whilst many such abuses are not openly justified, it is argued here that the MHCA's construction of the mentally ill, psychiatric institutions and the state justify, and even necessitate a fundamental abuse of psychiatric patients. In short, by viewing "Mental Health Care Users" as disabled, the MHCA can dismiss the private (illness-induced) experiences of such "Mental Health Care Users" and instead seek to impose an arbitrary normative standard of thought and conduct upon them. Numerous other abuses are given legitimacy by the MHCA: incarceration, compulsory treatment and restrictions on interpersonal relationships are all quite blatantly presented in the text.

It is important at this point that the reader does not limit his or her thoughts on what has been stated above to what has now become an obsolete stereotype of abusive

psychiatric treatment of the type popularised in the 1960's by the "anti-psychiatry" expounded by Laing and Cooper - for example Electro-convulsive Shock Therapy, long periods of solitary confinement and so on. Whilst such things may still take place, psychiatry certainly manifests a more enlightened approach to mental illness than in Laing and Cooper's time. The full extent of abusive treatment will be shown to be much wider and vastly more subtle however, existing as a function of the power that psychiatry has to demarcate specific acts as sick or healthy, and thus right or wrong. Abuse occurs not only as a result of direct psychiatric intervention, but as part of Western society's absolute acceptance of contemporary psychiatric doctrine. In short, society has reached a position where psychiatric discourse categorises and regulates human conduct even without the direct intervention of the discipline / profession itself.

BACKGROUND AND THEORETICAL PERSPECTIVES.

With the transition to African National Congress leadership in 1994 (as well as in anticipation of this by the National Party government), the emphasis of health care policy decisions was on providing equal opportunities for health care for all sectors of the population. The shortcomings of pre-1994 policy are noted, in general, by Walt (1994), specifically in relation to (racially) disparate responses to mental health care needs based O' Donoghue (1989) and Van der Westhuizen (1990), and finally in terms of the social factors that increase mental illness among the economically worst-off of the population (Council Committee: Mental Health, 1989).

Pillay (1999) states that policy is implemented in order to meet the needs of a given constituency. Therefore a (revisionary) mental health policy would aim at correcting previous deficiencies in the provision of mental health care, as well as meeting the needs of people with a mental illness in general. In problematising the theoretical perspective on which mental health/illness is based, I assert that this concept of "need" is complex in the case of mental health policy. Mental health policy, it will be shown, is predicated upon the (dominant) disease model of mental illness (that is, that the bulk of mental illnesses reside in an endogenous deficiency or malfunction). The debates on these issues are intricate and will not be considered in this section. Rather, the debate will be unravelled below, where it is of direct relevance to the analysis of the MHCA.

It must be noted, however, that the perspective taken here is that that states of mental health/illness are arbitrary categories, defined in relation to each other, and contingent on socio-historical factors. Consequently, mental health "needs" have no objective existence, and are a discursive production, legitimised for the most part by the medical model of mental illness. Thus, the very starting point of the MHCA's project is problematised here.

Consequently, I do not intend to depart from the discourses reproduced in the MHCA to examine, for example, its objectives and efficacy – such a task is better left to interpretivist, positivist or economic researchers. What follows is a "critical discourse analysis" (Parker 1992; 1997), that will map out the ideologies and assumptions that construct the MHCA. It will be shown that the overarching position offered to the primary object of the text – the "mentally ill" – is largely non-agentive. This allows the actions and desires of psychiatric patients to be negated (especially) by the state and the profession of psychiatry – who in turn are constructed as *a priori* psychologically healthy and removed from the world of the mentally ill. The effect of this is that psychiatry is

positioned as the protector, simultaneously, of both the sick and the sane. A central theme throughout what follows is the contingency of this position as the righteous healer / protector, and that the state and psychiatry can be repositioned as oppressive and abusive to the interests of “mental health care users” – both as people and as patients.

DISCURSIVE CONTRADICTIONS: FREEDOM, DOMINANCE AND THE NATURE OF ILLNESS.

The MHCA is riddled with contradictions, both within and between clauses. It will be shown that these contradictions not only undermine the credibility of this document, but render its understanding of mental illness and mental patients illogical. It is further argued that one of the reasons for these contradictions is the use of language that is employed specifically to avoid an oppressive tone (as in Prior, 1993), and to present the interventions of psychiatry in a humanitarian light. These liberal pieces of text are not, however, in line with the effect of the document taken as a whole. Consider the following:

A health establishment may not cause a mental health care user to receive psychiatric medication for more than six months unless authorised by a mental health care practitioner who is designated to provide medication and review psychiatric treatment. (MHCA:8)

The problem arises here with the terms “mental health care user” and “cause”. The word “cause” itself implies a necessary and sufficient condition for an event (effect) to occur – in this case, the administration of psychiatric drugs to a mental patient. Although the statement’s explicit aim is towards restricting unilateral decision-making on the part of the health care establishment, it must be borne in mind that this coercion is rendered perfectly acceptable for the first six months of treatment! The free will of the patient is entirely undermined, and his or her motivations are inconsequential when placed against the “causative” powers of the health care system. Such a positioning of the establishment and patient is blatantly contradicted by the term, “mental health care user”. A “user” has *free choice* – someone who has agency in appropriating something for his or her own ends. For example, a user of a fitness centre makes use of the facilities provided (following a mutually beneficial contract) to achieve the aim of increasing muscle tone, body mass and so on. There is neither choice, nor even subjectivity offered to the patient in this clause, it hinges only on the wishes of the establishment – it states what the establishment cannot do, but makes no provision for the desires of the patient. In sum, it would seem that the term “mental health care user” is employed simply to appear more palatable, perhaps as a result of the negative representations of mental patients that dominate public discourses of mental illness (Parker, Georgaca, McLaughlin, Harper and Stowell-Smith, 1995). When positioned against other (more pivotal) discourses within the document, it represents little more than a tiny piece of humanistic jargon, standing almost alone amidst an overarching speech act of domination and coercion.

The theme of freedom, rights and coercion is made even more contradictory with a reference to the very preamble of the MHCA:

Health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services

[and that] the Constitution of the Republic of South Africa, 1996, (Act No. 108 of 1996) prohibits against unfair discrimination of people with mental or other disabilities...that the person and property of people with mental disorders and intellectual disabilities, may at times require protection and that members of the public and their properties may similarly require protection from people with mental disorders or mental disabilities...further that there is a need to promote the provision of mental health care services in a manner which promotes the maximum mental well-being of users of mental health care services and communities in which they reside. (MHCA:1)

I submit that this statement contains a number of irreconcilable contradictions, revolving around the potentially conflicting interests of the state, mental patients and the [healthy] community at large. It is interesting to note, again, the terminology employed; in this case mentally ill people are labelled as “disabled”. Again it is asserted that this is merely a linguistic twist that retains, against its intention, an implicitly negative attitude towards the mentally ill. The term will be shown to be even more problematic below, with its blatant question-begging approach to what constitutes the “abled”.

Health is defined above as being comprised of physical, mental and social well-being. The first condition is not thought problematic here, although it has been argued that even physical sickness is constructed solely in terms of its effects – that it is only the meaning that humanity superimposes on an event or state of being that makes it sick or healthy (Sedgwick, in Reznick, 1991). Whilst this is an interesting perspective, it quite simply does not seem tenable: a lung riddled with cancer, so that it can hardly function is surely “less healthy” than one that can breathe with ease. Against this example it would seem that the only counter would be to question that the ability to breathe constitutes some sort of good; or at least claim that there is no intrinsic bad in not being able to breathe. Some may argue that this is no different in the case of mental illness. This is not so: an individual with a lung disease could be under the threat of an imminent death as a result of an inability to breathe. An individual who is experiencing an episode of major depression may be likewise under the threat of death, but an intervention of, perhaps, suicide would be required for this to occur – one does not die (naturally) of a mental illness. Thus, the fundamental difference between these two examples lies in the factor of human agency: the ultimate, negative culmination of physical illness (death) occurs without intervention, whereas any such negative culmination of mental illness requires an event categorically different from the “illness” itself. In short, “bodily sickness” is measured against an individual, biological model of healthy functioning. Mental illness can only be measured against a social model of “healthy” functioning. The latter is something that is in a state of flux: in a pandemic where entire populations are infected with a disease, sufferers may be considered normal, but certainly not healthy. By contrast, if an individual rejects the behavioural standards laid down by his or her social/cultural group, they are considered abnormal, and consequently of unhealthy mind – that is, in the westernised world – sick. Thus, any equation between what constitutes mental and physical illness does not hold.

Thus, I would support the view that sickness can be identified biologically, but further – and very importantly – that sickness can only be identified biologically; and finally, that *only sickness* can be identified biologically (thus it requires that mental illness is viewed very differently from its physical counterpart). The notion of *physical* health / illness survives these criteria; but the concepts of mental health and “social well-being”

(nothing but a metaphor for mental health) are problematised. The MHCA does not recognise this problematic, and simply leans on the power of the disease model of psychiatry in order to assert, without qualification, its definition of what constitutes illness. Boyle (1990) argues that psychiatry has made no progress in finding an organic cause of schizophrenia since Kraepelin and Bleuler “discovered” it; and recent genetic research is judged to be inconclusive even by the researchers themselves (Bower, 2002). The problems here are made more explicit by the MHCA’s use of “social well being” as an indicator of health, which serves to reserve the (state’s) right to treat those who have been somehow alienated from their communities simply because they are deviant. According to the DSM-IV-TR (APA, 2000), an *inability* to conform to social norms and maintain healthy relationships with others is symptomatic of psychopathology (specifically, for example in Avoidant Personality Disorder – yet many other disorders bear this tinge). It would seem that this argument must hinge on the “inability” of the mentally ill to forge relationships, as dictated by a fundamental pathology. However, as Szasz (1974; 1994; 2001) points out, this view is philosophically unsound; and rather sets up a situation in which psychopathology can be seen to reside simply in the deviant behaviour itself (Laing, 1967). It should be noted here that the MHCA is based on democratic principles, and in order for democracy to continue smoothly it must sacrifice personal autonomy for the satisfaction of the larger population. Thus, individual freedom and democracy are, in a sense, mutually exclusive terms. In short, the MHCA makes no provision for the possibility of a truly free, rational decision to refuse to conform to the rules of a given society – and thus traps the patient into a determinism apparently dictated by an organic pathology. The full pervasiveness of this theme will be shown below.

The MHCA’s recognition of the rights of those with “disabilities” (mental or otherwise) to be free from discrimination now raises two interrelated issues, hinging upon how discrimination is defined, and more importantly, “unfair” discrimination.

One of the MHCA’s explicit aims is to protect the “mentally disabled” from being discriminated against by the healthy / “abled” (the state and psychiatry’s representatives are assumed to be included among these) – an aim that rests on the tacit premise that the mentally ill are not blameworthy of their condition / actions (they are merely suffering from an illness). What the policy omits is that they *are* in fact liable to be discriminated against (and blamed) by the very agents of psychiatry and the state – as allowed for in the Act itself! Furthermore, the reasons cited for such interventions are that the “disabled” are a hazard to both themselves and the rest of the population.

The representation of the mental patient as dangerous to others has been challenged by demonstrating that more people are killed as result of psychopharmacological treatments than there are homicides committed by people diagnosed with a mental illness (Parker et al., 1995). In the process of protecting people from the mentally ill, mental patients are in fact put at more risk of being fatally injured than are the rest of the population. If they are not to blame for their condition – if they are not somehow *wrong* – why the disparate prioritising?

This does not challenge the argument that mental patients need protection from themselves, however, and there are two sides of this that need to be discussed. The first, and more obvious, is the perception that someone with a mental illness is likely to

intentionally cause harm to his or her own person. The implications of this for policy are complex, and have repercussions for (or perhaps even are caused by) the state's level of interventionism. "Protecting" an individual from his or herself is essentially an imposition on their free will. This is well documented in the literature on the ethics of psychotherapy – for example, the ethical dilemma faced by a therapist suspecting a client may commit suicide (Welfel, 1990). That debate is admittedly slightly different in that it weighs up personal safety of the patient with their right to confidentiality, rather than their right to inflict self-harm, but the point remains the same. The assumption behind this "protection" is that the mentally ill have no control over their actions, and thus their free will is already undermined, making it justifiable to substitute a pathological determinism with a healthy, more "rational" cause / effect relationship. This runs the risk of being an extremely circular argument, as it is in fact the possibility of causing harm to oneself that forms part of their pathological symptoms. This paper, coming from the perspective that psychopathology is [often] simply a category developed for undesirable personality or behavioural traits, holds that the fundamental reason (pathology) does not impede the free choice of the individual (Szasz, 2001). Another alternative is that society and the state wish to restrict the possibility of harming oneself due to religious / moral considerations that have passed into the dominant discourses of moral conduct (Frankena, 1981), and finally, legislation. If this religio-moral evolutionary argument holds true, the privileging of an arbitrary code of conduct over the personal rights of the individual is simply bizarre in a secular state.

The second case - the possibility of inflicting harm upon oneself unintentionally – is more problematic. Certain diagnostic criteria for a psychotic, or a manic episode are examples of this, where the recklessness brought about by the sick individual's behaviour may cause, among other things, physical or financial harm (APA, 1994) – for example, falling from a window whilst trying to escape an hallucinatory source of danger, or spending one's life savings in a manic shopping-spree. Again, it is argued that there is an air of circularity about this – that these behaviours are precisely what define the pathology, and that pathology itself implies that the individual no longer has agency. There seems a large degree of rationality in following a period of intense sadness (depression) with purchasing material goods. Whether it can cause harm of other kinds (for example having to mortgage one's home) or not makes no difference. Given that capitalist societies are encouraged to place great value in material possessions, how can filling up a void caused by some or other life trauma in this manner be constituted as ill? Perhaps more importantly, such actions require conditions that are simply beyond the boundaries of what can be determined as sick or healthy. In the example above the patient requires transport, one or more shops and either cash-in-hand or a credit facility to display the symptoms of their illness. The point here is that there is an overstretched and non-necessary relationship between the disorder and its symptoms, and I maintain that such a link exists only through the patient's free will – and not as an *effect* of an illness.

Nevertheless it is conceded that certain *behaviours* (note: not disorders) are more likely to result in an injury of some kind. That these behaviours should fall under the treatment of psychiatry, however, remains problematic. Even in the possibility of an acute schizophrenic testing their perceived invincibility and plunging to their death, this argument still holds. Firstly, by pathologising an internal mental state (of which there is no objective yardstick) freedom of thought is inhibited, and furthermore, restricting

someone from injuring themselves occurs before the event, and thus rests merely on the *potentiality* of it happening. To conclude, the effect of this is that psychiatry and the state are not simply undermining freedom of action, but indeed, the freedom to have private experience (a further facet of this will be discussed below). *The state, then, can be seen to discriminate against people with mental illnesses*, largely as a function of their removal of the individual's rights to free action, and imposing an abstract (moral) ideology upon them.

THE RIGHTS OF THE PATIENT AND INVOLUNTARY CARE.

This section will discuss the responsibilities of the Mental Health Establishment (hereafter, MHE) in providing the "mental health care user" (MHCU) with treatment, as well as the rights of the MHCU. It will be shown that the policy delegitimizes the voice of the patient and allows almost free reign to the authorities of the MHE, as well as other organs of state.

- 1) *A health care provider or a health establishment may provide care, treatment and rehabilitation service to, or admit a mental health care user only if –*
 - a) *the user has consented to the care, treatment and rehabilitation service or to admission*
 - b) *authorised by a court order or a Review Board; or*
 - c) *due to mental illness, and delay in providing care, treatment and rehabilitation services or admission may result in the –*
 - (i) *death or irreversible harm to the health of the user;*
 - (ii) *user inflicting serious harm to himself or herself or others; or*
 - (iii) *user causing serious damage to or loss of property belonging to him or her or others.* (MHCA:9)

The considerations laid out in (c) above will not be discussed at length here, due to its similarities with the preceding section. The essence of the statement reproduced above is that if the MHCU has not consented to being treated or admitted, an MHE may still "treat" the patient – if allowed to by the judiciary, or even in its own judgement (there are restrictions on this final part, but it remains the case that mental health professionals can admit a patient, against their will, if there is agreement among two qualified practitioners that the condition of the MHCU warrants this). The point need not be laboured that even a lack of agreement about a diagnosis of a specific disorder can result in compulsory treatment, and furthermore, that these professionals are in the service of the institution in any case, and thus likely to share the same assumptions as a result of their training and so on. Thus we can expect their agenda and criteria to be no different, both from each other and the institution / ideology which they serve. More simply put: by virtue of their immersion in a single dominant paradigm, psychiatrists will interpret certain behaviours in a similar (pathological) fashion (Terre Blanche, 2002) – even in instances where psychiatrists' specific diagnoses conflict, there is often consensus that the patient suffers from a disorder of some sort.

As regards involuntary admission, the policy states that the patient's consent is not required if:

The mental health care user is incapable of making an informed decision on the need for the care, treatment and rehabilitation services. (MHCA:13)

In this instance it is left up to the authorities to define when one is incapable of making a decision (i.e. when an individual is too sick to know they are sick, they do not recognise the need for treatment, and thus require treatment). The patient, then, is strangled in the web of one of the stickiest of psychiatric paradoxes – either he or she is ill by their own admission; or ill because they refuse to admit it! Consider the following (Prior, 1993:162):

Patients, in general, tended to lack insight into their psychiatric conditions. That is, they failed to draw upon even the vaguest principle of psychiatric medicine to account for their circumstances...it was only when patients came to accept a medical interpretation of their condition as one of 'being mentally ill' that staff felt able to talk of progress being made.

Essentially, this statement implies that psychiatric healing is, to an extent, the abandonment of one's personal experience of the world in favour of adopting a more acceptable psychiatric discourse of *sickness*. This argument will be returned to below when discussing periods of incarceration. It is interesting to note that the draft bill (2000) included "or is unwilling to receive treatment", as a third subsection of 26 (2b). This paper will not speculate on the reasons for this change, but does assert that given the above, omitting it from the final Act makes little practical difference in its effect.

A further interesting aspect of involuntary treatment and admission is that:

The applicants [the individual/s requesting that an individual receive care] referred to in paragraph (a) must have seen the mental health care user within seven days before making the application. (MHCA:14)

Presumably, this allows for the applicant to witness the behaviour of the person suspected to be "insane". Arguments made above concerning the pathologisation of internal states and behaviour will be extended here. A person's speech and behaviour are seen as indicative, or in this case, symptomatic of their mental state (Groth-Marnat, 1997). It is argued here that this link cannot be ascertained, and rests entirely on the interpretation of the applicant, and finally the clinician – both of whom are likely to have comparable ideas of what constitutes psychopathology, albeit to a different degree of expertise and experience (Parker et al, 1995). Consider the following example: a man exits a nightclub, and starts to walk down the street, at which point he stumbles over a loose pavement-stone. He then moves slowly away, head downcast and muttering to himself. He is followed by another man who walks briskly towards his car, pauses to say a quiet goodnight to his companion, and then drives away without any sign of a glitch. The point is that we infer a mental state upon each of them – that the former is drunk, and the latter, sober. Whether or not this inference is correct in a specific instance is irrelevant. What is important is that there is no *necessary connection* between a mental state and a supposed behavioural manifestation of it. The first man may in fact have had a reaction to a new brand of contact lens and left in pain and discomfort before finishing his first drink; whilst the second man had been drinking all night, yet not display any easily identifiable indicator of his mental state. In the case of the proviso of the policy, it relies on a link between outward behaviour and mental state that can be flawed in terms of the problem of induction, and furthermore, by the fact that identifying and measuring mental states in terms of external behaviour commits a blatant category

error. Of course, the very nature of the problem of induction is as a thought experiment, and no one takes its warnings too seriously. However, psychiatry does not have the luxury of being able to postulate links. These links must exist as a hard and fast, causative link where symptoms and signs correspond directly, and with certainty, to a mental disorder. Because what constitutes normative cognition, behaviour and emotion are contingent on social, historical and political factors; deviation from these cannot be seen as pathological, and thus, inferences of mental illness based on (mis)behaviour are illogical.

The MHCA allows for an appeal to be lodged against the decision to proceed with involuntary treatment within 30 days (29(1)(a)). Furthermore, following the 72 hour assessment period, the MHE is under no obligation to review the case for six months, and then after that, the policy stipulates assessments be made only every twelve months. Rosenhan's (1973) classic study demonstrates the lengthy amount of time taken for *voluntary* patients (who had stopped manifesting pathological symptoms on admission) to be released. The policy essentially imposes a long-term sentence on the MHEU, especially upon those who are being treated involuntarily. The fact that the head of the MHE may deem a patient capable of making informed decisions about their health status (in effect be able to terminate treatment) only on information received, personal observation or the "representation" of the patient (MHCA, 31 (1)) and the head clinician's interpretation of this, shows that one of Rosenhan's conclusions remains in place – that is the possibility of sane representations being deemed insane by the relevant authorities. This is worsened by the fact that an appeal can only be lodged by the same category of person applying for the patient's involuntary care (MHCA, 35 (1)). Aside from the more tacit measures employed to eliminate resistance to treatment (as above), this gives the MHE legal rights to disregard the protests of the patient.

INSTITUTIONAL ABUSE.

The policy states that:

In exercising the rights and in performing the duties set out in this Chapter, regard must be had for what is in the best interests of the mental health care user (MHCA:8) ...

and:

The care, treatment and rehabilitation service administered to a mental health care user must be proportionate to his or her mental health status and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation. (MHCA:9)

and finally:

Every person, body, organisation or health establishment providing care ... must take steps to ensure that –

- a) users are protected from exploitation, abuse and any degrading treatment;*
- b) users are not subjected to forced labour; and*
- c) care, treatment and rehabilitation services are not used as punishment or for the convenience of other people. (MHCA:9)*

I shall now proceed to analyse these statements inasmuch as they constitute a single position. It will be argued that these principles can only be upheld by the policy and MHEs if they are defining the terms used in an extremely loose manner, and in such a way that their own built-in contraventions can be disguised as otherwise.

The intention of the policy, at this point, is to ensure that the power vested in it is not abused by the MHE, and that the [therapeutic] interests of the MHCU remain paramount. It is further stated that the conditions for treatment should be no different to other types of illness. An examination of the section on involuntary admission above reveals this to be incoherent given that the right to refuse treatment is upheld in the case of physical illness (in this case it seems that the state of mind of the mentally ill is likened to being unconscious, yet sane!). The interests of the MHCU are quickly subverted by the MHE, and it seems, even, that the interests of the MHCU are in fact assumed to be identical with those of the MHE.

Given that the authorities can overrule the will of the patient, we have to ask what “proportionate” and “appropriate” treatment entails – appropriate to whom and proportionate to what? It seems obvious that this decision is left entirely up to the mental health experts. Similarly, the stipulation that treatment can only be on “therapeutic” grounds can also be seen as misguided. Consider Scheff’s (1966; 1980) arguments that the diagnosis and subsequent therapy of mental patients is, simply, punishment – and instead of treatment aims at the protection of a societal status quo. He contends that a diagnosis of psychopathology arises when an individual breaks a “residual social rule” – a rule that is so entrenched in a culture that it appears natural, rather than contingent upon the rule-makers. Thus, the rule-breaking appears pathological rather than simply an (im)moral choice, and the resultant response of the societal enforcers (in this case, psychiatrists) appears therapeutic rather than disciplinary. Szasz (1973; 1995) warns of the emergence of the “Therapeutic State” in which the state finds justification for depriving “sick” individuals of their freedom under the seemingly legitimate guise of a medical intervention.

According to the arguments above the conditions that treatment shall not be punitive or for the convenience of others is not met. This is not to say that any given psychiatrist has as the conscious motive of the punishment of a psychiatric patient, but rather, the therapeutic system itself leads to a misguided attempt at treatment.

The MHCA also intends to defend the patient from physical (or any other type of) abuse. It is suggested that the moral imposition of “the sane society”, and more particularly the MHE, upon mental patients constitutes psychological abuse of the most profound degree. At a more micro-level, abuse is both psychological and physical, and is most easily illustrated with the widespread and controversial use of psychiatric drugs. A detailed analysis of this issue is beyond our scope here, yet it should suffice to say that there are devastating side effects to many psychiatric drug treatments (Modrow, 1992; Parker et al., 1995) and furthermore even concerns over the therapeutic effect of such drugs (Rubin, 1995; Shimran, 1995). Terre Blanche (2002) argues that mental health care is being increasingly dominated by bio-psychiatry. As this becomes, steadily, an orthodoxy, the possibility of criticising the use of such drugs is diminished and mental health care practitioners’ use of drug treatments is, almost *a priori* justifiable. This justifiability is exactly what allows the MHE to remain with the appearance of

benevolence when coercing a patient to take psychiatric drugs. The inclusion of “neuroleptic induced disorders” in the DSM-IV-TR is certainly worth noting here. For example, Neuroleptic Induced Tardive Dyskinesia (APA, 2000) involves involuntary movements of the patient’s muscles and is caused by psychiatric drug treatments. These symptoms “may disappear” with increased dosage of the drug treatment! (APA, 2000). It is almost too obvious to even mention the shortcomings of classifying this as a disorder, when the causes of the disorder are laid out in the DSM-IV-TR as the very same as the treatment – both of which are controlled by the MHE. It is important to note briefly that being coerced into taking drugs need not take the form of physically forcing a patient to take his or her medication. If pharmacology represents the cutting edge in the fight against mental illness, and the patient has “managed” to succeed in gaining the insight to judge him or herself as sick, it would be a feat of irrationality to refuse such medication!

The MHCA also allows for a number of other abuses within the setting of the MHE. For example, according to the MHCA (p. 10) the head of the health establishment may “limit intimate relationships of health care users only if, due to mental illness, the ability of the user to consent is diminished.” This limitation (again) revolves around the assumption that mental illness does not form some genuine experience for the patient, and that they are determined by their illness towards an action they would not follow were they not ill. Again, an artificial norm has been constructed for the patient. The link (argued to be either causative, associative or symptomatic) between sexuality and madness dates back to the beginnings of modern psychiatry (Szasz, 1976) and beyond (Foucault, 1990). In some instances, sexual hyperactivity is itself a symptom of pathology – thus there is the possibility that heightened sexual desires do in fact preclude the very possibility of acting upon them (at the behest of the head of the MHE). It should be noted here too that excessive sexuality remains socially frowned upon, and whilst not (anymore) quite one of Scheff’s (1966) residual rule-breakings, it is however an indicator of the broader link between social deviance and the symptomatology of psychopathology. The restrictions imposed on what constitutes a healthy sexual appetite are completed by including sexual *hypoactivity*, or reduced sexual desire, as indicators of psychopathology as well! In sum, there seems to be both protective and punitive aspects in the above clause of the MHCA.

To conclude, this section has argued that the MHCA’s attempt to ensure that medical care is not perverted into punishment and abuse does not hold. Rather, psychiatric care, in itself, can be fundamentally abusive – and simply defined as acceptable by its containment within a system that is highly successful in passing itself off as a flourishing branch of medical science. Furthermore, at an institutional level, the MHCA justifies a number of human rights abuses that are quite overtly, more similar to punishment than to treatment.

CONCLUDING REMARKS.

It is necessary, in closing, to acknowledge that the very critique of contingency that this paper makes on the MHCA can be levelled against itself – both after all are viewing the nature of psychopathology through a very different lens. Furthermore, I do not take the perspective that the provisions of the MHCA have no beneficial aspects whatsoever. To claim otherwise would be to undermine the plight of people suffering from psychological distress; a position I do not intend to take. It is important that the difference between

psychological distress and illness is noted here. Issue is taken, however, with the disease model of psychiatry reproduced in the MHCA and the effects that follow such a representation of the mentally ill. Thus I assert that invoking a disease-based aetiology for behavioural deviance and psychological distress (itself contingent upon normative social standards), both allows and justifies mental health policy to impose moral prescriptions upon those diagnosed as mentally ill, restrict freedom of thought, action and eventually movement, and to perpetuate abuses of human rights under the banner of medical science.

Many of the points made here seem to be aimed only at those patients who are being treated for psychiatric disorders against their will. This is not as simple a matter as that: Even in the case of voluntary treatment, the patient is subject to a host of social pressures and restrictions that can become part of the individual's way of seeing the world, and his or her own place within it. In short, in a highly psychologised society, people may find it increasingly easy to be positioned, and position themselves, in the category of mentally ill; as alternative ways of viewing their own behaviour and thoughts are restricted.

In conclusion, I am not claiming that the proviso of the MHCA does not have some sort of social usefulness. However, such a social good is not objectively existent; but rather works in tandem with the assumptions reproduced in the MHCA. Furthermore, it is argued that this social good is misplaced, and serves to undermine the free will of a minority group, even in instances where there is an absence of any overt risk to the "sane majority".

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