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Notational conventions

I have followed the conventions of Systemic Functional Linguistics in this thesis, using small capitals when talking about systems (AFFECT, JUDGMENT, and APPRECIATION) and lower case when talking about instances of these systems (a judgment, an appreciation).

In the body of the text and citations I have used the convention of –ve and +ve to refer to negative and positive dimensions of the categories of JUDGMENT, AFFECT and APPRECIATION, and these categories will be in bold (for example –ve propriety, -ve capacity, +ve happiness). In the citations from the data they are abbreviated as follows:

<table>
<thead>
<tr>
<th>JUDGMENT</th>
<th>AFFECT</th>
<th>APPRECIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>propriety- prop</td>
<td>happiness- happ</td>
<td>impact -imp</td>
</tr>
<tr>
<td>veracity - ver</td>
<td>security - sec</td>
<td>quality-qual</td>
</tr>
<tr>
<td>capacity- cap</td>
<td>satisfaction -sat</td>
<td>balance - bal</td>
</tr>
<tr>
<td>tenacity- ten</td>
<td>complexity - compl</td>
<td>value- val</td>
</tr>
</tbody>
</table>

In the analysis, the conventions for coding attitude are as follows: JUDGMENT in red, APPRECIATION in blue and AFFECT shaded yellow. Lexical items or spans of text which realise these systems will look like this. Invocations are underlined.

He was cruel (-ve prop)
He was sad (-ve happ)
It was good (+ve val)

All tabbed citations are in 10 point Times New Roman while the body of the text is in 12 point Times New Roman.
Chapter 1 Media language and social processes

As communicating beings, we are adept at perceiving the ‘point of view’ in any utterance, without necessarily understanding how we do so: social life is a constant exchange of opinions and perspectives, through which we negotiate our membership of different communities and construct our identity.

One of the major arenas for this exchange in modern society is the print media, by virtue of the large audience it reaches and its involvement in the social, political and cultural life of the nation. For this reason, linguistic analysis of the print media provides us with important insights into commonly held values and issues of importance to its readership.

This study is concerned with investigating some of the ‘points of view’ evident in media discourse when talking about psychotic mental illness, using APPRAISAL theory as a tool to conduct an in-depth qualitative analysis on a small corpus of ten feature articles from the Australian broadsheet newspapers The Age, The Sydney Morning Herald, and The Australian. As Martin and White write, APPRAISAL:

..is concerned with how writers/ speakers approve or disapprove, enthuse and abhor, applaud and criticise and with how they position their readers to do likewise. It is concerned with the construction by texts of communities of shared feelings and values, and with the linguistic mechanisms for the sharing of emotions, tastes and normative assessments. It is concerned with how writers/ speakers construe for themselves particular authorial identities or personae, with how they align or disalign themselves with actual or potential respondents, and with how they construct for their texts an intended or ideal audience.

The analysis presented in this thesis aims to identify some evaluative patterns which occur across a small corpus of feature articles, in order to examine in detail some of the ways that we talk and think about psychotic illness in public discourse.
1.1 Language, mental illness and the world of social relations

Discourses connected to psychotic illness are of particular interest to linguists because they focus attention on the links between linguistic practice and the construction of identity and social position. We can see this in the way people with mental illnesses resist being ‘labelled’ – a friend once related her horror at seeing that she had been classified as having schizophrenia in the Centrelink database after her first psychotic episode.

It can also be seen in statements such as the following:

Schizophrenia is not just the name of an illness….Schizophrenia is a metaphor [which is] always negative, always derisive. The metaphor forwards images of acting out, violence, of incomprehensible, bizarre or contradictory behaviour and thinking…. The word schizophrenia is a metaphor of defamation. (Finzen 1999:13)

The connection between language and social process which is implied by contestations of this kind is one of the cornerstones of Systemic Functional Linguistics, which takes as given the mutual influence of language and social process. As Halliday (1978:183) points out:

The relation of language to the social process is not simply one of expression, but a more complex natural dialectic in which language actually symbolises the social system, thus creating as well as being created by it.

Fairclough (1995:55), in his book *Media Discourse*, notes that all language ‘represents social identities, social relations and systems of knowledge and belief’. The articles in the data are no exception: in looking at them we find ways of talking about psychotic illness which reflect attitudes and prevalent conceptions about the subject.

In the data under discussion, we find that people with psychotic illness are described as individuals and as communal beings interacting with family members and institutions such as the courts and health system. The way that these interactions are construed in media discourse is the main focal point of interest in this thesis: how
does the media talk about mental illness? What is the social and moral status of people who have this sort of illness? How does the media accommodate difference in the form of impaired social functioning? In other words, how is the social reality of psychotic illness construed in the data? Are there moves afoot to change ideas and practices connected to psychotic illness? These questions will be addressed throughout the thesis.

1.2 De-institutionalisation, media portrayals and social justice

Until recently in Australia, people with severe psychotic illness were typically confined in psychiatric hospitals. As Foucault (1976:66) has written, with the advent of institutionalisation for the mentally ill, ‘the world of madness was to become the world of exclusion.’ Conversely, since the 1980s when the process of de-institutionalisation began in earnest in Australia, society at large has had to find ways to include the mentally ill and come to terms with their social presence.

The increasing visibility of people with psychotic illness has resulted in a need for more comprehensive understanding of the nature of this illness as well as a growing politicisation of the debates connected with mental health. Issues of homelessness, stigmatisation, and the connection between mental illness and criminal activity have become more and more widely discussed. The mentally ill are no longer out of sight or mind, and society is forced to engage with them. This move towards community care, and the consequent necessity for the wider community to interact with people who have psychotic illness on a far more regular basis, is one reason why media portrayals of mental health issues have become politicised.

This intersection of media discourse, politics and the world of mental health is illustrated by the work of Pirkis (2002), who was contracted by the Commonwealth Department of Health and Aged Care to write The media monitoring project: a baseline description of how the Australian media report mental health and illness. This project aimed not only to give an overview of reporting practices in this area, but to provide some guidelines on improving these practices, in particular with regards to reducing the stigma associated with mental illness. The fact that it was commissioned by a federal government department underscores the political importance of mental health and the extent of the concern with the way mental health issues are construed in the media.
The issue of media portrayals of mental illness has also received widespread interest in the field of linguistics, where a number of discourse analysis studies look at portrayals of mental illness in the media. Many of them (Allen and Nairn 1997, Hazelton 1997, Nairn 1999, Nairn et al 2006) focus on ‘negative’ portrayals, especially with the ways that psychotic illness is shown in the media to lead to violent crime. For example, Nairn et al (2006:248) examine the coverage of two stories in the New Zealand press about men with psychotic illnesses who have committed violent crimes and conclude that:

…they embodied complementary stereotypes of mental illness as either pushing a competent person lethally out of control or as causing incompetence and violent, criminal action.

They go on to comment that this sort of portrayal feeds community fears about people with mental illness, creating the impression that:

…the nice young man next door might suddenly become criminally lethal, or one of the ‘potentially dangerous patients’ released into the community might prey on a citizen’s family.

The headline and kicker from the recent article below illustrates claims that mental illness is portrayed as being strongly connected to violent crime.

**NSW: Schizophrenic jailed for 10 years over murder**

Australian Associated Press General News, 10 August 2007,

SYDNEY, Aug 10 AAP - A schizophrenic teenager who battered his friend to death with a lump of timber has been jailed for 10 years by a Sydney court.

There has also, however, been research indicating that such stereotypes are not as common as the research would lead us to expect (Corrigan et al 2005); that media representations of psychotic illness are changing; or that responsibility for violent crimes committed by mentally ill people is attributed to institutional failure rather than to the innately violent nature of people with psychotic illness (Paterson 2006). Francis et al (2004:541), looking at media discourse on mental health issues on Australian TV and radio and in the print media, state that:
…in contrast to previous research, the current study found that media reporting of mental health/illness was extensive, generally of good quality and focussed less on themes of crime and violence than may have been expected.

Findings on representations of mental illness in the media, then, have been contradictory, perhaps because of the use of different methodologies. There has been a tendency to reach conclusions based either on large volumes of material collected over periods ranging from several months to a year (Francis et al, 2004; Hazelton 1997; Ward 1997; Wahl 1996), or through analysing articles covering a single event (Nairn 2006, Paterson 2006). Findings also vary across countries: for example a study by Meagher et al (1995) found that news coverage of mental illness in Ireland was primarily positive.

This thesis aims to complement the body of existing research in two ways: firstly, by using data sourced from the Australian print media; and secondly, by looking at the way that meanings unfold and interact within a small corpus. APPRAISAL theory provides a tool for analysing the data in a systematic fashion. By looking at a larger number of variables in a smaller corpus, the construction of identity and social relations can be examined in a more multi-faceted and detailed manner.

1.3 Data and methodology

The data used for the current analysis consists of ten feature articles on the subject of psychotic illness published in Australian broadsheets (The Sydney Morning Herald, The Age and The Australian). An initial search was done using the search terms psycho$, schizophren$ (where $ is any ending), ‘mental illness’, and ‘mentally ill’ over the previous year. Articles about other mental illnesses such as depression were eliminated, as were articles which contained only oblique references to psychotic illness. The end result of this search was a corpus of 18 feature articles which took psychotic mental illness as their main subject matter. I was primarily interested in the construction of identity of people with psychotic illness in these articles.

A preliminary look at this data showed that people with psychotic illness were shown as interacting with, or belonging to, five main institutions or groups. These were: the art community, families, the prison system, the hospital/health system and the research community. The articles were categorised according to which of these groups
were central to the article: this provisional classification showed a fairly even spread across the five categories, so that each category contained either 3 or 4 articles. The two longest articles from each category were then used to form a small corpus, which consequently comprised ten long feature articles.

1.3.1 Feature articles and genre

According to Martin (1992), genres are ‘staged social processes’: that is, they are institutionalised forms of discourse which perform particular functions and play particular roles in society. With regards to media discourse, Iedema et al (1994) distinguish a number of different types of media genres, one of which is the Media Commentary. The media commentary is a type of argumentative text which is distinguished from ‘hard news’ genres in a number of ways. On one hand, ‘hard news’ is described by White (1997:101) as:

…both those reports which are primarily grounded in a material event, such as an accident, natural disaster, riot or terrorist attack, and those grounded in a communicative event such as a speech, interview, report or press release.

‘Hard news’ is usually seen as conveying ‘objective’ information about something which has happened.

Argumentative texts, on the other hand, have a different social purpose. They are often described as offering opinion rather than information. As Iedema et al (1994: 1) put it:

…the social purpose of argumentative texts is to argue a case in such a way that the audience is convinced of the truth of the viewpoint or the merits of the proposal.

They identify three main sub-genres of the media commentary. These are distinguished by their function, and described in table 1.1 below.

<table>
<thead>
<tr>
<th>Text type</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media Exposition</td>
<td>To persuade that/ persuade to</td>
</tr>
<tr>
<td>Media Challenge</td>
<td>To question, argue against, challenge</td>
</tr>
<tr>
<td>Media Discussion</td>
<td>To survey/ canvas</td>
</tr>
</tbody>
</table>

Table 1.1 Types of media commentary
Although Iedema et al state that commentaries are usually found on the editorial page and comprise letters to the editor, ‘opinion’ and ‘comment’ columns, this is not the case with the articles discussed in this thesis. Eight of the ten feature articles are commentaries: the two exceptions are an autobiographical narrative and an interview/review. An overview of the articles, genre and their provenance is given in table 1.2 below. See Appendix 2 for a more comprehensive overview.

<table>
<thead>
<tr>
<th>Headline</th>
<th>Newspaper and section of paper</th>
<th>Genre</th>
<th>Words</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 15, Kylie killed her mother. The demons are gone, but she’s still a prisoner of her past</td>
<td>The Sydney Morning Herald News and features</td>
<td>Media exposition</td>
<td>2506</td>
</tr>
<tr>
<td>The fears of a clown</td>
<td>The Sydney Morning Herald Spectrum-books. The interview</td>
<td>Interview/review</td>
<td>1144</td>
</tr>
<tr>
<td>In the mind’s eye</td>
<td>The Australian Review-feature</td>
<td>Media challenge</td>
<td>1937</td>
</tr>
<tr>
<td>A life revealed, a brother found</td>
<td>The Age Essays/ideas/comment</td>
<td>autobiographical narrative</td>
<td>2349</td>
</tr>
<tr>
<td>Jailed in body and mind</td>
<td>The Australian Features; feature</td>
<td>Media exposition</td>
<td>1712</td>
</tr>
<tr>
<td>They were young, troubled and dependent on a health system that let them die. Now their parents are asking what went wrong</td>
<td>The Age Extra: Sunday Age</td>
<td>Media exposure</td>
<td>1871</td>
</tr>
<tr>
<td>Lighting a dark prison</td>
<td>The Sydney Morning Herald Health and Science</td>
<td>Media discussion</td>
<td>1286</td>
</tr>
<tr>
<td>Teens at most risk from dope</td>
<td>The Sydney Morning Herald Health and Science</td>
<td>Media challenge</td>
<td>1576</td>
</tr>
<tr>
<td>The fight to save Nathan</td>
<td>The Australian Magazine; features</td>
<td>Media exposition</td>
<td>3892</td>
</tr>
<tr>
<td>Trapped in a system near collapse</td>
<td>The Sydney Morning Herald</td>
<td>Media exposition</td>
<td>1365</td>
</tr>
</tbody>
</table>

Table 1.2 Overview of data: genre classification, source and location

The fact that these pieces are neither found on the opinion page, nor specifically labelled as opinion pieces, is significant. Rather than being characterised as representing somebody’s personal point of view, they are labelled ‘features’ and thus classified as in-depth investigations on matters of widespread importance.

Discourse concerned with convincing people to think in a particular way must assume that people do not think this way already. The point of argumentative genres, then, is to change the reader’s mind, and in doing so they can play instrumental roles in pushing for social change. The way that resources of APPRAISAL are used within these

---

1 The article about Kylie Fitter and They were young and troubled... do not have headlines as such in the Factiva archive. They will be referred to when cited as Kylie Fitter and Young and troubled
genres to demand social and institutional change with relation to psychotic illness is discussed in Chapter 4.

1.4 Conclusion

As Fairclough points out, (1992: 55), echoing Halliday:

Language is...constitutive in both conventional ways which help to reproduce and maintain existing social identities, relations and systems of knowledge and belief, and in creative ways which help transform them.

In this thesis, I look at the way that existing social relations are constituted in the texts, as well as the role that the articles in the corpus (in particular the argumentative texts) play in processes of social change. In looking closely at the ways the texts represent social relations and seek to align readers into communities of shared values, we can gain valuable insight into both the workings of rhetoric and the issues of importance to these communities.

Talking about mental health means talking about issues which are crucial in the world today: it means talking about human rights, about social inclusion, and about the responsibility of the state towards its citizens, alongside more scientific discussions about medication and research into causes and cures. Looking at media discourse surrounding mental health can provide vital insight into the way that issues of social justice are played out in the public arena.
Chapter 2 Theoretical Foundations

The study described in this thesis takes place within the framework of Systemic Functional Linguistics (henceforth referred to as SFL), using APPRAISAL theory to look at the ways that evaluative meaning is developed and distributed in a corpus of feature articles on psychotic illnesses taken from three Australian broadsheets. Of particular concern is the way that evaluative meaning plays out with regards to people with psychotic illness and their families on one hand, and the institutions which affect their lives on the other (the prison, court and legal system, the State Government, and the health system). The following outline of SFL, APPRAISAL theory and Bernstein’s theory of knowledge structure provides the reader with the necessary tools to understand the analysis in this thesis.

2.1 Language and Systemic Functional Linguistics

Systemic Functional Linguistics is a theory of language which looks at language as a system of oppositional choices, which we use as a resource to create meaning. Within this framework, language is described in terms of what it does rather than how it is structured, and how it both influences and realises the social context within which it is found. Language, in SFL, is a paradigmatic system and the linguistic choices which we make are significant in that they are chosen over and above the other possible choices.

2.1.1 Realisation

A fundamental concept in Systemic Functional theory is the conception that language as a semiotic system exists simultaneously on three different levels of abstraction. At its most concrete level, language consists of basic phonological (or graphological) units which are the fundamental units for building meaning. At the next level of abstraction, these building blocks are ‘recoded’ into words and structures on the level of lexicogrammar. From an SFL perspective lexicogrammar is not constructed out of phonology and graphology: rather the lower level abstractions are seen as resources for realising the higher level abstractions. (Martin and White, 2005: 9) The third level of abstraction in SFL theory is the level of discourse semantics: this refers to the way meanings are distributed not at clause level, but across text as a whole. See Figure 2.1 below for diagrammatic modelling of this.
2.1.2 Metafunctions

In SFL, all language, at the level of the clause, is considered to have three complementary functions, known as metafunctions, which map onto each other and are construed by different grammatical resources.

The ideational metafunction is concerned with the way in which language is used to construe experiential meaning: that is, events and processes that take place in the world as psychological or material happenings, or, as Martin and White (2005:7) put it:

…what’s going on, who’s doing what to whom, where, when, why and how, and the logical relation of one going on to another.

The textual metafunction deals with the way that information is packaged and distributed in text: this metafunction is realised through resources that indicate to us what information is important, and organise it in ways which make text coherent.

The interpersonal metafunction is realised through the resources that construe social reality: that is, it refers to the way that social relationships are enacted in language. The complementary nature of these three metafunctions is usually modelled as in Figure 2.2 below.
2.1.3 Paradigmatic choice and system networks

In SFL, where meaning is understood to be construed and generated through meaningful choice of a particular grammatical or lexical option from an array of available options, the complexity of these choices is most frequently best represented through the use of system networks. These diagrams represent the process of choice moving from left to right with increasingly fine-grained distinctions. Within these networks any feature can be treated as an ‘entry condition’ into another system, and it is also possible to use this modelling to show simultaneous choice. The diagram below shows a system network overview of APPRAISAL theory, and leads into a section of more detailed description of this theory.
2.2 APPRAISAL theory

The current study uses Martin and White’s 2005 version of APPRAISAL theory as a tool for conducting detailed qualitative analysis of a corpus of feature articles. Within SFL, APPRAISAL is an interpersonal discourse semantic system. APPRAISAL theory provides a comprehensive resource for examining and analysing the deployment of evaluative meaning in text. It is a system which has been designed especially to deal with the lexicogrammatical resources of English, though a body of research which uses APPRAISAL as a tool of exploration for other languages is also growing (Tann 2005, Spaccavento 2006).
APPRAISAL theory classifies interpersonal resources into three domains: ATTITUDE, which is primarily concerned with construing types of feeling; ENGAGEMENT, which deals with the various voices and opinions referenced in discourse and the ways in which these interact; and GRADUATION, which is concerned with ‘modulating meaning by degree’, (Martin and White: 2005: 40): that is, the resources for strengthening and intensifying (or de-intensifying) different meanings. The first two of these domains (ATTITUDE and ENGAGEMENT) will be explored in more detail below, as it is these domains which are relevant to the analysis presented in the thesis.

2.2.1 ATTITUDE

ATTITUDE, as previously mentioned, is a subsystem of APPRAISAL which is concerned, at the most basic level, with the ways that texts and their writers evaluate and construe feeling. Martin and White (2005: 42) describe ATTITUDE as ‘involving three semantic regions covering what is traditionally referred to as emotion, ethics and aesthetics.’ These ‘semantic regions’ correspond to the systems of AFFECT, JUDGMENT and APPRECIATION respectively: AFFECT refers to construals of emotion, JUDGMENT to evaluations of human behaviour, and APPRECIATION to ‘evaluations of semiotic and natural phenomena’ (Martin and White, 2005:43). Each of these three realms of meaning can be further divided according to the ways in which they are valued (or not) by a given culture: that is, into ‘positive’ (praising) and ‘negative’ (criticizing) categories. It is important to state at the outset that the domains of ATTITUDE do not necessarily correspond to grammatical categories: rather they are semantic realms which can be realised grammatically in various ways. This will become clearer when we look at ATTITUDE in more detail below.

In Martin and White’s framework, the system of AFFECT is conceived of as ontogenetically prior to the other systems (Painter 2003, Martin and White 2005), and is thus considered to be the system which gives rise to the others: JUDGMENT, from this perspective, is feeling directed towards the behaviour of people while APPRECIATION is feeling directed towards the material and abstract phenomena of the world. This construal is represented diagrammatically in Figure 2.4 below. Because of the status of AFFECT as the primary system, we will start our description of APPRAISAL theory with the system of AFFECT.
2.2.2 AFFECT

AFFECT, in APPRAISAL theory, is divided into three subcategories, which are described in terms of either ‘disposition’ or ‘surge of behaviour’ (Martin and White 2005: 51-3) This approach acknowledges the embodied nature of emotion, which in many cases cannot be separated from its physiological manifestations: for example, *she wept* and *she was sad* are both ways of describing the same emotion. An example like this is also useful for illustrating the way that, as already mentioned, attitudinal resources spread across grammatical categories.

The table below shows the basic subcategories of AFFECT: un/happiness, in/security and dis/satisfaction. For a more detailed description of the system of AFFECT, including further subcategorisations and descriptions of behaviour associated with AFFECT, see Appendix 2.
Table 2.1 Basic categories of AFFECT

<table>
<thead>
<tr>
<th>Negative (-)</th>
<th>Positive (+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>unhappiness</td>
<td>happiness</td>
</tr>
<tr>
<td>grieving, sad, miserable</td>
<td>cheerful, happy, thrilled</td>
</tr>
<tr>
<td>dissatisfaction</td>
<td>satisfaction</td>
</tr>
<tr>
<td>bored, fed up, angry</td>
<td>fascinated, interested, intrigued</td>
</tr>
<tr>
<td>insecurity</td>
<td>security</td>
</tr>
<tr>
<td>anxious, nervous</td>
<td>confident in, trusting</td>
</tr>
</tbody>
</table>

Emotions are connected, in folk taxonomies, with a lack of control. As Bednarek (forthcoming, 2008: 3) points out:

…the view of emotions as irrational probably goes back as far as Plato’s and Darwin’s observations on emotion and emotional expression. The aspect of control is also very important in the metaphorical construction of emotions, with a focus on attempt at control, loss of control and lack of control.

This is significant in the data we are looking at here because the frequent and varied attribution of AFFECT to both people who have psychotic illness and their families can also be seen as strongly connected to a wider construal of these groups as helpless, especially bearing in mind that the emotions they experience are primarily negative ones, which are by their very definition a-volitional and unwanted. Realisations of –ve happiness and –ve security are especially dominant in this context, and some examples can be seen below.

a) “I cried (-ve happ) non-stop for weeks,” Kylie says. “I was devastated (-ve happ) by what had happened.” (Kylie Fitter)

b) The members of the group have more in common than their grief, pain (-ve happ) and anger (-ve sat). (Young and troubled)
c) He was scared (−ve sec) that someone – he could not explain who or why– was planning to kill him. He became too frightened (−ve sec) to sleep, even in his own bed. (Trapped in a system near collapse)

As Jordens (2002: 117) points out, expressions of insecurity in particular, are a ‘principle means by which speakers position themselves in discourse as vulnerable’, (italics in original). Since expressions of AFFECT are important in inviting the reader to feel empathy for particular participants (Martin and White 2005, Jordens 2001, Iedema et al 1994), the frequent attributions of affect such as those shown above are crucial to the way in which readers are positioned to feel with people who have psychotic illness and their families, and against institutions and those who represent them.

2.2.3 JUDGMENT

The system of JUDGMENT within APPRAISAL comprises the lexical resources for evaluating human behaviour. Resources of JUDGMENT play a kind of moral policing role in the culture: JUDGMENT values what people are, or what they do, within a wider social understanding of what is both admirable and appropriate- in other words, what they should be or do if they are to be respected members of society.

In looking at the feature article data on psychotic illness, JUDGMENT is perhaps the most relevant APPRAISAL category. What we are concerned with are the different types of judgments directed at institutions (and their representatives) on one hand and individuals with a mental illness and their families on the other.

Although it is not always obvious to what extent groups or aggregates of people can be judged, it is clear in the data discussed here that institutions such as the government, the legal system and the mental health/medical system are judged collectively according to ethical norms. Although Agents are frequently effaced in clauses which judge institutions, talking about the ‘cruel, inhumane and degrading’ treatment which a prisoner has received is clearly a way of holding the prison system itself morally responsible for this treatment. Similarly, terms like ‘political expediency’, though they do not specifically target a particular individual, are arguably judgments on the questionable collective ethics of politicians. In fact, perhaps this effacement of agency makes it even clearer that the institutions in question are being judged collectively.
Evaluations of JUDGMENT, within APPRAISAL theory, are divided into two broad categories, social esteem and social sanction. Martin and White liken the division between these categories to the Catholic differentiation of venial and mortal sins, and then clarify for non-Catholics in the following terms:

For the rest of us, it’s perhaps a question of who we turn to for help- too much negative esteem, and we may need to visit a therapist; too much negative sanction and a lawyer might get called in (Martin and White, 2005:53).

The category of social esteem comprises three subcategories: normality (how out of the ordinary somebody is), capacity (how capable they are) and tenacity (how reliable or determined they are.) Sharing values connected to social esteem, according to Martin and White, ‘is critical to the formation of social networks (friends, families, colleagues etc.)’ (Martin and White, 2005: 52). Some examples of inscribed positive and negative social esteem from the corpus are included in table 2.2 below.²

² As previously pointed out, resources of ATTITUDE can be realised by different grammatical categories. In the data we find both nominal realisations of judgment (‘bizarre behaviour’) and adjectival realisations (‘discerning.’)
<table>
<thead>
<tr>
<th>SOCIAL ESTEEM</th>
<th>Positive (+) [admire]</th>
<th>Negative (-) [criticise]</th>
</tr>
</thead>
<tbody>
<tr>
<td>normality</td>
<td>award winning, talented, skilled</td>
<td>mad, unpredictable, misfit, bizarre behaviour</td>
</tr>
<tr>
<td>capacity</td>
<td>expert, discerning, articulate, adept</td>
<td>naïve, sick, struggling</td>
</tr>
<tr>
<td>tenacity</td>
<td>motivated, determined, committed</td>
<td>acquiescent, indifferent, lack of interest</td>
</tr>
</tbody>
</table>

Table 2.2: JUDGMENT: social esteem

The other subcategory of JUDGMENT is the category of social sanction. This type of JUDGMENT, Martin and White (2005:52) say, is:

…often codified in writing, as edicts, decrees, rules, regulations and laws about how to behave as surveilled by church and state- with penalties and charges against those not complying with the code. Sharing values in this area is what underpins civic duty and religious observances.

The subcategories of social sanction are veracity (how truthful a person is), and propriety (how likely-or unlikely- a person is to do something criminal or immoral). Examples of lexis which may realise these categories can be found in table 2.3 below.

<table>
<thead>
<tr>
<th>SOCIAL SANCTION</th>
<th>Positive (+) [praise]</th>
<th>Negative (-) [condemn]</th>
</tr>
</thead>
<tbody>
<tr>
<td>veracity</td>
<td>truthful, honest, straightforward</td>
<td>in denial, tricked, sublimating</td>
</tr>
<tr>
<td>‘how honest?’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>propriety</td>
<td>generous, gentle, polite</td>
<td>cruel, inhumane, degrading</td>
</tr>
<tr>
<td>‘how ethical?’</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2.3: JUDGMENT: social sanction

Because it is relevant to interpreting the data in question, it is useful to look at the different JUDGMENT categories in terms of the modality systems they are connected to. This is important in demonstrating the distinction between categories which refer to innate or involuntary behaviours or abilities; and intentional behaviours or actions for which people can be held fully responsible.
As Iedema et al (1994:12) point out, assessments of capacity ‘all relate directly to whether a participant can or can’t perform some action or achieve some result’: the category of capacity, in other words, is connected to the modality category of ability/ potentiality. The system of tenacity, on the other hand, is related to the modality category of inclination and veracity is connected to the modality category of probability (Iedema et al, 1994: 12-13), while propriety has its roots in the system of obligation and is connected to the extent to which a person “compl[ies] with or def[ies] a ‘system of social necessity’” (Iedema et al, 1994: 3)

In the feature article data the distinction, in terms of agentiveness and responsibility, between categories of capacity and (to some extent) normality on one hand, and the categories of tenacity, veracity and propriety on the other, is particularly clear and has important consequences for the construal of the different categories of people who are judged in the articles. Judgments of –ve capacity such as sick, irrational, unstable, and of –ve normality such as troubled, disturbed, hearing voices (primarily applied to people with psychotic illness); and judgments of –ve tenacity (they were indifferent), 3 -ve propriety (cruel, inhumane and degrading treatment) and -ve veracity (the whitewashed version of events presented by lawyers for the hospitals) create completely different construals of the degree of moral responsibility of characters in the text. This is part of a wider pattern in the texts of portraying people with psychotic illness as helpless and at the mercy of both illness and institutions: as such, it is relevant to processes of alignment in the texts which guide readers to both empathise and sympathise with people with psychotic illness and to regard institutions critically.

It is worth pointing out here that in analysing the texts, clinical depression (which is referred to on a number of occasions as being one of the symptoms of psychotic illness) has not been treated as AFFECT, but rather as a judgment of –ve capacity. Also, terms such as isolation and withdrawal, though they may also be seen to be indicative of a particular affectual state, have been treated as judgments of –ve normality as they describe, in the vast majority of cases, unusual behaviours symptomatic of psychotic illness.

3 These sorts of evaluation have been categorised as judgments of –ve tenacity in the context of mental health staff failing to listen to the parents of mentally ill people. Such usages of what may initially appear to be affectual terms in this context do not have affectual connotations: rather they are connected to representatives of institutions failing to act as if they care.
2.2.4 APPRECIATION

The sub category of APPRECIATION is used to talk about ‘meanings construing our evaluation of things, especially things we make and performances we give, but also including natural phenomena (Martin and White, 2005:56).’

Table 2.4 below gives examples of different types of APPRECIATION, taken where possible from the data used in this thesis.

<table>
<thead>
<tr>
<th></th>
<th>Positive (+)</th>
<th>Negative (-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>reaction: impact</td>
<td>fascinating, remarkable,</td>
<td>tragedy, harrowing,</td>
</tr>
<tr>
<td>‘did it grab me?’</td>
<td>amazing, thrilling</td>
<td>distressing, gruesome,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>emotionally draining, scary</td>
</tr>
<tr>
<td>reaction: quality</td>
<td>fine, good, beautiful,</td>
<td>insalubrious, “hole”, awful,</td>
</tr>
<tr>
<td>‘did I like it?’</td>
<td>pleasant</td>
<td>unspeakable, dingy</td>
</tr>
<tr>
<td>composition: balance</td>
<td>harmonious, balanced,</td>
<td>irregular, contradictory,</td>
</tr>
<tr>
<td>‘did it hang together?’</td>
<td>well-formed</td>
<td>shambles, exaggerated, a mess,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>jumbled, debris</td>
</tr>
<tr>
<td>composition: complexity</td>
<td>clear, obvious, plain,</td>
<td>extravagant, simplistic, unclear,</td>
</tr>
<tr>
<td>‘was it hard to follow?’</td>
<td>consistent, simple</td>
<td>complicated</td>
</tr>
<tr>
<td>valuation</td>
<td>best, crucial, important,</td>
<td>problem, risk, ineffective,</td>
</tr>
<tr>
<td>‘was it worthwhile?’</td>
<td>productive, effective,</td>
<td>worst, substandard,</td>
</tr>
<tr>
<td></td>
<td>beneficial, high-quality,</td>
<td>inadequate, difficult,</td>
</tr>
<tr>
<td></td>
<td>significant, key, ideal</td>
<td>pointless, archaic, trivial</td>
</tr>
</tbody>
</table>

Table 2.4: Types of APPRECIATION

In the data, there are frequent appreciations of the individual and family experience of psychotic illness on one hand, primarily (but not only) in terms of –ve impact -for example tragedy, crisis, and nightmare.
Psychotic illness itself is also negatively appreciated in general in terms of both its effects 
(*a burden, a problem, a risk*) and in terms of the difficulties associated with developing 
suitable treatments and understanding causes (*complicated, diagnosis is difficult, 90% of 
cases are unexplained*). Symptoms are also frequently appreciated in negative terms.

On the other hand, with regards to institutions, and to some extent the wider community, 
we see policies, facilities and ideas being negatively evaluated. Some examples can be 
seen below.

a) “It is **not a very efficient** (-ve val) use of the health dollar if you merely hold somebody for a few 
days or a week. *(Teens at most risk from dope)*

b) **how pernicious** (-ve val ) it can be to romanticise art by the mentally ill. *(In the mind’s eye)*

c) Nathan Hull’s letters from jail often read like **dispatches from a substandard** (-ve val) school 
camp. *(The fight to save Nathan)*

As we can see, the range of **APPRECIATION** is wider than that of JUDGMENT or AFFECT, 
which are used primarily to evaluate people - **APPRECIATION** is used to evaluate everything 
from objects to nominalised acts. Table 2.5 below shows the typical targets (for 
JUDGMENT and APPRECIATION) in the texts, while Table 2.6 shows the typical triggers for 
AFFECT.
<table>
<thead>
<tr>
<th>Type of ATTITUDE</th>
<th>Subcategory</th>
<th>Typical target</th>
</tr>
</thead>
</table>
| JUDGMENT         | capacity and normality | -mentally ill individuals  
|                  | propriety, tenacity and veracity | -institutions such as the State government, prison system, courts and mental health system, - employees of these institutions and their behaviour |
| APPRECIATION     | quality and impact | -experiences of mental illness  
|                  | value         | -policies  
|                  |              | - facilities  
|                  |              | - illness  
|                  |              | - ideas |

Table 2.5 Overview of targets of JUDGMENT and APPRECIATION in the texts.

<table>
<thead>
<tr>
<th>AFFECT</th>
<th>Typical trigger</th>
</tr>
</thead>
</table>
|        | -psychotic illness  
|        | - the associated experiences, for both those who have it and those close to them |

Table 2.6 Overview of affectual triggers in the texts

### 2.3 Invoking ATTITUDE

Until now, we have been concerned with evaluation which is arguably part of the semantic freight of particular lexis, and which belongs, metfunctionally speaking, to the interpersonal metafunction. Below are some examples of inscriptions of JUDGMENT, AFFECT and APPRECIATION.
a) She is so gentle (+ve prop) and polite (+ve prop) as she offers tea and biscuits (Kylie Fitter)

b) Onlookers watched in horror (-ve sec) as Mrs Fitter raced into a neighbor’s house, only to see her son smash down the door and Mrs Fitter emerge, screaming in terror (-ve sec). (Kylie Fitter)

c) Tackling misconceptions (-ve val) about cannabis use is the key (+ve val) to reducing the harm (-ve val) it causes, writes Ruth Pollard. (Teens at most risk from dope)

However, within the APPRAISAL framework, attitudinal meaning can be divided into two broad categories: that which is inscribed (or explicit) and that which is invoked (or implicit). As Martin and White (2005:62) point out:

…avoiding invoked evaluation…. amounts to a suggestion that ideational meaning is selected without regard to the attitudes it engenders- a position we find untenable.

In newspaper discourse in particular, where authors may take pains to show themselves to be ‘objective’, looking at invocations can provide a way of systematically describing the evaluative dimension of texts which may lack inscriptions altogether. Looking at the feature articles in the corpus which we are discussing here, we find that invoked evaluation is very common, and that an analysis which ignores it misses out on a substantial amount of the evaluative content of the text.

Invoked ATTITUDE, as indicated above, can be generated through the selection of particular types of ideational meaning, which direct (or assume) a reader to share a particular evaluation with the author of a text. There are three different types of invocation identified by Martin and White, each described by separate terminology. ATTITUDE is provoked through the use of lexical metaphor, flagged through the selection of non-core vocabulary, and afforded through other types of ideation. These subcategories will be described in more detail below. Figure 2.5 gives an overview of the options for invoking ATTITUDE, which will be discussed further below.

\footnote{See Coffin and O’Halloran (2006) for a further discussion of this.
2.3.1 Provoking JUDGMENT through lexical metaphor

In the feature articles, lexical metaphor frequently provokes judgments of –ve capacity. As Bednarek (2005b:1) points out, ‘metaphors are crucial devices for establishing particular construals of newsworthy events,’ and in these texts they play a fundamental role in portraying people with psychotic illness as being unable to control their actions.

One of the most powerful metaphors in these texts is the metaphor of psychotic illness, and experiences connected with it (including interactions with institutions such as the health system) as a type of imprisonment. This and connected metaphors are widespread across the generic range of the data, appearing in articles about scientific research as well as the expositions. In four of the ten articles analysed they appear in the headlines, a dominant position from which they are likely to influence the reading of the entire text. Table 2.7 below shows some examples of this.

---

5 The metaphors referred to here are live metaphor, rather than the cryptotypic metaphors described by Lakoff and Johnson (1980) such as the conduit metaphor.
<table>
<thead>
<tr>
<th>In headlines and kickers</th>
<th>In body of articles</th>
</tr>
</thead>
</table>
| **Trapped** in a system near collapse | -In early 2004, Darius’s life began to fold in on itself  
-At home, his world contracted further |
| She is still a **prisoner** of her past | -The only possible rationale can be in a law and order environment is (sic) battening down against possible risk |
| **Lighting a dark prison** | -Scientists are hoping to unlock the mystery of the causes of schizophrenia.  
-She watched as her twin disappeared into the deep pit of mental illness  
-scientists are seeking to unlock the causes of schizophrenia  
-the diagnosis that to many is a life sentence [schizophrenia] |
| **Jailed** in body and mind | -these artists are free to emerge from such induced states…. People suffering from severe mental illness are not[free]  
-[people with psychosis] are in a dark place |
| In the mind’s eye | -sitting in the corral-like dock |
| The fight to save Nathan | |

**Table 2.7 Psychotic illness as prison and associated metaphors**

Martin (2007a:10) describes ways in which evaluative meaning and interpersonal prosody ‘[take] advantage of the periodic structuring principle associated with textual meaning.’

The positioning of the prison metaphor in the headlines and leads seems to be a prime example of evaluative meaning ‘dominat[ing] discourse from informational peaks.’

Three of these texts take up the metaphor later in the article to a greater or lesser extent: interestingly, the only one which doesn’t is a text which deals with solitary confinement of people with psychotic illnesses in NSW prisons, and which regularly refers to them as being locked up in more literal terms.

A second metaphorical strand which invokes –ve capacity: control are metaphors of uncontrolled movement or disintegration, used to refer to the experiences of people with a psychotic illness. These refer primarily to the progress of the illness, as in the examples below.

a) “That’s when Nathan was deteriorating.” (-ve cap) his mother says. “I could see it; the episodes were getting more frequent.” *(The fight to save Nathan)*

b) Despite being her son’s constant carer during **his two year downward spiral**, (-ve cap) she was excluded from key decisions on his treatment. *(Trapped in a system near collapse)*
c) Her son, Darius, was *unravelling (-ve cap)* before her eyes, as increasingly terrifying delusions consumed first his mental and then his physical health. (*Trapped in a system near collapse*)

As the examples above show, these metaphors invoke *–ve capacity* so strongly that they almost seem to be inscriptions.

### 2.3.2 Flagging ATTITUDE through use of non- core lexis

Non-core vocabulary is used to ‘flag’ evaluation in the data. Again, the type of ATTITUDE primarily flagged in the texts under discussion is that of JUDGMENT, exemplified below:

a) She believed her mother was already dead, and it was a bad spirit the pair was *slaying (-ve prop)*. (*Kylie Fitter*)

b) He was *gassed and dragged (-ve prop)* away. (*Jailed in body and mind*)

c) She is *locked up (-ve prop)* every afternoon after university. (*Kylie Fitter*)

Often, as in examples above, these judgments are flagged through the use of non-core lexis which implies both use of disproportionate or inappropriate force, and agency. The JUDGMENT is directed at the Agents of these material processes, although they can be effaced as in examples b) and c) above.

### 2.3.3 Affording ATTITUDE

Finally, ATTITUDE can be invoked through ideational meanings that take their evaluative colouring from the surrounding text and world knowledge of the reader. Thus we can read examples a) and b) below affording AFFECT and JUDGMENT respectively, despite the fact that it is not explicitly inscribed. In example a), the affectual reading is afforded by a shared understanding between reader and writer that to lose a child is something which results in sadness and grief. In the second, a reading of *–ve propriety* is afforded if one shares the view that it is inappropriate to institutionalise a teenage boy with grown patients.² APPRECIATION, on the other hand, tends to be inscribed rather than invoked: perhaps because inscribed APPRECIATION is not as likely to generate charges of subjectivity.

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² The issue of hospitalising teenagers and young people with much older people is very much a live issue in the mental health world. Advocates claim that this further marginalises young people with mental illness and isolates them from their peers.
a) Each member has lost a child (-ve happ) - and, in one case, a boyfriend- first to mental illness, then to death. *(Young and troubled)*

b) At first, medicine seemed the ideal way to help David Shannon, who by now had been institutionalised with adult psychiatric patients (-ve prop). *(Lighting a dark prison)*

In this section, I have argued the case for including both inscriptions and invocations in the analysis presented in this thesis. The examples above provide an illustration of the evaluative weight of invoked ATTITUDE, and show that it is as important as inscribed ATTITUDE in characterising both people with mental illness and the institutions with which they come into contact.

### 2.4 ENGAGEMENT

We have looked above at the system of ATTITUDE to talk about the types of values expressed in the texts. The system of ENGAGEMENT, on the other hand:

...is concerned with the linguistic resources by which speakers/ writers take a stance towards the value positions being referenced by the text and with respect to those they address (Martin and White, 2005: 92).

That is, it is concerned with who expresses these values, how they do so, and how this construes the social universe. The resources of ENGAGEMENT are a way of negotiating solidarity and alignment, and analysing them is crucial (in the feature corpus in particular) to understanding the stance we are expected to take, as readers, towards the material in the texts.

The ENGAGEMENT system has been developed out of Bakhtin’s foundational work on heteroglossia and dialogism, and the idea that text is created through a process of give and take, all texts referencing other texts, both previous and potential. In the words of Bakhtin, all utterances, written and oral, must be regarded as existing:

...against a backdrop of other concrete utterances on the same theme, a background made up of contradictory opinions, points of view and value judgments...pregnant with responses and objections. *(Bakhtin (1981: 281), quoted in Martin and White, (2005:93))*

The relationships described above are looked at in text in terms of two broad categories: heterogloss and monogloss. Monogloss refers to utterances which do not explicitly
reference the ‘backdrop’ of other utterances, while heteroglossic utterances do such referencing. ENGAGEMENT resources are the resources of heteroglossia: that is, it is concerned with the linguistic resources which act as indicators of these other voices in text, and the way the author views these other voices.

Within ENGAGEMENT, heteroglossic utterances are divided into two broad subcategories: the category of dialogic contraction, which refers to the resources for rejecting or refuting alternative positions, and that of dialogic expansion, which comprises the resources which 'actively make allowances for dialogically alternative positions and voices (Martin and White, 2005: 102).'

What is of interest in the data under discussion is the categories which exist at the dialogic poles, so to speak: explicit refutation of other voices on one side, and the explicit acknowledgment of other voices on the other side. The intermediate category (proclaim) will not be discussed further here with regards to the data as it is relatively infrequent in the articles.

A system network showing the subcategories of ENGAGEMENT, taken from Martin and White 2005, can be seen below. Categories in green are those which will be discussed further when talking about the feature articles in the corpus.
Dialogic contraction comprises two subcategories: **disclaim** and **proclamation**. Disclaiming resources are the way in which ‘the textual voice positions itself as at odds with, or rejecting, some contrary position.’ (Martin and White, 2005: 97) This is done through the resources of negation (*no, not, never, no one*) and concession (*but, however, while, although*). These resources are represented respectively by examples a) and b) below.

a) “You *don’t* change personality if you contract the illness, you *don’t* suddenly turn into someone else.” *(Fears of a clown)*

b) Many great artists have themselves been affected by mental illness. *But* it is important to draw a distinction [between being an artist and having a mental illness]. *(In the mind’s eye)*

In example a) above, Will Elliott is quoted, addressing and refuting the common idea that schizophrenia is a kind of split personality: in Martin and White’s terms, he rejects a contrary position. In example b), the inference that the correlation between artistic activity
and mental illness could indicate a causative relationship is rejected. In both cases, then, ideas which the writer assumes the reader to hold are explicitly addressed and rejected.

2.4.1.1 Disclaim: deny

The description of resources of disclaim: deny as heteroglossic may at first seem contradictory. However, through the explicit refutation of an ‘alternative’ position, disclaim: deny in fact acts as an indicator in the text of the existence and nature of this alternative position.

Resources of disclaim: deny are also used to talk about things which have not been done (in the feature article data, this is realised through negative polarity clauses with material or verbal processes), and in doing so invite the reader to share a particular assessment of the significance of these non-acts. This is a common resource used to talk about institutions and align the reader with the writer in condemnation of their in/ actions, as in examples a) and b) below: the first refers to an occasion when a psychotic young man appears at a local hospital asking for help, the second refers to the mother of another young man with psychotic illness who has tried to get information about her son’s treatment.

a) It appears no one offered him assistance. (The fight to save Nathan)

b) Teresa said her questions about her son’s medication were not answered. (Trapped in a system near collapse)

The manner of this alignment and the consequences for reader/ writer relations and the construal of different groups represented in the texts will be discussed further in Chapter 4.

2.4.1.2 Disclaim: counter

Resources of disclaim: counter (similarly to the resources of disclaim: deny described above) also ‘project onto the addressee particular beliefs or expectations (Martin and White, 2005: 121).’ Countering resources such as but, while, despite, even though, and yet construe an audience who shares these beliefs and expectations with the writer, and are consequently as surprised as the writer when these expectations are not met. Thompson and Zhou (2000:124) describe these resources as ‘conjuncts with attitude.’
Conjuncts such as *but*, then, tell the reader that ‘what follows is not what he or she expects to find (Thompson and Zhou, 2000: 121).’ Obviously the nature of this unexpectedness can vary greatly, but Bednarek (2006b:1) identifies two main uses of these types of contrastive evaluative resources in a corpus of news stories: *semantic opposition* and *denial of expectation*. The semantic opposition usage, which explicitly juxtaposes two lexical items against each other, is exemplified in the example below (taken from Bednarek, 2006b:1):

John is tall, *but* Bill is short.

*Denial of expectation* resources of contrast, on the other hand, are concerned with countering an *inference* which the reader makes based on the information given in the previous clause. It goes without saying that this inference is based not solely on the ideational meaning of the preceding clause, but on other knowledge and understandings possessed by the writer, and presumed to be shared by the reader. The example given by Bednarek is as follows:

John is tall, *but* he doesn’t play basketball.

In this example, it is the shared knowledge of writer and reader that tall people often play basketball which makes the utterance fully comprehensible- the inference which is refuted is an inference made on the basis of this shared knowledge.

In the articles discussed in this thesis, it is ‘denial of expectation’ countering resources which are most interestingly and commonly used as ways of evaluating. These resources are used not only to allude to shared knowledge of how things operate in the world, but to generate powerful implicit criticism of the behaviour of particular categories of participants in the texts: namely, institutions and their representatives. Hence the example below carries a powerful implicit criticism of the way things are done in the prison system, which is created through a juxtaposition of what occurs and what we would expect to occur.

*Though* the use of solitary confinement has been widely condemned for 40 years, Singh says, "experts say the mentally ill people least able to handle the isolation are most likely to be locked up in solitary." *(Jailed in body and mind)*
What is being countered here is an inference the reader may make that 40 years of condemnation of the practice of solitary confinement would cause the practice to be discontinued. The fact that this is not the case is presented as both unexpected and reprehensible through the use of but.

In summary, the resources of disclaiming in the data are shown to have a particular rhetorical purpose. These resources are concerned with aligning reader, writer, and the mentally ill people and their families represented in the texts into a community of shared values from which the institutions and their representatives are excluded. This will be discussed at more length in chapter 4.

2.4.2 Dialogic expansion: attribute and entertain

Having looked at some of the ways in which authors of the texts act to close down dialogic space through the resources of dialogic contraction, let us now move on to the role of the resources of dialogic expansion. These are the linguistic resources by which other voices are introduced into the text; these voices play a fundamental role in news discourse in particular, where one of the devices for developing an impression of authorial objectivity is to use the voices of other participants to evaluate (see Gruber 1993, Martin and White 2005 for detailed discussion of this).

Any speaker is himself [sic] a respondent to a greater or lesser degree. He is not, after all, the first speaker, the one who disturbs the eternal silence of the universe. And he presupposes not only the existence of the language system he is using, but also the existence of preceding utterances—his own and others’—with which his given utterance enters into one kind of relation or another (builds on them, polemicizes with them, or simply presumes that they are already known to the listener). Any utterance is a link in a very complexly organised chain of other utterances. (Bakhtin, 1986 quoted in Körner 2004:48)

2.4.2.1 Attribute

One of the primary methods for introducing other ‘voices’ into media discourse is the attribution of particular utterances or ideas to the various textual participants, frequently through mental or verbal reporting verbs which project them. Within the ENGAGEMENT category of attribute, we find the two major subcategories of attribute: acknowledge and attribute: distance. Distancing attributions, often marked in media discourse through ‘scare quotes’ as well as specific types of verbal processes (such as claim) are
‘formulations in which there is an explicit distancing of the authorial voice from the attributed material (Martin and White, 2005: 113).’ **Acknowledging attributions**, on the other hand, are attributed utterances which give no overt indication of authorial stance with regards to their content. In the feature article data, though both types of **attributions** occur, it is perhaps most fruitful to examine acknowledging **attributions** in more detail.

In looking at **attributions** we are concerned both with who is doing the (represented) talking, and what they are saying. When we talk about who, we are not concerned only with the individual, but also with the capacity in which they are speaking: are they experts or spokespeople, family members or people describing their own experience? In the texts in question, three main sources can be distinguished.

1. Family member of person with a mental illness as source
2. Person with a mental illness as source
3. Experts / spokespeople / documents as source

In terms of the origin of attributed projections we are primarily concerned with who says so (or thinks so), using the categories described above. However, it is also crucial to any analysis of intersubjective positioning to look at what is being said. In the data in question, this what is the key to understanding the construction of social roles in the texts as well as the role that the media texts in question play in the social process. This will be discussed further below when describing Bernstein’s theory of discourse structure.

**2.4.2.2 Entertain**

The final **ENGAGEMENT** resource which will be described in more detail here is that of **entertain. Entertain** is the category of dialogic expansion which includes the linguistic resources of modality and evidentiality. This category of **ENGAGEMENT** is concerned with the ways by which:

…the authorial voice indicates that its position is but one of a number of possible positions and thereby, to greater or lesser degrees, makes dialogic space for these possibilities. (Martin and White, 2005: 104)
Modality, as Halliday (1994:88) puts it, is a collective name for the ‘various kinds of indeterminacy’ between positive and negative polarities. Table 2.7 below shows the different categories of modality and some examples.

<table>
<thead>
<tr>
<th>Type of modality</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>modalisation</td>
<td>he might have known</td>
</tr>
<tr>
<td></td>
<td>he probably knew</td>
</tr>
<tr>
<td></td>
<td>he certainly knew</td>
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<tr>
<td>usuality</td>
<td>he occasionally goes</td>
</tr>
<tr>
<td></td>
<td>he sometimes goes</td>
</tr>
<tr>
<td></td>
<td>he always goes</td>
</tr>
<tr>
<td>obligation</td>
<td>do it</td>
</tr>
<tr>
<td></td>
<td>you should do it</td>
</tr>
<tr>
<td></td>
<td>you must do it</td>
</tr>
<tr>
<td>inclination</td>
<td>he’s willing to do it</td>
</tr>
<tr>
<td></td>
<td>he’s keen to do it</td>
</tr>
<tr>
<td></td>
<td>he’s determined to do it</td>
</tr>
</tbody>
</table>

Table 2.8 Types of modality (adapted from Halliday, 1994:91)

In Martin and White (2005), most of the description of the category of entertain describes realisations of the modal category of probability. However, what is most interesting in the data examined in this thesis is the way that the categories of evaluators described above make use of the modal category of modulation: obligation. This category is concerned with directives indicating the obligatoriness or necessity of an action or event.

Modulations of obligation, in other words, is concerned with who gets to tell who what to do. It includes imperatives and other requests for compliance, often realised in the data as either verbal processes which imply the need for compliance (such as suggest, recommend, demand) or modals such as must, need to, should. Examples a) and b) below are some illustrative examples of modulations of obligation found in the texts. It can also be realised through clauses like c), which, interestingly, use APPRECIATION to argue for the validity and necessity of a particular course of action. Modal components realising modulations of obligation in the examples below are italicised and in bold.

a) The NSW State Coroner recommended that prison inmates who were mentally ill should be put into solitary confinement only as a last resort. (Jailed in body and mind)

b) Read, in particular, the essay in the catalogue by Alan Fels. (In the mind’s eye)
The creation of centres of excellence around Australia was **vital**, he said. *(Teens at most risk from dope)*

What is of interest here is who makes these requests for compliance, who they are directed at, and why some people have the right to use them while others don’t. A useful theory for looking at the way that both institutions and mentally ill individuals talk about knowledge and experience is Bernstein’s theory of knowledge structures, which will be discussed in section 2.5 below.

### 2.5 Dialogic expansion and knowledge structure

Bernstein, in some of his later work (Bernstein 1999), distinguishes between two different types of discourse which represent and express different types of knowledge. He refers to these as ‘horizontal’ and ‘vertical’ discourses.

#### 2.5.1 Horizontal and vertical discourse

Horizontal discourse is described by Bernstein as rooted in ‘everyday or ‘common-sense’ knowledge (Bernstein 1999:159),’ to which every member of society has access. This knowledge is ‘likely to be oral, local, context dependent and specific, tacit, multi-layered, and contradictory across but not within contexts.’ *(ibid)* He goes on to state:

> …in the case of horizontal discourse, its knowledges, competences and literacies are segmental. They are contextually specific and ‘context dependent’, embedded in on-going practices, usually with strong affective loading, and directed towards specific, immediate goals, highly relevant to the acquirer in the context of his/her life. *(Bernstein, 1999:161)*

Vertical discourse, on the other hand, is described by Bernstein as having two different forms, described below, relating to two different types of knowledge structure.

A vertical discourse takes the form of a coherent, explicit, and systematically principled structure, hierarchically organised, as in the sciences, or it takes the form of a series of specialised languages with special modes of interrogation and specialised criteria for the production and circulation of texts, as in the social sciences and humanities.

‘Hierarchical’ knowledge structures such as those described in the discourse of scientific disciplines are characterised by Bernstein as follows.
This form of knowledge attempts to create very general propositions and theories, which integrate knowledge at lower levels, and in this way shows underlying uniformities across an expanding range of apparently different phenomena. Hierarchical knowledge structures appear, by their users, to be motivated towards greater and greater integrating propositions, operating at more and more abstract levels. Thus, it could be said that hierarchical knowledge structures are produced by an 'integrating' code. (Bernstein, 1999:162)

Horizontal knowledge structures, on the other hand, and the ‘series of specialised languages’ which are used to express these knowledge structures, are described by Bernstein as belonging to the realm of the humanities. Maton and Muller (2007 forthcoming: 18) use the field of sociology as an example, saying that the specialised languages ‘refer to its wide array of competing theoretical approaches, such as functionalism, structuralism, Marxism, post-modernism and so forth.’

2.5.2 Types of knowledge structure in the data

With regards to the feature article data being analysed here, we can think of horizontal discourse (particularly in attributed speech and thought), as discourse which represents individual time-bound experience: encounters and events which take place on particular occasions, between particular individuals or groups, often indicated through the use of the deictic pronoun ‘I’. This is primarily the province of the families of individuals with psychotic illness in the texts, and of the individuals with psychotic illness themselves. The example below is an example of this sort of narrated, horizontal discourse: Nathan Hull’s mother describes an incident which took place in the local hospital on an occasion when her son was ill.

“I accompanied him to the outpatients departments at the hospital once and the nursing staff were laughing at him. The doctor came to me and said, ‘That bloody kid of yours is on drugs- we’re getting these bloody druggies every Friday.’…” (The fight to save Nathan)

Thoughts and utterances for which the ‘expert’ category are textually responsible, on the other hand, tend towards the hierarchical. Though this does not necessarily imply exclusive use of the vocabulary and concepts of hierarchical knowledge structures, the attributions to experts in the texts (including evaluations made by author-as-expert) are characterised by a much greater tendency to generalisation. The knowledge of experts is shown to be connected to some process of empirical investigation, frequently their own professional experience, which they then use as the basis to claim that this is how things
are on a wider basis. The example below is an instance of this, where John Mendoza generalises from his own experience to comment on trends in drug use, in a passage which (in Bernstein’s terms) tends towards the ‘hierarchical’ side of horizontal knowledge structures.

Yet, disturbingly, there has been a corresponding, albeit smaller, increase in the use of ecstasy and methamphetamine over the past six years, says the chief executive officer of the Mental Health Council of Australia, John Mendoza. *(Teens at most risk from dope)*

The significance of the *attribution* of different types of discourse (in Bernstein’s terms) to different categories of speaker obviously has implications for the way that power relations are represented in the texts. This will be examined more closely in chapter 4, where I argue that the right to direct modulations of obligation at institutions and their representatives depends primarily on the representation of certain experience as generalised rather than individual. Thus the transformation of individual experience (described through horizontal discourse) into recurrent experience (realized through discourse that leans towards the hierarchical) by ‘expert’ sources is a crucial part of the rhetorical development of the text, which enables these experts to demand changes in the system.

### 2.6 Conclusion

In this chapter, we have looked at the theoretical foundations of the research, including a detailed examination of APPRAISAL theory and the subsystems of ATTITUDE and ENGAGEMENT, as well as Bernstein’s theory of knowledge structure. I have introduced some of the salient patterns found in the data, and pointed out some ways in which these patterns construe the two broad categories of institutions and their representatives, and mentally ill people and their families, with regards to one another and the reader.

This distinction (between institutions and their representatives and private citizens) has been set up here because it is crucial to the way that the social universe is construed in the texts, including the ways in which the reader is invited to share certain judgments about people and institutions with the writers. It is also strongly connected to the role that the texts play in advocating for certain groups and in demanding social change.

The following chapter will look in more depth at patterns of ATTITUDE, and the way that these are deployed in the articles, while Chapter 5 will provide a more detailed analysis of
ENGAGEMENT strategies and the ways in which these are used to affiliate the reader with a particular community of shared values.
Chapter 3 Negotiating empathy and sharing condemnation

This chapter is concerned with the ways in which the reader of the ten feature articles analysed in this thesis is invited to sympathise with some groups of people and condemn others through the deployment of resources of ATTITUDE (AFFECT, JUDGMENT, and APPRECIATION). Here we will look at who is judged and how, what is appreciated and how, and who feels what and why, and the reading position that is naturalised by the deployment of ATTITUDE in the texts.

Of particular interest is the way in which the resources of ATTITUDE are used to construe people with a psychotic illness as victims, both of the incapacitating effects of the illness and of the social institutions which are responsible for their welfare (the health system, the prison system and the government) and the people who work or speak for them.

The first half of the chapter will provide a broad overview of the resources of ATTITUDE in the texts, and some examples of ways in which they act to characterise institutions on one hand and people with psychotic illness and their families on the other. The second half will look at two texts in more depth to show some of the ways in which resources of ATTITUDE work to create a particular construal of blame and responsibility when dealing with violent acts committed by people with psychotic illness, through characterising them as victims rather than perpetrators.

Partly this is done through portraying psychotic illness as something which deprives a person of control and prevents normal functioning. This is primarily done through judgments of –ve capacity, and has the effect of lifting responsibility from people with psychotic illness (which is especially important in a criminal setting, as we will see in section 3.6) and representing them as helpless. Institutions and their representatives, on the other hand, are construed as conscious and empowered agents
who must be held responsible for their actions, and are judged accordingly in terms of –ve propriety, -ve tenacity and occasionally –ve veracity.

Although resources of JUDGMENT are perhaps most important in creating this construal of the two groups, resources of AFFECT and APPRECIATION also play a role.

3.1 Double logogenesis

Coffin and O’Halloran (2006), in a study on the portrayal of Eastern European migrants in British tabloids, pioneered a technique they call the ‘double logogenetic’ method. This included conducting an APPRAISAL analysis of a small corpus of tabloid articles on the same subject, which were published between April 23 and April 30 2006, as well as an APPRAISAL analysis looking at the unfolding of evaluative meaning in a single article about migrants published on May 1. Their aim was to look at how a target readership is specifically primed to take a particular reading position by the ‘build up over a period of time of particular patterns and realisations of evaluative meaning.’ (Coffin and O’Halloran, 2006:81) They examined this process of priming by looking at the disposition of meanings in a corpus, which they then used as the basis for examination of a single text. This method aimed to show some ways in which readers are positioned through exposure to certain evaluative tendencies and syndromes in successive texts, as well as being positioned through the logogenetic unfolding of individual texts.

In looking at feature article data collected over a period of 8 months, the notion of double logogenesis is a useful one. We can perhaps assume that a synoptic look at types of ATTITUDE throughout the ten texts in question will reveal something of how the ‘ideal reader’ is being positioned over a period of time, especially if patterning is congruent across the corpus.

However, in order to show the significance of this patterning, a synoptic overview is not enough. As Martin (2003:177) says:

..it is texts that mean, through their sentences and the complex of logogenetic contingencies among them- they do not mean as a selection from, or a sum of, or… an average of, the meanings within the clause.
For this reason I have included a section dealing with the logogenetic unfolding of two of the ten texts analysed for this project. These texts have been chosen because the attitudinal work that is done to enlist our sympathy on behalf of people who have committed violent acts is illustrative of wider patterns across the data. Before looking at logogenesis, however, we will begin with an overview of types of attitude in the texts.

3.2 AFFECT

In the data, the divide between institutions and their representatives on one hand, and individuals with psychotic illness and their families on the other, is well illustrated by looking at the very different attribution of affect to these groups. There is almost no inscribed affect attributed to the institutional representatives who are being criticised, though there is the occasional attribution of affect to ‘experts’ who are speaking critically against institutions. On the other hand, there is a large amount of affect attributed to people with psychotic illness and their families. Affect resources, in the data, then, serve to characterise particular groups of people and further, to invite the reader to sympathise with these groups.

3.2.1 Characterising the mentally ill and their families

Table 3.1 below shows the lexical items used to inscribe negative affect attributed to families and people with psychotic illness. These are the most salient types of affect found in the texts, and as the table indicates, feelings of –ve security predominate for people with illness, and feelings of –ve happiness for family members. All the examples here are inscriptions of affect.
<table>
<thead>
<tr>
<th>Mentally ill people</th>
<th>-ve security</th>
<th>-ve happiness</th>
<th>-ve satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>paranoid</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>fear</td>
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<td></td>
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<tr>
<td>frightened</td>
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<tr>
<td>troubled</td>
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</tr>
<tr>
<td>lonely</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>anxiety (2)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>too frightened to sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>had no self esteem</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>troubled</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>wary</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>agitated (6)</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>Their ‘loved ones’</td>
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<tr>
<td>dread</td>
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<td></td>
<td></td>
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<tr>
<td>anxious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>fear</td>
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<td></td>
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<tr>
<td>horrified</td>
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<td></td>
<td></td>
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<tr>
<td>worried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>glancing round anxiously nervous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>terrible haunted look in their eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pain (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>she finds it terribly painful</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>one hurt stands apart sad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>despair (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sad</td>
<td></td>
<td></td>
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<tr>
<td>sadness (2)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>unbearably hard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>grief (3)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>grieve for grieving</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>distress</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>wept</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>crying (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ache of missing suffering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tears running down her cheeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bereaved</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘tearing my heart out’</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>stricken faces</td>
<td></td>
<td></td>
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</tbody>
</table>

Table 3.1 Realisations of AFFECT: families and individuals
(those in bold occur ≥ 3 times in the data)

The triggers for these emotions are usually psychotic illness itself, in a general sense, for both those who have it and their family members. The illness causes those who have it to feel wary, anxious, scared, agitated and so on, while it causes their families to feel grief, pain and sadness through its effect on their relatives. Below are some examples from the texts.

7 All the examples in this cell come from same text, *The fight to save Nathan*: this will be discussed further in section 3.6
8 ‘troubled’ has been double coded as a judgment of –ve normality and as –ve security because in the texts it is used to describe both behaviour and state of mind.
a) “If you put somebody who is paranoid (-ve sec) and agitated (-ve sec) and greatly distressed (-ve happ) in a solitary confinement setting for 23 hours a day, you cannot expect that to have a calming effect.” (Jailed in body and mind)

b) Like shedding skin, I let go slowly, dropping the hot tightness of my grief (-ve happ) to reveal a heavy sadness (-ve happ); peeling that back to find moments of sharp pain (-ve happ) for the brevity of his life; lifting that to reveal the ache of missing (-ve happ) what he might have been. (A life revealed, a brother found)

In example a), Robert Lewin, a forensic psychiatrist, is describing the effects of solitary confinement on people with psychotic illness at an inquest into the death of a prisoner with schizophrenia who committed suicide while in the isolation cell at Goulburn jail. In example b), Georgia Blain describes her grief over her brother Jonathon’s death by drug overdose. He had been overdosing regularly and living on the streets as a result of his schizophrenia. This is a significant cause of negative affect in the texts, where many of the people with psychotic illness are shown to commit suicide, or end up in prison or a psychiatric hospital as a result of the illness. In fact, Will Elliott is the only person with psychotic illness in the texts represented as escaping one or the other of these fates.

The characterisation of individuals with mental illness and their families in affectual terms, then, is critical to the way in which we, as readers, think about them. As White points out,

By appraising events in affectual terms, the speaker/writer invites their audience to share that emotional response, or at least to see that response as appropriate and well motivated…. When that invitation is accepted, then, solidarity or sympathy between speaker and listener will be enhanced. Once such an empathetic connection has been established, then there is the possibility that the listener will be more open to the broader ideological aspects of the speaker's position.

(http://www.grammatics.com/APPRAISAL/APPRAISALOutline/UnFramed/APPR
AISALOutline.htm, accessed 20/09/07 at 13:54)

The frequency of attributions of –ve security and -ve happiness to people with psychotic illness and their families, then, has an important role in assisting readers to choose sides: we are ‘invited to share the emotional response’ of people who have experienced psychotic illness themselves, either firsthand or through a ‘loved one.’
Further, the frequent attribution of \(-ve\ affect\) to both people who have psychotic illness and their families can also be seen as strongly connected to a wider construal of these groups in terms of \(-ve\ capacity: control\), (this will be discussed further below in section 3.4 on JUDGMENT.) As already pointed out in chapter 2, emotions are by their very nature a-volitional: in this case, bearing in mind that the majority of them are negative, we can also assume that they are unwanted. Adding to this, there are also a number of occasions where people with psychotic illness are described in ways which explicitly code a lack of control over their emotions:

a) But if you look at some of the typical symptoms…… Flat, blunted or constricted affect or emotion; \((-ve\ cap: control)\) poverty of speech and lack of motivation, it would seem that not much about [schizophrenia] is compatible with creative excellence.

b) He became irrationally \((+ve\ cap: control)\) angry over a bet he’d failed to place on a horse

Positive AFFECT in the texts, on the other hand, frequently describes feelings of affection generated by familial ties: people with psychotic illness love (and are loved by) their families and people close to them.

a) Many carers of the mentally ill face unnecessary obstacles in helping their loved ones \((+ve\ happ: affection)\) survive, writes Julie Robotham. (Trapped in a system near collapse)

b) I remembered how much I had loved \((+ve\ happ: affection)\) my brother as a child. (A life revealed, a brother found)

Construing family relations as an affectual trigger in this way encourages us, as readers, to empathise with the families’ experience of their loved one’s illness: that is to feel \(with\) them as well as for them.

There is one further type of AFFECT which will be discussed here. This is \(-ve\ satisfaction\) which occurs as a response to the behaviour or activities of institutions and their representatives. It is interesting to look at this because the experts and advocates criticising the system and speaking on behalf of people with psychotic illness also show this kind of AFFECT, along with families and individuals. The first example refers to the process of drafting new privacy legislation to allow carers better access to information about people they care for. The second is self explanatory.
a) Professionals are angry (\textit{ve sat}) that the process has stalled. \textit{(Young and troubled)}

b) It was February 6, nine days after she had been discharged from the Alfred Hospital….. and only three days after Lucas had phoned the head of the hospital’s crisis assessment team, appalled (\textit{ve sat}) that its members had not been visiting her daughter, only making phone contact. \textit{(Young and troubled)}

Once again, note that this type of \textit{AFFECT} contributes to positioning the reader in a particular way. Not only are we encouraged to sympathise with people with psychotic illness and their significant others through hearing about their grief and difficulty, but we are also encouraged to share their dissatisfaction, and that of ‘experts’ speaking on their behalf, with the way that things are done by institutions.

\textbf{3.2.2 Similarities and variation in the texts}

The dominant affective flavour, then, of most of these texts, is based on recurrent inscriptions of \textit{ve happiness} and \textit{ve security} associated with the symptoms of psychotic illness, and the difficulties of family members of those who have it. The two exceptions are \textit{Fears of a clown} and \textit{Teens at most risk from dope}. In the first case, Will Elliott (a novelist with schizophrenia who has just won a prize for his first novel) is characterised by strongly positive feelings of \textit{ve happiness} (\textit{happy, pleased and delighted}) and \textit{ve satisfaction} (\textit{pride}) This can be explained by the fact that the experience he is shown to have (winning an award for a novel) is a very positive one: the only unmitigated one of its kind in the data.

In the second case, the article describes the dangers of cannabis use and its connection to psychotic illness in young people, and some ways in which this needs to be (and is being) addressed. \textit{AFFECT} is minimal in this article. However, negative evaluations of psychotic illness and its problematic nature are carried out instead through the recurrent use of \textit{APPRECIATION} to assess the illness. This can perhaps be explained by the attempt to be ‘scientific’ and ‘objective’ in this article, which appears in the health and science section of the newspaper, and will be elaborated on in section 3.3, which deals with \textit{APPRECIATION}.
### 3.2.3 Summing up AFFECT

In the section above we saw that AFFECT was used across the articles to negotiate empathy in the reader for those who experience psychotic illness, either themselves or in somebody close to them, and, in a number of instances, to encourage the reader to share criticism of institutions. Through AFFECT, psychotic illness is construed as something which has a strongly negative effect on the lives of those who come into contact with it, and as readers we are inclined to feel compassion for people who have this experience. This is congruent with a wider tendency for authors to naturalise a reading position which is critical of institutions and compassionate towards individuals and their families. This tendency is realised through resources from all the attitudinal categories, including that of APPRECIATION which we will look at in the next section.

### 3.3 APPRECIATION

APPRECIATION, in the texts, is used to appreciate a range of different things. With regards to institutions, policies, nominalised acts and facilities are the primary targets of appreciations. With regards to individuals and their families, the main kind of appreciations are those of quality and impact related to their experience of illness. Psychotic illness itself and the available treatments are also negatively appreciated.

#### 3.3.1 Appreciating experiences of illness

In the ten feature articles analysed for this research project, one of the most salient types of APPRECIATION is negative appreciation of the life experience of people who have mental illness and their families. This is frequently appreciated in terms of –ve impact, as in the examples below. These assessments of experience often refer to the interactions of psychotic family members with institutions such as the legal system, or the mental health system, which frequently result in suicide. Example a) below refers to the influx of mentally ill people into NSW prisons- the ‘nightmare’ refers to the whole preceding passage. Example b) refers to the suicide of Darius Tremtiazy, who killed himself during a 3 month wait for psychiatric assessment. The ‘harrowing stories’ in example c) refer to the experiences of people who belong to a support
group for people whose family members have died through suicide or misadventure in which psychotic illness is implicated.

\[
\begin{array}{l}
a) \text{The head of the NSW prison system, Ron Woodham, told ABC-TV’s Four Corners last year: “…..It’s unbelievable.(-ve impact) In our big remand jails, particularly of a Friday night, it’s like a casualty ward.}
\\
\text{It’s not until you talk to someone caught up in the nightmare (-ve impact) that it snaps into focus. (The fight to save Nathan)}
\\
b) \text{Investment alone will not prevent tragedies (-ve impact) like that of Darius Tremtiaczy. (Trapped in a system near collapse)}
\\
c) \text{Today, ten of the group’s members are present, each with a harrowing (-ve impact) story to tell. (Young and troubled)}
\end{array}
\]

The symptoms of psychotic illness are also sometimes described in terms of their affective impact on the person who has them. This twinning of AFFECT and reaction has been described elsewhere - as Martin and White (2005:57) point out:

…clearly there are strong links between the APPRECIATION variable reaction and AFFECT, including derivationally related lexis.

In the two examples below, psychotic phenomena are described in terms of their affective impact.

\[
\begin{array}{l}
a) \text{He withdrew from their world and entered his own, often terrifying (-ve impact) parallel universe. (Lighting a dark prison)}
\\
b) \text{Her son, Darius, was unravelling before her eyes as increasingly terrifying (-ve impact) delusions consumed first his mental and then his physical health. (Trapped in a system near collapse)}
\end{array}
\]

As Martin and White have done, I have distinguished between AFFECT and APPRECIATION on the basis of the trigger/appraised, by coding terrified as AFFECT and terrifying as APPRECIATION. However, it is important to point out that these sorts of appreciations contribute strongly to the affective tone of the texts rather than to a more abstracted syndrome of APPRECIATION.
3.3.2 Appreciating illness and treatments

In all the texts, psychotic illness itself is negatively appreciated as an abstract phenomenon, often in terms of value. Illness and symptoms are talked about as ‘problems’ or ‘trouble’: the illness is ‘bad’, or ‘severe’.

a) A vicious cycle (-ve val) of self-medication and worsening (-ve val) symptoms is amplified by torrid teenage emotions. *(Teens at most risk from dope)*

b) I decided the best way to help was to understand what was causing the disease so that we could come up with therapies and treatments to deal with the root of the problem (-ve val). *(Lighting a dark prison)*

c) His parents were told that his problems (-ve val), which included wandering into traffic and displaying fear and aggression towards them, were behavioural, not psychotic. *(Young and troubled)*

Psychotic illness, in the examples above, is a sort of harm which is done to people: it is something which is negatively valued in its own right as well as causing damage to those who are unlucky enough to contract it. This is particularly noticeable in the article *Teens at most risk from dope*; psychotic illness is evaluated over and over again as a negative effect of cannabis use. Some examples from this article can be found below.

- the harm (-ve val) associated with cannabis use
- the harm (-ve val) it [cannabis] causes
- the dangers (-ve val) of cannabis use
- teens at most risk (-ve val) from dope
- problematic (-ve val) cannabis use [ie leading to psychotic illness]
- it is harmful (-ve val) for a subgroups of people
- cannabis-related problems (-ve val)
- many young brains are at risk of harm (-ve val) from cannabis

Schizophrenia is also described (primarily in the two ‘scientific’ articles, but also elsewhere) in terms of –ve complexity, as something which confounds professional researchers, as we see in the examples below.

a) Schizophrenia is complicated (-ve compl) because the disease is episodic and varies greatly in its symptoms and severity. *(In the mind’s eye)*
b) Scientists are hoping to unlock the mystery (-ve compl) of the causes of schizophrenia. (Lighting a dark prison)

Evaluations of the complicated nature of psychotic illness can also take the form of negative appreciations of treatment and research itself rather than the illness.

a) The past two decades of schizophrenia research has been dominated- and hampered (-ve val) by a simplistic (-ve compl) genetic hypothesis. (Lighting a dark prison)

b) For patients with schizophrenia, these treatments were widely recognized as less than perfect (-ve val). (Lighting a dark prison)

c) the drugs are sometimes administered haphazardly,[and] their side effects can be unpredictable (-ve comp)…Late last year he told his mother he felt he was suffocating from the effects of the drugs. (The fight to save Nathan)

These sorts of negative appreciations construe psychotic illness as problematic for the sufferer rather than society as a whole. Again, this is a way of talking which affords a sympathetic stance on the part of the reader towards people who have illnesses like schizophrenia.

### 3.3.4 Appreciating policies and facilities

As we saw above, the articles which appeared in the health and science section of the papers tended to use resources of APPRECIATION to evaluate illness rather than institutional policies, actions and facilities. In the media expositions and the art review In the mind’s eye, however, institutions and the mental health system in particular are also negatively appreciated in a variety of different ways. Most striking and widespread amongst these evaluations are negative appreciations of –ve value and –ve composition- some examples can be found below.

a) The disintegration (-ve bal) of the mental health system has been so well documented over the past 15 years that the scale of the problem (-ve val) seems to defy solutions. (The fight to save Nathan)

b) Trapped in a system near collapse (-ve bal). (Trapped in a system near collapse)
c) Privacy concerns are a fig leaf hiding a treatment shambles (\textit{-ve bal}). \textit{(Trapped in a system near collapse)}

d) The state’s impoverished (\textit{-ve val}) mental health service. \textit{(In the mind’s eye)}

The facilities provided by hospitals and prisons are also negatively appreciated, primarily in terms of \textit{-ve value}, but also in terms of other APPRECIATION categories.

a) Amid the clutter (\textit{-ve bal}) at the Juniperina detention centre. \textit{(Kylie Fitter)}

b) Nathan Hull’s letters from jail sometimes read like dispatches from substandard (-\textit{ve val}) school camp. \textit{(The fight to save Nathan)}

Institutional policies and practices connected with mental health are also negatively appreciated in some articles.

a) The disastrous (\textit{-ve val}) policy of deinstitutionalising huge numbers of mentally ill people. \textit{(In the mind’s eye)}

b) Solitary confinement of mentally ill inmates is archaic (\textit{-ve val}). \textit{(Jailed in body and mind)}

These sorts of appreciations act to construe the activities, policies and facilities of institutions as flawed in some way. Resources of APPRECIATION form part of a wider tendency for the authors of the texts to adopt a critical stance towards institutions which will be explored in greater depth in section 3.5 below.

\textbf{3.3.5 Positive evaluations of institutions}

In the data, we also find positive appreciations connected with institutions. These do not counter the negative appreciation as such, but are mainly found in one environment. This is in the realm of irrealis: that is, in events which are marked as \textit{not} having occurred.

In the texts in question, ‘irrealis’ positive appreciations co-occur with modals such as \textit{need} or \textit{should}, or with future tense or nominalised processes which indicate that these evaluations pertain to some future or hypothetical state. Lexical items realising this unfinished or hypothetical state of affairs are italicised and written in bold in the examples below.
a) Burton said a draft bill was in preparation and would include proposals for improved (val) information sharing and involvement of carers in the development of care plans for the mentally ill. Her spokeswoman said one aim was to make the revised act “more functional (val) and written in plain (compl) English”, which might extend the time needed to draft it.

b) “There are now good (val) indications that we are on the threshold of really understanding this. Once we understand one of the cellular or genetic pathways, we will very quickly be able to develop better (val) treatments.”

Thus, positive appreciations, for the most part, are not evaluating the resources, facilities, policies and so on which currently exist in the field of mental health, which are overwhelmingly evaluated in terms of –ve appreciation. Instead they are expressing an intention to do things differently (and better) in future.

3.3.6 Summing up APPRECIATION

APPRECIATION, as we have seen in section 3.3, is used to negatively evaluate psychotic illness and the kinds of encounters people have with it, either personally or through family members. Negative appreciations of illness and experience occur regularly and give an impression of psychotic illness as something difficult and troublesome with a strong affective impact. APPRECIATION is also used to negatively evaluate institutions, in particular the mental health system. These institutions are evaluated as entities (the disintegrating mental health system), but also through their policies and facilities (the disastrous policy of de-institutionalising large numbers of mentally ill people).

As readers, we are positioned through APPRECIATION as well as AFFECT to sympathise with those who have personal experience of psychotic illness on two fronts: firstly, in terms of the problems it causes them, and secondly, because of the inadequacy of the institutions which are supposed to be assisting them. This overall tendency of the texts to naturalise a sympathetic stance towards people who experience psychotic illness on one hand, and a critical position towards institutions and their representatives on the other, is also manifest in the way that resources of JUDGMENT are used. This will be discussed in section 3.4 and 3.5 below.
3.4 JUDGMENT

The attitudinal resources which contribute most comprehensively and clearly to the portrayals of institutions and individuals across the texts are the resources of JUDGMENT. These are crucial to placing people with a mental illness in the texts in the role of victim, both of their illness and of the institutions with whom they come into contact. Though the attitudinal resources of AFFECT and APPRECIATION discussed above support this portrayal, it is the resources of JUDGMENT which do the most work. Resources of JUDGMENT construe people with psychotic illness as helpless on one hand, and at risk of abuse by the social institutions which would be expected to care for them on the other. This is primarily done through frequently recurring judgments of –ve capacity of people with psychotic illness, and judgments of –ve propriety, -ve veracity and –ve tenacity directed at institutions and their representatives with regards to their dealings with mentally ill people. A synoptic overview of types of JUDGMENT directed at these two groups across the texts can be seen in table 3.2 below. In this count, both inscribed and invoked judgments have been included.9

<table>
<thead>
<tr>
<th>People with psychotic illness</th>
<th>Institutions and their representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ve</td>
<td>-ve</td>
</tr>
<tr>
<td>Social esteem</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>81</td>
</tr>
<tr>
<td>Normality</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>Tenacity</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Social sanction</td>
<td></td>
</tr>
<tr>
<td>Propriety</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Veracity</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3.2 Overview of JUDGMENT in the texts

3.4.1 Constructing the victim: judging the mentally ill

As the table above indicates, the most common types of JUDGMENT (and the most common types of ATTITUDE found overall in the texts) are judgments of –ve capacity

---

9 See Appendix 3 for a full listing of instances of JUDGMENT in the texts.
of people with psychotic illness. These judgments most frequently revolve, as touched on briefly in Chapter 2, around notions of control.

Judgments of –ve capacity are crucial to understanding the construction of psychotic illness because of the way they position those who have these illnesses as a-volitional victims of their own mental state and circumstances. The section below will examine some ways in which judgments of –ve capacity are realised in the texts; look at other types of judgments found in the data; and analyse the way that people with psychotic illness are portrayed through these resources.

3.4.2 Judgments of –ve capacity

As already mentioned, the majority of the judgments of mentally ill people revolve around a lack of control over both thoughts and behaviour, realised through judgments of –ve capacity that are connected to the way that physical, mental and social functioning are impaired as a result of the illness. People with psychotic illness are shown as both acting and thinking in ways over which they have little or no control.

Sometimes this is done through clear inscriptions predicating general lack of control, as in the following examples.

a) He died around the corner from the hospital where he was an involuntary (–ve cap) patient being treated for schizoaffective disorder. (Young and troubled)

b) psychosis… entails the kind of loss of control (–ve cap) that is antithetical to the production of great art because it is involuntary (–ve cap). (In the mind’s eye)

c) And while her brother struggled (–ve cap), Cynthia Shannon-Weickert studied. (Lighting a dark prison)

Cognitive and social tasks which people with psychotic illness cannot perform are also more specifically described.

a) The lost earnings from people unable to work (–ve cap) because of schizophrenia totalled $488 million in 2001. (Lighting a dark prison)
b) Those things that are part of becoming a mature adult, learning to navigate social situations, planning for our future, are the very things that people with schizophrenia cannot (−ve cap) do. *(Lighting a dark prison)*

There are also several examples where the illness is construed as an Agent in the clause: these are read as judgments of −ve capacity because they show people with psychotic illness being acted on by something outside their control.

a) Schizophrenia robbed Stephen Cusworth of his happiness and his friends. *(Young and troubled)*

b) My brother was sick during high school….It’s just so awful to see someone robbed of their life at such an early stage (−ve cap). *(Lighting a dark prison)*

c) Increasingly terrifying delusions consumed (−ve cap) first his mental and then his physical health. *(Trapped in a system near collapse)*

We also see a set of clear inscriptions dealing with a lack of control over thoughts as a feature of psychotic illness.

a) She lost the capacity (−ve cap) for rational thought. *(Kylie Fitter)*

b) His mind would not be stilled (−ve cap). *(The fight to save Nathan)*

c) He was unbalanced (−ve cap). *(Jailed in body and mind)*

These judgments of −ve capacity are generally construed as being connected to the illness rather than being stable features of the abilities and state of mind of the person. This is made clear in many of the texts through inscriptions of +ve normality as well as +ve capacity describing people either before the onset of the illness, in an interlude in the symptoms, or (far less frequently) after their recovery. The texts usually distinguish between talents and abilities that people have while well (+ve normality and +ve capacity), and the lack of control and odd behaviours which characterise their periods of illness (realised through judgments of −ve capacity and −ve normality, as well as AFFECT as described above).
Stephen Cusworth
A champion (+ve norm) sportsman

Vivienne Lucas
-A talented (+ve norm) professional dancer
-Made heroic (+ve ten) efforts to start again

Ann Cameron
-A gifted (+ve norm) photographer

Darius Tremtiaczy
-The professional (+ve norm) who in his previous life had treated the feet of homeless people in inner-city hostels

Will Elliott
-an award-winning (+ve norm) novelist

David Shannon
- Competing for the top grades in maths and science 10 (+ve norm)

Nathan Hull
-he’d been ranked among the brightest (+ve norm) pupils students
-A clipping from the paper shows Nathan at 13, holding up his certificate of distinction (+ve norm) for maths and science
-his very high intellectual abilities (+ve norm)

Kylie Fitter 11
-dux in year 11 (+ve norm)
-more discerning (+ve cap)
-has insight (+ve cap)

Table 3.3 Judgments of people with psychotic illness when well and unwell

<table>
<thead>
<tr>
<th>When well</th>
<th>When unwell</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Cusworth</td>
<td>A champion (+ve norm) sportsman</td>
</tr>
<tr>
<td>Vivienne Lucas</td>
<td>-A talented (+ve norm) professional dancer</td>
</tr>
<tr>
<td></td>
<td>-Made heroic (+ve ten) efforts to start again</td>
</tr>
<tr>
<td>Ann Cameron</td>
<td>-A gifted (+ve norm) photographer</td>
</tr>
<tr>
<td>Darius Tremtiaczy</td>
<td>-The professional (+ve norm) who in his previous life had treated the feet of homeless people in inner-city hostels</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Will Elliott</td>
<td>-an award-winning (+ve norm) novelist</td>
</tr>
<tr>
<td>David Shannon</td>
<td>- competing for the top grades in maths and science 10 (+ve norm)</td>
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<tr>
<td>Nathan Hull</td>
<td>-he’d been ranked among the brightest (+ve norm) pupils students</td>
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<td></td>
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</tr>
<tr>
<td>Kylie Fitter 11</td>
<td>-dux in year 11 (+ve norm)</td>
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<tr>
<td></td>
<td>-more discerning (+ve cap)</td>
</tr>
<tr>
<td></td>
<td>-has insight (+ve cap)</td>
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<td></td>
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</tr>
</tbody>
</table>

3.4.3 Summing up JUDGMENT and individuals

The patterns of JUDGMENT in the texts provide us with a particular construal of mental illness. It is represented as form of –ve capacity, and unusual behaviours associated with it are shown to be a result of this incapacity rather than of a conscious choice to behave strangely. This involuntary nature of the illness, along with its significant effects on the social, cognitive and intellectual functioning of the individual, invite our sympathy and naturalise a reading position where we feel

30 The full clause here is ‘no longer competing for the top grades in maths and science’ : I have taken it as a JUDGMENT of +ve norm because it indicates that he was doing so at one point.
31 Kylie Fitter’s case is slightly different as she recovers rather than deteriorating: thus the evaluations which describe her during her illness are superseded by positive judgments of normality and capacity. This differs from most of the others described as they are shown to lose rather than gain their special powers when illness overcomes them.
compassion towards the people who are unfortunate enough to be afflicted by it. This process is also enhanced by the strong tendency to judge institutions and their representatives negatively in terms of other JUDGMENT categories described below.

3.5 Constructing the victimiser: judging institutions

In stark contrast to the judgments of –ve capacity used above to evaluate people with a mental illness, institutions and their representatives are most frequently judged in the data in strongly moral terms. After judgments of –ve capacity of people with psychotic illnesses, the next most common type of judgment is –ve propriety directed at institutions, and these judgements are complemented by judgments of –ve tenacity and –ve veracity which describe institutions and their representatives behaving in an immoral fashion.

The institutions which are judged frequently in terms of –ve propriety have no mitigating offset against their non-proprietous acts. They are represented as being fully responsible and the main rhetorical thrust of five of the ten articles analysed is to criticise institutions including the courts, prisons and legal systems, the health system and mental health workers, and the government, and to show how they maltreat people with psychotic illness. In the following section, we will look at some of these judgments in more detail.

3.5.1 Propriety

Judgments of –ve propriety of institutions are inscribed and invoked, and directed at both institutions and the individuals representing them. We also often see them keeping company with judgments of –ve capacity, a union which strengthens their evaluative weight. The following example refers to Scott Simpson, who committed suicide in Goulburn Jail after more than two years in solitary confinement. During this time he was allowed out of his cell for no more than an hour a day.

The Human Rights and Equal Opportunities Commission has stated that the conditions of his imprisonment constituted cruel, inhumane and degrading (-ve prop) treatment under the UN’s International Covenant on Civil and Political Rights. (Jailed in body and mind)

12 Trapped in a system near collapse, Kylie Fitter, They were young and troubled…. The Fight to Save Nathan and Jailed Body and Mind
The strength of this judgment of *–ve propriety* is enhanced further when we look at the preceding paragraph, where Scott Simpson’s mother writes to the head of the prison about her concerns and receives the following response:

“I can advise that Scott’s placement at the HRMU [High Risk Management Unit] is considered to be beneficial (*+ve val*) to him and his future management” 13 *(Jailed in body and mind)*

The sheer incompatibility of this *+ve appreciation: value* of Simpson’s confinement with the fact of his suicide gives added depth to the inscription of *cruel, inhumane and degrading*.

We also see this interplay of *–ve capacity* and *–ve propriety* in the headline of another article.

They were young, troubled and dependent (*-ve cap*) on a health system that let them die (*-ve prop*)

These examples have been chosen because of the proximity of *–ve propriety* and *–ve capacity* to one another and the clearly inscribed nature of the JUDGMENT: however, across the texts as a corpus the same patternings are found: *-ve capacity* (of the mentally ill) juxtaposed with *–ve propriety* (of institutions), each compounding the effect of the other.

A second important way in which judgments of *–ve propriety* are inscribed in the texts is through the use of verbal processes with a clear evaluative component, for example, *admit* (which carries the semantic weight of an awareness of wrongdoing). Some examples of this type of evaluative verbal process can be found below.

a) Victorian Supreme Court Chief Justice Marilyn Warren has condemned (*-ve prop*) the lack of access to psychiatric care for women in Victoria’s prison system in two judgments in recent months. *(Jailed in body and mind)*

b) While cross-examining a psychiatrist called as an independent expert at the inquest into the death [of Ann Storm], Storm’s lawyer, Dr Ian Freckleton, elicited the admission (*-ve prop*) that

---

13 It is interesting to note that the head of Goulburn prison is the same Ron Woodham quoted above in the section on APPRECIATION, lamenting the fact that the prisons are “like a casualty ward, especially of a Friday night”.

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psychiatric hospitals “regularly discharged patients who are posing a significant risk to others or themselves.” *(Young and troubled)*

c) Prison staff “admitted *(−ve prop)* to the use of restraints, body belts and so forth.” *(Jailed in body and mind)*

In the examples above, however, it appears that the ideational content of the ‘admission’ or ‘condemnation’ plays just as important a role as the evaluative dimension of the verbal process. It is obvious that saying:

…psychiatric hospitals regularly discharged patients who are posing a significant risk to others or themselves,

still invokes a judgment of *(−ve propriety)*, and perhaps just as strongly or more so.

This hypothesis is supported when we look at some other invocations of *(−ve propriety)* in the data which seem to evaluate much more powerfully than the inscriptions we have looked at so far. The following invocation, which can be categorised as *affording JUDGMENT*, carries a much stronger evaluative weight than the news that some behaviour has been *criticised* or *condemned*. The doctor’s words invoke a very strong judgment of *(−ve propriety)* because of the impression of callousness they give, especially in view of what happens afterwards. In other words, we as readers are invited to criticise and condemn the doctor ourselves, rather than being told that somebody else has done so.

Maria-Hore-Lacy’s son, Ricky, was diagnosed with paranoid schizophrenia at 21 and killed himself, age 24, in 1995. The year before, as her son was discharged from hospital, a doctor told her: “One day your son is going to kill himself *(−ve prop)*.” *(Young and troubled)*

This example affords a strong judgment of *(−ve propriety)* because the doctor is shown failing to act in circumstances which are construed as warranting action. This idea of failure to act is another major way of negatively judging institutions, and is frequently played out through judgments of *(−ve tenacity)*.
3.5.2 Tenacity

Judgments of \textit{–ve tenacity} in the texts, as pointed out above, frequently (though not always) take the form of portraying failure to act: that is, sins of omission rather than commission.\footnote{See Chapter 4 for a more comprehensive discussion on the evaluative role of negative polarity in the articles.} On top of doing things they shouldn’t, institutions and their representatives are shown not to do things they should, as in the examples below.

a) When he was discharged by the hospital’s crisis and assessment team, his parent, Helen and Cyrus, were told that his problems… were behavioural, not psychotic. Unsurprisingly, they feel that \textit{the system let them and their son down} \textit{(–ve ten)}. \textit{(Young and troubled)}

b) Psychiatrists rarely \textit{work weekends}, which is one reason police and hospital emergency staff have learned to dread the long, spooked interlude between Friday evening and Monday morning when \textit{the damaged and the troubled are left to fend for themselves} \textit{(–ve ten)}. \textit{(The fight to save Nathan)}

c) It is \textit{politically expedient} \textit{(–ve ten)} to keep forensic patients incarcerated. \textit{(Kylie Fitter)}

Judgments of \textit{–ve tenacity} often show institutions and representatives as either not bothering at all to assist people with mental illness or their families (as in a) and b) above), or acting out of self interest (as in example c). Again, judgments of \textit{tenacity} imply a failure to do something which is within one’s powers: in this case, the negative moral evaluation is strengthened by the fact that the things which are not done are things which should be done. It is also strengthened by describing the consequences of inaction: one example is the case of Nathan Hull, where the fact that \textit{no-one would listen} renders tragedy \textit{inevitable}.

3.5.3 Veracity

Finally, institutions are also judged in terms of \textit{–ve veracity}, and there are a number of cases where institutional representatives are shown to deliberately misrepresent the truth. Some examples can be found below.

a) Privacy concerns are often an \textit{excuse} \textit{(–ve ver)} for poor clinical practice. \textit{(Trapped in a}
b) The whitewashed (-ve ver) version of events presented by lawyers for the hospitals. (Young and troubled)

Phrases such as technically correct and officially illegal also carry connotations of wilful misreading of the law in the first case and of failure to comply with the law in the second. In all of these cases, there is no doubt that these things are done intentionally by people in full control of their faculties. Even a statement which inscribes –ve capacity, such as the one below, is expanded later in the text into an explicit coding of –ve veracity.

Doctors and nurses sometimes misunderstood (-ve cap) privacy legislation, she said, and believed they couldn’t or shouldn’t talk to significant others.

Privacy’s often an excuse (-ve ver) for poor clinical practice. (Trapped in a system near collapse)

3.5.4 Summing up JUDGMENT and institutions

Judgments of unmitigated social sanction (particularly -ve propriety, though there are a number of instances of judgments of –ve veracity) and social esteem (particularly –ve tenacity) are used in the majority of the texts to evaluate institutions. In other words, as well as encouraging us to sympathise with those who have mental illness, these articles also encourage us, as readers, to take a dim view of institutional morality.

3.6 Summing up ATTITUDE

Throughout the first half of this chapter, we have looked in some detail at the ways in which ATTITUDE has been used in the texts as a device for characterising different groups of people and further, for encouraging readers to take a particular stance with regards to these groups.

Resources of AFFECT and APPRECIATION position the reader to sympathise with the mentally ill and their families through describing the affectual impact of illness and the difficulties which is causes. The overwhelming construal of people with mental illness in terms of –ve capacity emphasises both the involuntary nature of the illness
and the extent of its effects on individual functioning, which also positions the reader to be sympathetic rather than condemn the acts of people who are psychotic.

Institutions and their representatives, on the other hand, are characterised as immoral, lazy, and dishonest through choice, through judgments of –ve veracity and tenacity. These sorts of judgments unequivocally invite us, as readers, to condemn the activities of institutions and the behaviour of their representatives: this invitation to condemn is supported by the negative appreciations of institutional policies and facilities, and on a more general level of institutions themselves.

The construal of mentally ill people as victims, then, takes place on two fronts: judging them to be helpless and with little or no control over their fate and actions on one hand, and showing them to be at the mercy of institutions with inadequate resources and immoral staff on the other.

As discussed in chapter 1, the construal of people with psychotic illness as victims is particularly interesting when we consider that other discourse analysts have been mostly concerned with a tendency to stereotype psychotic people as violent in newspaper discourse (Allen and Nairn 1997, Blood et al 2002, Pirkis et al 2002, Blood and Holland 2004, Nairn et al 2006.)

The consistency of the portrayals of people with psychotic illness as victims seems to be acting as a refutation of this stereotype. In order to examine this in more detail, I will look below at the logogenesis of two texts dealing with violent acts committed by people with psychotic illness, and the ways in which the texts position us to see them as victims rather than criminals.

3.7 Logogenesis of two articles about psychosis and violence

In the section above, we have looked at some common attitudinal syndromes in the data, and discussed some of the ways in which these contribute to a particular construal of psychotic illness and those who have it, as well as leading readers to condemn the behaviour of institutions.

The construal of moral responsibility and the tendency to represent people with psychotic illness as victims is illustrated by the two articles in the corpus which deal
in detail with people who have committed violent acts while in the throes of psychotic illness. In one of these articles, a young man stabs two people in a hospital in a violent confrontation, as a culmination of years of intermittent psychosis. In the other, a fifteen year old girl, briefly sharing the psychotic state of her father and brother (who both have diagnosed schizophrenia), helps them to kill her mother.

The first article is entitled *The fight to save Nathan*, and the Kicker reads:

Dale Hull spent years trying to get treatment for her mentally ill son. But no one would listen and a tragedy was inevitable.

The article about Kylie Fitter, opens with this line:

At 15, Kylie killed her mother. The demons are gone, but she’s still a prisoner of her past.\(^\text{15}\)

These articles are notable in that they display all the most salient patternings of ATTITUDE identified across the corpus: judgments of \(-ve\) capacity for people with psychotic illness against judgments of \(-ve\) propriety, \(-ve\) tenacity and \(-ve\) veracity of institutions and their representatives; negative appreciations of illness and experience set against negative appreciations of institutional facilities and policies; recurrent attributions of \(-ve\) happiness and \(-ve\) security to those with psychotic illness and their families.

Both articles are media expositions (this was the most common genre in the data, constituting five of the ten articles analysed), and both state their position in a synoptic lead segment. The kicker of *The fight to save Nathan* talks about *inevitable tragedy* as though it is something which befalls Nathan himself; it is not until much later that we learn that the tragedy could also refer to violent acts committed by Nathan- that is, someone else’s tragedy, caused by him. Kylie’s violent act, on the other hand, is explicitly acknowledged in the headline of the article.

Both the articles use similar attitudinal resources to encourage us to think kindly of the psychotically ill protagonists. Kylie is both positively judged and appreciated in the opening stage of the article as the following passage shows. Her physical charms

\(^{15}\) As mentioned in Chapter 1, in the Factiva archive this article has no headline as such and the first element is this, which could perhaps be better described as a Kicker.
(described in terms of APPRECIATION) and upstanding moral nature (described in terms of JUDGMENT) are inscribed by the author at the outset.

She is so gentle and polite (⁺ve prop) as he offers tea and biscuits in a child-like (-ve cap) voice that it defies imagination Kylie Fitter helped kill her mother in a crime of biblical proportions.

Seated in the living room of an inner city terrace, the willowy (⁺ve app: qual), 20 year old spun-sugar (⁺ve app: qual) blonde, sweetness itself (⁺ve prop), is out on weekend leave from jail. (Kylie Fitter)

Similarly, Nathan is described in the opening phase of The fight to save Nathan as ‘amiable’ and ‘troubled’: the first a judgment of ⁺ve propriety, the second a double coding of –ve security and –ve normality which occurs relatively frequently as an descriptor of people with psychotic illness. These opening Judgments position the compliant reader to think well of them, which is important in light of the graphic descriptions of their violent acts that come later.

Both Nathan and Kylie are also described in terms of their affective state: Kylie is characterised by -ve happiness (cried non-stop for weeks, devastated, very sad) and some –ve satisfaction, as in the example below.

She has passed through many phases, fury (-ve sat) at her father for having tricked her, anger (-ve sat) at the mother she idolised for having left her so vulnerable. (Kylie Fitter)

She is also shown to have strong feelings of ⁺ve happiness: affection for her parents.

Her parents were her world. She loved (⁺ve happ: affection) them both. (Kylie Fitter)

Through AFFECT we are positioned to see Kylie as a feeling and dutiful daughter: the gulf between this description and the detailed account of her participation in the murder is made comprehensible through the claims of –ve capacity and irrationality due to illness: she is portrayed as behaving in an unusual fashion due to circumstances beyond her control.

Nathan, on the other hand, is described in terms of –ve satisfaction, primarily anger. This is shown as being partly a result of his illness, as in the examples below.
a) He **complained** (-ve sat) that the teachers were dumb

b) He became irrationally **angry** (-ve sat) about a bet he’d failed to place on a horse and **stormed** (-ve sat) out of the house after shouting at his mother.

However, Nathan’s **–ve satisfaction** is also characterised as a legitimate response to mistreatment and neglect from mental health professionals.

He recalled **trying to keep calm** but **feeling a building sense of anger**.(-ve sat) He kept thinking of all the doctors, psychiatrists and nurses who had **failed him** (-ve ten) over the years, insisting there was nothing wrong with him. An idea popped into his head to stage a siege as a **protest** (-ve sat).

Contextualising **–ve satisfaction** like this (especially anger) provides us with a rationale for Nathan’s acts, and makes him an altogether less threatening character, which makes it easier to think of him as a victim of the system: the judgment of **–ve tenacity** directed against the different members of the health system provides a reason for his actions and works to direct the blame away from him.

Both the articles include detailed descriptions of the violent crimes and judgments of **–ve propriety** of Kylie and Nathan, both inscribed and invoked. Nathan is described as the ‘offender’, ‘guilty of assault’, ‘pleading guilty to charges of malicious wounding’, and as **grabbing, stabbing and attacking his victims**.

Kylie Fitter’s crimes are described in similarly forceful terms, flagging judgments of **–ve propriety** through infused lexis and through the claim of intentionality from the judge.

Kylie Fitter, the NSW Supreme Court found, had taken part in the “**concerted attack on the quarry with no less an intent than to kill.**”(-ve prop) Justice Graham Barr said she had **dragged** (-ve prop) her mother and **kicked** (-ve prop) her, **punched** (-ve prop) her and **held her legs** (-ve props the **attack** (-ve prop) was carried out. (-ve prop)

However, true responsibility is lifted from both Kylie and Nathan through inscriptions of **–ve capacity**. In Kylie’s case, we are given the **verdict not guilty by reason of mental illness**, and judgments of **–ve capacity** abound to support this and convince
the reader of her ultimate innocence. Kylie is described, at the time of her mother’s murder, as vulnerable, fragile, a victim of an upbringing that made her unfit for the world. She is considered unable to make her own bed, and has no idea [how to cut a carrot-]. All of these are inscriptions of –ve capacity. In her present situation (at the time of writing the article she is imprisoned) she is described as a political prisoner (-ve prop) and a victim of political expediency. (-ve ten) By portraying her in terms of -ve capacity, and then judging the state government in terms of –ve propriety and -ve tenacity, we are provided with a new angle on guilt and blame: she is not a perpetrator but a victim, who is being unjustly incarcerated.

In Nathan’s case, there is a similar process of transferring blame. Responsibility for his violent act is explicitly attributed to the psychiatrist who had previously assessed him and found that he did not require treatment. As in the case of Kylie, Nathan is evaluated in terms of –ve capacity and this lays the way for claims of –ve propriety against institutional representatives.

But Judge Norris notes that Nathan had a serious mental illness (-ve cap), which was left untreated largely because of Weppner’s surprising (-ve imp) and “somewhat less that sympathetic” (-ve prop) assessment of him nine months earlier. Had he received treatment, says the judge, the stabbing of Gary Lyons and Jason Schurr might not have occurred.

In both articles, very intentional construals of violent acts seem to be set up in order for the author to explicitly refute them. The texts unfold using APPRAISAL resources to construct an actus rea but not a mens rea\textsuperscript{16}: the initial judgments of –ve propriety against the culprits are refuted through judgments of –ve capacity, and culminate in a new configuration of guilt and blame where institutions are shown to be ultimately responsible: for the crime itself in one case, and the victimisation of the culprit in the other.

\textsuperscript{16} Literally in Latin, "guilty mind." The intent required to commit the crime. It is a prerequisite to conviction for a crime involving a moral wrong, but it is not a prerequisite to conviction for an act that is a crime only because a statute designates it to be a crime, eg, overtime parking. 

[brandonlclark.com/glossary.html Actus rea refers to the ‘guilty act’ - that is, the actual doing rather than the intent.]
Table 3.6 below provides an overview of the configurations of evaluative resources which have been identified in this section. The usual conventions apply - invocations are underlined.

<table>
<thead>
<tr>
<th>Evaluative phase</th>
<th>The fight to save Nathan</th>
<th>Kylie Fitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ve propriety of mentally ill protagonists in opening</td>
<td>-amiable</td>
<td>-gentle</td>
</tr>
<tr>
<td>-polite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>affective characterisation of mentally ill protagonists</td>
<td>-Cried non-stop for weeks</td>
<td>-complained</td>
</tr>
<tr>
<td>-devastated</td>
<td>-protested</td>
<td></td>
</tr>
<tr>
<td>-very sad</td>
<td>-felt a growing sense of anger</td>
<td></td>
</tr>
<tr>
<td>-loved her parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-ve propriety of mentally ill protagonists</td>
<td>- Concerted attack on the quarry with no less an intent than to kill</td>
<td>- stabbed [Mr Schurr]</td>
</tr>
<tr>
<td>- dragged her mother, kicked her, punched her and held her legs as the attack was carried out</td>
<td>- his crimes</td>
<td></td>
</tr>
<tr>
<td>- the offender</td>
<td>- agreed to plead guilty to charges of malicious wounding and wounding with intent</td>
<td></td>
</tr>
<tr>
<td>-ve capacity of mentally ill protagonists</td>
<td>-vulnerable</td>
<td>-had a serious mental illness which was left untreated...</td>
</tr>
<tr>
<td>-fragile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-a victim of an upbringing that made her unfit for the world</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-unable to make her own bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-had no idea [how to cut a carrot]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-not guilty by reason of mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer of blame to institutions or institutional representatives</td>
<td>-a political prisoner (-ve prop)</td>
<td>….largely because of Weppner’s surprising (-ve impact) and “somewhat less than sympathetic” (-ve prop) assessment of him nine months earlier.”</td>
</tr>
<tr>
<td>-a victim of political expediency (-ve ten)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had he received treatment, says the judge, the stabbing of Gary Lyons and Jason Scherr might not have occurred.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3.4 Evaluative phases and blame in Kylie Fitter and The fight to save Nathan

3.7 Conclusion

The analysis of the articles above demonstrates the way that the syndromes of ATTITUDE found across the data play out in particular texts to construe people with psychotic illness as victims, even when they have committed violent acts against others. This construal occurs consistently across the texts, though it is most remarkable in the texts examined above because the crimes of Kylie Fitter and Nathan
Hull make it more difficult to portray them as victims. This seems to indicate that representing the mentally ill in this way is a consistent choice made by a variety of authors across a variety of genres.

The construal of people with psychotic illness as victims is not consistent with frequent findings by discourse analysts (Blood and Holland 2004, Nairn et al 2006) that people with schizophrenia in particular are disproportionately represented as violent criminals, and that this inevitably leads to stigmatisation of mental illness in society. This is not only the finding of discourse analysts but also a popular refrain in the mental health world, as evidenced by the existence of websites such as SANE’s ‘stigma watch’ website,\(^\text{17}\) where people can report instances of stigmatising language which they find in newspapers and other media. This website has been set up to police negative stereotyping of the mentally ill, and has led on a number of occasions to newspapers publishing apologies for the way they have dealt with mental health issues.

The incompatibility between the portrayal of the psychotically ill as victims found in the feature article data, and this common stereotype of the dangerous psychotic, raises the possibility that the authors of these articles are choosing, either consciously or unconsciously, to undermine this stereotype through use of particular attitudinal resources. In these articles, people with psychotic illness are construed as being at risk, rather than constituting a risk to society. The types of ATTITUDE found in the data, then, and the way that people with psychotic illness are characterised, may be part of an effort to provide an alternative image to that of the ‘violent schizophrenic’.

However, within this data, it is also possible to use other subcategories of the APPRAISAL framework to test the theory that language here is being used as a way of urging change. The next chapter will look at the way that resources of ENGAGEMENT are deployed in the data as further evidence that the feature articles in the corpus are engaging with wider discourses of mental health and taking part in demands for better services and policies and new attitudes.

\(^{17}\) [http://www.sane.org/stigmawatch/stigmawatch/stigmawatch.html](http://www.sane.org/stigmawatch/stigmawatch/stigmawatch.html)
Chapter 4 Challenging perceptions and demanding change

This chapter is concerned with the various voices which are referenced in the texts, and the evaluative dimension of this play of voices. Here we look at the way that ENGAGEMENT resources of disclaiming (denial and countering) and projection (attribution) are used in the texts, as well as modulations of obligation which fall into the broader ENGAGEMENT category of entertain.

Section 4.1 examines some of the ways in which the articles challenge the treatment that mentally ill people receive and refute ideas about psychotic illness through resources of dialogic contraction. In the previous chapter we saw how different values were realised lexically in the texts: we now look at some of the ways in which grammatical resources invoke criticism of institutions, discussing conjunction and negation as powerful sources of evaluation.

As Martin (2004:341) points out:

- Texts have texture. They map logic onto rhetoric. In so doing they challenge discourse analysts to understand ideational meaning in relation to interpersonal meaning in relation to textual meaning.
- And if we are social linguists to understand this triangulation in relation to the social system it enacts.

Section 4.1, then, is primarily concerned with some of these mappings, and the way that they relate to the social system.

Section 4.2 builds on this by examining resources of attribution, and looking at the different types of knowledge (in Bernstein’s terms) projected by ‘expert’ and ‘lay’ sources. This segment is concerned with the process of transformation in the texts of horizontal discourse about individual experience into a more hierachical, generalised discourse about the way things work in the mental health world, and the ways that this transformation enables demands for change.
4.1 Dialogic contraction

The resources of dialogic contraction which are particularly salient in the data with regards to the two groups we are concerned with (institutions on one side, families and people with psychotic illness on the other) are those of disclaim: counter and disclaim: deny. These resources are used in quite different ways when talking about these two groups. In this section I will discuss the way that resources of dialogic contraction are deployed in the media expositions in the data to criticise institutions and to align the reader with the writer in this criticism.

4.1.1 Disclaim: counter and institutions

Five of the ten articles analysed are media expositions whose main rhetorical purpose is criticising the various social institutions with which mentally ill people come into contact: the legal and prison system, and the medical (mental health) system. The government is also implicated in a number of the articles.

Disclaim:counter is one of the primary ways in which negative judgments of institutions are invoked in these texts. This section looks at the evaluative weight of countering resources in the data and considers the reasons for this evaluative weight.

Stubbs (2001:438) states that:

…[a]mongst the many dualisms that plague linguistics is the question of how much meaning is expressed in the text as opposed to how much is in the mind of the hearer or reader. How much do we get out of a text and how much do we read into it?

He goes on to note that:

[i]n order to understand language in context we actively make sense of it, by using our knowledge of what is normal and what is expected. (Stubbs, 2001:439)

This is particularly relevant when looking at the use of countering resources as a way of aligning reader and writer. Bednarek (2006b) discusses the use of contrast in British newspaper discourse with reference to the distribution and discourse functions of but.
As already discussed in chapter 2, the type of countering items we are most interested in here are those indicating ‘denial of expectation.’

Coordinating conjunctions such as but, Bednarek points out, ‘can be used to evaluate very subtly and inexplicitly.’ (2006b:2) She quotes Quirk (1985:935) in saying that the idea of unexpectedness expressed by but ‘depends on our presuppositions and our experience of the world.’ Thus, a statement such as She’s Russian, but she doesn’t drink, only makes sense if the hearer is aware of the stereotype that Russians are heavy drinkers. In fact the statement itself is enough to invoke this stereotype.

In the feature article data on mental illness, but and other resources of countering such as however, despite, although, nevertheless, yet, still, while, rather than, instead of, are used frequently, and to powerful evaluative effect. In the world of these texts, many of the presuppositions which are contradicted through use of resources of dialogic contraction are connected to our notions about institutional reliability and responsibility, and the rights of individuals who come into contact with these institutions. Using the existence of the disclaiming resources of heteroglossia as evidence, I will discuss some of the ways in which meaning ‘in the text’ makes use of meaning ‘in the mind of the reader,’ (in the words of Stubbs quoted above) to generate evaluation.

Below are some examples of resources of disclaim: counter invoking negative judgments of the way institutions do things.\(^\text{18}\) (Countering resources are in bold italicised type.) In the majority of these cases, the countering term is what Bednarek (2006b:7) calls ‘denial of expectation’ but, in which the second part of a proposition refutes an inference which the reader is likely to have drawn from a previous proposition. In the examples below, the likely inference which is being refuted is included in brackets after the countering item. The refuting proposition and the invoked judgment are included in the bottom panel.

\(^{18}\) A full list of these usages can be found in Appendix 5.
Figure 4.1 Examples of disclaim: counter invoking –ve judgments of propriety

It may be helpful here to think of the different institutions as types of schema. Tannen (1993: 60) defines schema in the following way:

…we use the term “knowledge schema” to refer to participants’ expectations about people, objects, events and settings in the world, as distinguished from alignments being negotiated in a particular interaction.

The use of resources of countering in the data makes use of this schematic understanding of the role and responsibility of institutions to align the reader with the writer in condemning these institutions. Resources of countering, as Martin and White (2005:21) point out:
...project onto the addressee particular beliefs or expectations, or...particular axiological paradigms... Frequently, such counters are aligning rather than disaligning in that they construe the writer as sharing this axiological paradigm with the reader. The writer is presented as just as ‘surprised’ by this exceptional case as it is assumed the reader will be.

The ‘axiological paradigm’ which is being countered in the examples described above is the expectation that institutions and their representatives will behave, collectively, in ways which have the best interests of individuals in the community at heart. The evaluative dimension of the countering, in this case, stems from the fact that our expectations of these institutions are not being met: the dimension of alignment from the fact that reader and writer are similarly shocked by this.

4.1.2 Disclaim: deny and institutions

The critique of institutions played out through countering resources described in section 4.1.1 above is also supported and played out in a similar fashion through the second resource disclaim: deny. Negative polarity clauses in the data negate verbal or material processes: that is, they describe things which are not done or said, rather than refuting ideas. Analysed as a corpus, the overwhelming pattern in the data is for resources of disclaim: deny to be used to criticise the institutions represented in the articles, using the semantic patterns represented below. The inference which can be drawn from these negations is included in brackets after the examples.

He/she/they didn’t (BUT should have): for example;

a) Jason committed suicide in 1993 after being discharged from a psychiatric hospital without either of his parents being informed. (They should have been.) *(Young and troubled)*

b) Teresa said her questions about her son’s medication were not answered. (They should have been)

*(Trapped in a system near collapse)*

c) It appears no one offered him assistance. (They should have). *(The fight to save Nathan)*

There is also a similar pattern using the present tense: something doesn’t happen, or exist, (BUT should). This distinction between past and present corresponds to a distinction between one-off and recurring experience which will be discussed further in the second
half of this chapter. Examples of this patterning can be seen below: in all these cases, there is an inference that the thing which has not been done should be.

a) "The cells contain very little - a bed with a suicide-proof mattress -- and no personal property of any kind is allowed." (Jailed in body and mind)

b) The court does not impose a sentence. (Kylie Fitter)

c) Applicants for conditional release are not advised why they are knocked back. (Kylie Fitter)

Martin (1999), in analysing the autobiographical recount found at the end of Mandela’s *Long Walk to Freedom*, notes a strong pattern of negative clauses, which are ‘explicitly concerned with denying something somebody might have thought (Martin, 1999: 42).’ The resources of dialogic contraction, in the Mandela text, are used ‘to take account of reader’s beliefs and expectations and realign them with his own (Martin 1999:42).’

However, the patterns of denial in the feature articles on psychotic illness have a different effect. Resources of disclaim: deny in the data invoke a perception of the way things should be done, similar to the effect of resources of countering. Rather than ‘denying alternative positions (Martin 2004: 332)’ as these resources do in some types of texts, negative-polarity statements stand in opposition to our expectations of certain types of action and behaviour. Again, this makes use of our notions of natural justice and institutional responsibility to invoke evaluation.

Thus criticisms of the justice system are invoked through an interplay of our world knowledge, which provides us with a set of ideas and expectations about how the system should and does operate, and the ideational facts of what actually happens. The fact that forensic patients are held without imposing a sentence, for example, has to be judged against the common understanding that indefinite detention is an abuse of human rights. The fact that these patients can be refused release without being given any information as to why they continue to be detained also offends our notion of justice.

Overall the resources of dialogic contraction play a fundamental rhetorical role in the media expositions. The failure of institutions and professionals to behave in certain ways or do certain things, framed in terms of negative polarity (disclaim: deny) or refuted inferences of what should have been done (disclaim: counter) is a significant means of encouraging the reader to criticise institutions.
With regards to individuals with psychotic illness and their families, however, these resources are used quite differently.

4.1.3 Dialogic contraction: mental illness, families and individuals

Within both the media expositions and the other texts, **countering** resources are seldom used alone, but in the overwhelming majority of cases occur in tandem with **disclaim: deny**. However, in the non-expositional texts, rather than being used to invoke modulations of obligation and negative judgments as seen above, the resources of **dialogic contraction** are used to disabuse readers of errant notions they might have about people with psychotic illness in general; about the nature of psychotic illness itself; or about specific individuals with a psychotic illness described in the texts.

This is more consistent with the usage noted by Martin (1999:45), where Mandela uses the resources of **dialogic contraction** to both refute and replace mistaken ideas that the reader might hold, as in the example below.

> For to be free is *not* merely to cast off one’s chains, **but** to live in a way that respects and enhances the freedom of others.

They are also, in some texts, used to describe the helplessness of families in the face of psychotic illness and people with psychotic illness themselves. In these instances they relate to the judgment category of **–ve capacity**.

4.1.3.1 **Disclaim: counter and the mentally ill**

We will first deal with resources of **countering** used to replace ideas which we might hold about psychotic illness and people who have it. We see this usage in a number of the non-expositional texts. *In the mind’s eye*, for example, shows a pattern of using resources of **countering** to combat the idea that people with psychotic illness are innately creative, while *Fears of a clown* uses **countering** to address and explicitly replace ideas which we might have about psychotic illness. The two examples below come from *In the mind’s eye*. The first refutes an inference, while the second directly **counters** an idea.
Figure 4.2 Disclaim: counter in *In the mind’s eye*.

We also find **countering** used both in the expositions and the other genres to provide us with an alternative assessment of the individual characters of mentally ill people. Countering resources refute what we may think about them either based on our world knowledge, or on the information we are given in the texts about them.

The first example below refers to Kylie Fitter’s father, and appears to be acting to **counter** the reader’s expectation that somebody who is has psychosis can also be assumed to be unintelligent. In the second, we are given an alternative portrayal of Kylie Fitter through the use of **countering** resources. This example acts to **counter** our assumption that because she is in prison, she deserves to be there, and replaces it with the attributed claim that she is a ‘political prisoner’ - the implication being that she is not in jail for moral wrongdoing, but because of the self interest of the government. In c) we see a claim which is almost the reverse of that in a) - the likely inference that is being
countered is that Nathan Hull’s intelligence is a sign of +ve normality: instead, he is assessed in terms of –ve capacity.

Figure 4.3 Countering ideas about individuals with psychosis

In summary, we see resources of countering in the examples above being used to address and replace our mistaken ideas about people with psychotic illness. However, this pattern is much less salient than that of disclaim: deny, which is also used as a way of refuting/ replacing errant ideas. As can be seen in example in the left hand column above, the replacement of reader ideas in fact takes the form of a denial.

4.1.3.2 Disclaim: deny and the mentally ill

Disclaim: deny is often used to explicitly ‘refute something which someone might think,’ about mental illness or those who have it. A good example is the fact that there are 5 occurrences of not guilty by reason of mental illness in the data. In fact, every violent act committed by a person with psychosis is qualified with this phrase, reminding the reader that in the axiological world construed in the texts, guilt and responsibility are not
the same thing. In the case of Kylie Fitter, this claim of innocence is also supported by numerous claims that she has fully recovered from her psychosis: that she is no serious danger, has no symptoms of mental illness, and has had no recurrence of the one-off psychotic episode she experienced.

Aside from this, the media expositions, as we have already seen, are primarily concerned with evaluating institutions through the use of disclaiming resources. The other texts show more varied usage of these resources, but overall there is a pattern involving refutation of ideas about psychotic illness and people who have it.

In Fears of a clown, for example, the early part of the text is saturated with this sort of denial, explicitly refuting the idea of schizophrenia as a split personality. The interweaving of denial and countering is particularly pronounced. Refutation of particular ideas builds up prosodically across the first passage, to be replaced finally at the end of the passage with the proposition introduced by the countering lexeme instead. Countering is bold and underlined, denial is bold and italicised in the extract below.

"I've had people say that the face paint is meant to be representative of the illness,” Elliott acknowledges. “But that's not at all the way I see it At the time I wrote the book, I was thinking more about alcohol, which does have a transforming effect on people. But no, this is nothing like the experience of schizophrenia. You don't change personality if you contract the illness, you don't suddenly turn into someone else- instead, it's basically the world that changes around you ... This is just a piece of fantasy." (Fears of a clown)

In the mind’s eye shows a similar patterning, where the notion that people with psychotic illnesses are ‘naturally creative’ is refuted at regular intervals throughout the text. Two examples can be found below.

a) When we say that great artists are touched by madness we mean neurosis not psychosis. (In the mind’s eye)

b) it would seem that not much about the illness is compatible with creative excellence. (In the mind’s eye)

In Teens at Risk the resources of denial are concerned with playing down the connection between cannabis and psychosis.
a) Some use cannabis for a while then dump it as they take on the responsibilities of adulthood, suffering no serious effects. (Teens at most risk from dope)

b) 90 per cent of users experience few or no long term problems. (Teens at most risk from dope)

c) The incidence of psychotic symptoms is two to three times greater amongst those who have used the drug, yet, in this case, cannabis has not been proven as a major causal factor. (Teens at most risk from dope)

Finally, with regards to the family of people with psychotic illnesses, we see resources of denial used to construe both incomprehension and inability to help their ‘loved ones.’ In this usage, they form part of the patterning of judgments of –ve capacity in the texts. A pattern of negation of mental processes related to understanding, interwoven with expressions of inability to help, is particularly pronounced in the autobiographical narrative in the corpus. Here the author, Georgia Blain, narrates her family’s experience of her brother’s schizophrenia.

The experience made me realise it wasn’t possible just to step in and save him
I didn’t know how to understand his madness
I didn’t have a language for what was happening to him
It didn’t occur to me that he would find my depiction of the state he was in distressing
I didn’t understand.
My mother didn’t know if he was trying to get to the hospital.
Just as I had not known how to deal with his existence, there was no easy way to understand the space now occupied by his absence
I saw my mother as she had been all those years, chasing after him.. never quite catching him, never able to bring him back
I had no idea what you went through, friends would comment

4.1.4 Dialogic contraction: discussion

In section 4.1, we have looked at the different ways dialogic contraction is used in the corpus both with regards to genre and to the categories of people represented in the texts.

Overall, resources of dialogic contraction align the reader with the writer: in the expositional texts, we are positioned to condemn the activities of institutions and representatives, while in the non-expositional texts we are invited to share the greater knowledge of the speaker/writer.
In the previous chapter, we looked at ways in which the reader is encouraged to align with people with psychotic illness and their families, and in opposition to institutions and their representatives through resources of attitude. The findings of this chapter with regards to the usage of dialogic contraction, add a further dimension to this alignment process. Resources of disclaim: counter and disclaim: deny are used both to generate a critical view of institutions and to correct the perceived lack of information about psychotic illness in the community. As readers, we are affiliated with a moral community which condemns the behaviour of institutions and an intellectual community which values accurate information.

In the section below, we turn to the ways in which the resources of dialogic expansion are used to represent experience and drive social change.

4.2 Dialogic expansion: attribute and entertain

So far we have been concerned with the values realised both implicitly and explicitly in the texts. In this section we look at how those values are voiced: that is, ‘who gets to say what and how’ (Hood: 2004: 189), and how this constructs both identity and rhetorical effect in the texts. This section looks at projection of both speech and thought in the corpus and is concerned with the different types of knowledge projected by different categories of participants, and the ways in which sources are shown to interact and represent this knowledge in order to demand change.

In talking about types of knowledge I draw on Bernstein’s (1999, 2000) notions of ‘horizontal’ and ‘hierarchical’ discourse. Hood (2004: 203) describes horizontal discourse as representing a ‘way of knowing which privileges the subjective over the objective, the knower over knowledge.’ Hierarchical discourse, on the other hand, reflects ‘a process of integration, generalisation or theorisation,’ which “privileges the ‘objective’ stance and ‘knowledge’ over the ‘knower’ (Hood, 2004:203).”

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19 While hierarchical discourse forms part of a wider category of ‘vertical’ discourse, this has already been discussed in Chapter 2 and here I will not make reference to this wider category.
As Maton (2000:203) points out:

These modes represent ever-present and competing principles of legitimation; their empirical realisations are thus a function of the context. The degree to which any features of these modes become salient within a particular language of legitimation is dependent upon the structuring conditions of power and control inhering within empirical contexts; these enabling and evoking conditions set the parameters within which these features may be voiced.

These issues of power come to the fore when we are looking at who is able to represent what kind of knowledge in the text, as it appears that the types of discourse used are constrained by the category to which the speaker belongs. This will be discussed further in section 4.2 below.

I will also look at the category of entertain as it is used by the different evaluative sources and discuss the ways in which types of knowledge can be used to generate modulations of obligation with regards to social and institutional change.

This section is concerned primarily with the different categories of sources and the rhetorical weight of the way in which their interactions are construed: in the majority of the texts, most evaluations are attributed to sources other than the author. As already outlined in Chapter 2, there are three different sources of evaluation that appear in the corpus. These are:

1. Family member of person with a mental illness as source
2. Person with a mental illness as source
3. Experts / spokespeople / documents as source

‘Expert’ sources refer to anybody who is involved in the field of mental health in a professional capacity, as well as entities like tribunals and the semiotic artefacts created by expert sources such as reports, recommendations and submissions which are treated as projecting sources. The authors of the texts play one of these roles (primarily an expert role, though there is also one instance where the author is a family member). In general however the texts are constructed from a highly heteroglossic pastiche of voices other than the authors’. It must be pointed out that ‘expert’ voices can either criticise or defend the actions of institutions and their representatives, although they primarily criticise.
Having identified these categories, we now consider the ways in which particular sources map onto particular knowledge types, and the role that these mappings play in processes of social change.

**4.2.1 Attributing individual knowledge**

As projecting sources, families and people with a mental illness are almost entirely restricted to talking about their personal experience: that is, they project ‘horizontal discourse.’ The evaluative weight of their talk is often framed in terms of individual affectual impact and refers to what Hood (pace Bernstein) calls ‘contextually specific and non-theorising ways of knowing’ which derive their legitimacy from ‘the privileged and unique insight’ of the knower (Hood, 2004:203). The experiences they describe are generally specific interactions with specific individuals or groups, in a particular context.

Family members and ‘loved ones’ report their thoughts and feelings associated with the situation they find themselves in. This is a consistent pattern across the data: examples a)-c) below are some instances.

a) “I wondered what the triggers might be. The first time she helped me in the kitchen I wondered what she felt about knives. I asked her to cut a carrot and she had no idea. Her mother had done everything for her,” Mrs Johnston said. *(Kylie Fitter)*

b) “It was the first public tragedy after Ann died,” Storm recalls. “And I was crying for the parents. But we wanted out children’s deaths to be known and counted too.” *(Young and troubled)*

c) She adds, “You know, a year ago I couldn’t have imagined any of this happening to me. Catching the train at 7 in the morning to go and stand outside some prison in the sleet and hail, waiting to see my son… It’s like some nightmare that you think you’ll wake up from.” *(The fight to save Nathan)*

They also report interactions with their loved ones and institutional representatives. This often results in recursive serial projection when they attribute words and ideas to their interlocutors. *Attributions* within *attributions* are underlined in the extracts below. In example a), Teresa Tremtiaiczy attributes both thoughts and words to the local mental health team, while Caroline Storm reports her own words when talking to the staff at the psychiatric unit from which her daughter had been discharged.
a) “They thought I was a pushy mother,” said Polish-born Teresa. “They said, how old is he? Well, he’s old enough to look after himself.” (Trapped in a system near collapse)

b) “I said, ‘you can’t do that,’” she recalls. “but they don’t listen to carers.” (Young and troubled)

People with psychotic illness show a similar pattern of attribution: they are shown to project descriptions of personal experiences and interactions, thoughts and feelings: in other words, subjective experience.

a) He said, “I was protesting against the fact that no-one cared.” (The fight to save Nathan)

b) Elliott says he came to writing as a sort of recovery mechanism after being diagnosed with schizophrenia at the age of 19. (Fears of a clown)

c) “Years ago I loved [cannabis] it,” says one young man who has recovered from psychosis. “But now I just think back to my symptoms and how bad it was and the problems it caused my life, and I just really think it’s not worth it.” (Teens at most risk from dope)

The ‘horizontal’ nature of this discourse is generally indicated by deixis (‘I’), and tense (past), and the absence of modulations of obligation and generalisation. People with mental illness and those close to them describe and comment on their own experience, but don’t pronounce on the state of affairs in the wider world.

4.2.2 Attributing ‘expert’ knowledge

Expert sources, on the other hand very rarely describe their own personal experience in contextually situated, specific, narrated horizontal discourse. They may, using such discourse, narrate the experience of others (as the judge does in The Fight to Save Nathan) or describe the mental state of specific others, as in the examples below.

a) Yolanda Lucire, a forensic psychiatrist, assessed him in Albury six weeks later and reported that he was wary, antisocial, and may have schizophrenia. (The fight to save Nathan)

b) The Mental Health Review Tribunal has found her to be no serious danger three times now. (Kylie Fitter)

c) A nurse who worked in Risdon says, “He was locked up 23 hours a day. He didn’t see sunlight.” (Jailed in body and mind)
However, what is more striking is the very strong tendency for expert sources, to make claims ‘on the basis of some objective process of enquiry,’ with ‘an orientation to generalisation or theorisation.’ (Hood, 2004:203) Sometimes this generalisation is explicitly supported by referring to the experience of expert sources, as in examples a) and b) below. In example a), Gordon Parker generalises on the basis of what he has seen, while Charandev Singh’s claims are legitimated by the fact that he has investigated.

a) The executive director of the Black Dog Institute, Professor Gordon Parker, says there is little doubt he is seeing more and more young people with psychotic conditions where cannabis is involved. (*Teens at most risk from dope*)

b) Australian human rights advocate Charandev Singh has investigated more than 25 deaths in custody and detention, including what he describes as “a disproportionate number of deaths of mentally ill prisoners held in segregation.” (*Jailed in body and mind*)

More often, though, expert sources generalise about both recurring events and about groups of people without such explicit reference to the source of their knowledge. In example a) below, Greg Barns describes ‘routine’ procedures in the Australian prison system. Here the reader is positioned to accept his claims because of his professional role. In example b), Cynthia Shannon Weickert talks about ‘people with schizophrenia’ and the physical aspects of the illness. Again, as an ‘expert’, she does not need to explain how she acquired her knowledge, or justify her claims.

a) Barrister Greg Barns, legal adviser to Tasmania’s prison action reform group, says, “Solitary confinement is routinely used for prisoners who have a mental illness. Hundreds of prisoners around Australia are in solitary confinement.”

b) “There is a developmental program that unfolds in the normal human brain as we grow, mature and come into adulthood, and what happens in the brains of people with schizophrenia is that process gets derailed, truncated or terminated.” [Cynthia Shannon-Weickert, neurobiologist]

As the examples above show, the Verbiage projected by ‘expert’ sources is fundamentally different to the Verbiage projected by individual/ family sources in terms of Bernstein’s types of knowledge structure. In the following section we will look at the way that expert voices capitalise on individual experience to make the case for social change.
4.2.3 Interactions of attribute and entertain

Despite the limitations on types of knowledge which individuals and their families can discuss, the element of individual experience is obviously crucial to these articles. Eight of the ten open with a lead paragraph describing the experience of either a family member or a person with a psychotic illness, and all of the articles have attributions sourced to either family members or individuals with psychotic illness. Individual experience projected through attributions is regularly reconfigured by expert voices as recurrent. This is what enables the modulations of obligation which expert voices then direct towards institutions and professional communities.

In his study on interviews with clinicians and cancer survivors, Jordens (2002:185) describes a ‘Policy genre’ which is used by clinicians in the interviews. This genre, he says:

…construes behavioural routines (sayings and doings) that function as a practical way of proceeding in “situations like these”…. The genre can be glossed as “In this scenario, I do this, for these reasons.”

He goes on to describe the differences between this genre and the story genres favoured by the patient participants:

The Policy genre can be differentiated from story genres in that it unfolds in the present rather than past tense, it construes events as recurring rather than unique, and it construes the actors in the Scenario as members of categories of persons (patients, families, etc.) rather than as unique individuals. (Jordens, 2001: 185)

The ‘expert’ projecting sources in the corpus do not prescribe ‘ways of behaving in situations like these.’ However, they do demonstrate important features of the genre, namely the representation of experience as recurring, and the construal of the actors as categories, and the use of present tense - in effect saying that ‘in this situation, this happens, with these consequences.’

In the corpus the reconstrual of unique experience as recurring happens in nine of the ten texts, including the autobiographical narrative, and is crucial to the way they work to align the reader. Sometimes there is a move in the direction of this reconstrual by
individuals who have personal or familial experience of psychotic illness. In the autobiographical narrative, for example, Georgia Blain makes a step towards this reconstrual in the following passage:

…soon people I barely knew began to tell me how much the book had meant to them. I had an aunt, they would say. She was always odd; or, my cousin, he was like your brother. It seemed the world was filled with those of us who had lived with mental illness. (A life revealed, a brother found)

In other texts family members and people with mental illness also use their own experience as the basis for making claims about the way that things regularly happen in the world. In Jailed in body and mind, Tony Bull notes that his experience is not unique when he says:

“I’m not the only one it’s happened to….. I know seven were taken out of yard only the other week.” (Jailed in body and mind)

However, such instances are rare and take as their point of departure as an individual, subjective, time-situated experience. It is much more common to find individual experience reconstrued as recurring by expert sources, who then direct modulations of obligation towards institutions.

Figure 4.4 below shows how this happens in three of the articles. In Lighting a dark prison, individual experience is described by the author, and reconstrued by the expert voice as recurring. This generalisation is then taken up as the basis for a modulation of obligation towards the medical community. A list of examples from the 8 articles where this reconfiguration of experience and modulation of obligation occurs can be found in Appendix 6.

In Trapped in a system near collapse, individual experience is again made recurring by the expert voice of the forensic psychiatrist and used as a basis for the coroner to modulate towards clinicians. In the mind’s eye also moves towards generalisation and then modulation. In figure 4.4 below, projecting processes are underlined and emboldened and modulations of obligation are underlined, emboldened and italicised.

20 Note the use of quotations, however, instead of projecting process in Lighting a dark prison
The only article which makes no attempt to make individual experience recurring is *Fears of a clown*. This can perhaps be explained by the fact that the experience of Will Elliott, who is being interviewed in the article, is a positive one: he has won a prize for his novel and is judged by the author in positive terms. His experience is both exceptional and positive: there is no need to use it as the basis as a claim that things need to be changed.
As a rhetorical device, this reconstrual is extremely significant in that it provides the basis for requesting change. As Jordens (2002: 202) points out in his study of the discourse of cancer survivors and clinicians,

storytellers must understand that insofar as events are construed as unique, they can have no implications for policy…. In order for an individual case to have any implications at all for subsequent cases, some process of generalisation is likely to be at work….In other words, even though cases are unique, “situations” are not: they are potentially recurring.

The reconstrual of events as recurring is what makes the later modulations of obligation possible in these texts: the authors of both expositions and other genres orchestrate the various voices in the texts to enable demands for change as well as encouraging the reader to take a particular point of view. These demands cover a range of areas of policy and practice, as the examples below show. Modulations of obligation are directed only by ‘expert’ voices; this is consistent with the finding that certain ways of talking are the province of certain categories of people in the texts. Expert voices are marked in bold, modulations of obligation are emboldened and italicised.

a) He [doctor Brian Pezzutti, who had completed a select committee inquiry into mental health services in NSW] **recommended** the health minister “seek to amend the NSW Mental Health Act 1990 to allow limited disclosure of confidential information…to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client.” *(Trapped in a system near collapse)*

b) **Reviews** in 1992, 1993 and 1994 recommended the health minister lose the discretion to keep forensic patients locked up. *(Kylie Fitter)*

c) The **Mental Health council** says most of the effort **must** be directed at teenagers. *(Teens at most risk from dope)*

4.3 Conclusion

As the above discussion indicates, the interactions between different textual voices and points of view realised through the ENGAGEMENT system perform vital rhetorical functions and reflect existing power structures. Understanding this interplay of voices is crucial if we are to fully understand the social function of the texts.
The discussion of resources of ENGAGEMENT deals with both the resources of **dialogic contraction** (disclaiming) on one hand, and the resources of **dialogistic expansion** (attribute and entertain) on the other. We have seen resources of **dialogic contraction** being used in many of the texts as a fundamental tool to critique and direct the actions and policies of institutions. In the non-expositional genres they refute and replace commonly held stereotypes about psychotic illness and those who have it. The analysis of **attribution** also shows some ways in which the newspaper articles in the corpus push for change and advocate for the rights of people with psychotic disorders.

Media discourse here not only represents and reflects a particular social reality, but plays a role in processes of social change. As Korner and Treloar (2004:14) point out,

> [m]edia are powerful institutions. By turning events into public issues, they can influence regulatory agencies to act, often out of concern for their public image.

The feature articles in the corpus, as well as naturalising a particular reading position and reflecting a particular view of social reality, attempt to exercise this influence by demanding that things be different in future.

Both implicit requests for social change generated by use of **dialogic contraction**, and explicit modulations of obligation requesting change, form part of a wider process of alignment which is evident in the texts. Martin and White (2005:95) describe alignment as follows:

> By dis/alignment, we refer to agreement/disagreement with respect to both attitudinal assessments and to beliefs or assumptions about the nature of the world, its past history and the way it ought to be.

Processes of alignment are concerned with the development of solidary relationships between reader, writer and the communities represented in the texts. In the features considered here we are aligned with people with mental illness and their families into a community of ordinary citizens that stands in opposition to institutions and their practices. The resources of ENGAGEMENT play a vital rhetorical role in configuring the moral universe of the reader and aligning it with that of the writer, and in construing a shared vision for social and institutional change.
Chapter 5 Directions

In this thesis I have looked at the ways in which a small corpus of feature articles align readers into a particular community of feeling in relation to psychotic illness. The analysis of APPRAISAL resources in the corpus has revealed how axiology and rhetoric are realised through language, positioning us to ‘align with’ people who have these illnesses, and ‘stand against’ professional and institutional communities such as health workers and the government.

The findings of this thesis are significant on two fronts. First of all, they constitute a contribution to a growing body of work using the analytical framework of APPRAISAL theory to examine the way evaluative patterning unfolds both within texts (logogenesis) and across texts on the same topic (See Coffin and O’Halloran 2006, Martin 2007 in press, for other examples of this program). Secondly, the thesis contributes to ongoing discourse about the connection between media representations of mental illness and community attitudes towards the mentally ill by looking at media portrayals which show significant variations on the well-documented ‘violent psychotic’ stereotype.

5.1 Theoretical implications

As Macken Horarik (2003:314) points out:

…[c]urrent work in APPRAISAL theory attempts to build an account of the mesh of different types of evaluation in text and the effect of these on readers and listeners.

By using APPRAISAL analysis as a tool for revealing patterns of meaning, this thesis has revealed some examples of this ‘mesh of different types of evaluation’ in looking at the way one set of APPRAISAL resources (dialogic contraction) systematically invokes another (JUDGMENT). These layerings of evaluation highlight the need for a systematic way of modelling interactions between systems, a challenge which is yet to be taken up in discussions about APPRAISAL.
5.2 Media representations of psychotic illness

In Chapter 1, I noted the tendency of researchers to focus on violent representations of people with psychotic illness in the media. Both the existence of this stereotype and its negative effects on public perceptions have been described in numerous studies. A 1993 study conducted in Scotland (described by Cutliffe and Hannigan, 2001:316) found that:

…over 40% of a sample of 70 members of the public reported that they believed mental illness was associated with violence, and stated that the media was the source of their beliefs.


However, another study published in the late 90s (Rose, 1998) also identifies another dominant (though far less well-documented) theme in news representations of the mentally ill- that of:

…neglect of the vulnerable, pity for those stranded in an uncaring world and responsibility for the situation laid at the government’s door.

This study, which looked at television coverage of mental health issues in both 1986 and 1992, found that the data from both years ‘included violence and vulnerability’ (italics mine). Rose demonstrated how these two seemingly incompatible portrayals were brought together in the later data to add a new dimension to reporting which she claimed had not been present before. This new dimension was, as she describes it:

an explanatory framework or allocation of responsibility- a new narrative… of danger because of neglect, of threat because of a social policy refusal to accept responsibility.
Though this study refers to themes and content in the UK television media, it bears striking resemblance to the representations of people with psychotic illness found in the Australian data set used for this thesis, in particular the coverage of the cases of Kylie Fitter and Nathan Hull described in Chapter 3. While it is worth remembering that the corpus examined here consists of a small set of genres from a particular type of newspaper, the presence of such a narrative in the early 1990s in English television discourse indicates that these findings may have wider currency than the Australian broadsheets, and warrant further investigation.

In order to see how widespread the tendency is to portray people with psychotic illnesses in this way, it is obviously necessary to look at a wider range of media. Future studies examining hard news articles as well as comment, or tabloids as well as broadsheets would shed some light on the extent of this type of characterisation. Research into other types of mass media (television, radio) would also be helpful in establishing whether this is a common pattern.

Further, diachronic studies of media discourse could help in tracking the emergence of these portrayals, in particular looking at discourse in the media before and after de-institutionalisation and, in Australia, before and after interventions prescribing particular mores for reporting mental health (Pirkis et al 2002).

There is also a case for augmenting qualitative analysis with analysis of larger corpora. Searching a larger corpus to identify regular collocates of terms associated with psychotic illness could show differences across a wider range of data, revealing common usage in conversational or literary texts (see Bednarek, 2008 forthcoming for a methodological framework combining quantitative and qualitative methods which could be used.)

Further, just as the ‘violent psychotic’ stereotype has been shown to impact significantly on public attitudes to mental illness, it is worth asking what sort of effect portrayals of the ‘vulnerable psychotic’ have on readers: for example, does it provide a check on public fear about people with mental illness? How are stories of the type seen in this thesis read? By whom? How do they contribute to our collective understanding of mental health issues?
Though the aim of this thesis has been to describe rather than prescribe, such an investigation inevitably raises questions about how one *should* talk about mental illness. The analysis conducted here has found that people with psychotic illness are consistently represented across the texts in the corpus as incapacitated, powerless and unable to control their fate: whether this is any more ‘positive’ than portraying them as murderers and criminals is an important question.

Interestingly Stuart, (2003:652) in a Canadian study looking at the effects of an anti-stigma intervention on media discourse about mental health, classifies ‘stories portraying people with mental illness as victims rather than as perpetrators of crimes’ as ‘positive’ stories. It is hard to imagine any other circumstances where such stories could be classified in this way: such statements seem to indicate that ‘positivity’ is a matter of alignment rather than accuracy of reporting or the types of activities that people with mental illness are seen to engage in.

But what is ‘positive discourse’ when we are talking about mental health? Does perpetuation of a diametrically opposed ‘victim’ stereotype offset the violent psychotic stereotype and create ‘balanced’ reporting? A study on the subjective experience of stigma conducted in Germany found that people with schizophrenia identified their limited access to social roles such as partnership or professional roles as an important element of the marginalisation they experienced (Schulze and Angermeyer, 2003:308); contributing to reduced quality of life almost as much as stigmatising stereotypes linking mental illness and violence.

It may be time to move beyond emphasis on the extremity of psychotic illness and concentrate on the commonality of experience which we all share as human beings. As Kevin Macken, both a user and manager of mental health services (quoted in Nairn and Coverdale, 2005: 284) says: ‘We came off the same streets everyone else walks on.’

Perhaps showing people with psychotic illnesses walking the same streets, fighting the same daily battles and winning the same daily victories as everybody else is a more balanced and more positive way to approach the subject.
Bibliography


Appendix 1 The texts

1.1 The fears of a clown

Spectrum - Books
WILL ELLIOTT TALKS TO AARON TIMMS
1144 words
21 October 2006
The Sydney Morning Herald
First
30
English

THE INTERVIEW BOOKS

The popular transformation of the clown, from jester to psychopath, intrigues an award-winning first-time novelist.

The Pilo Family Circus

By Will Elliott

ABC Books, 256pp, $29.95

WILL ELLIOTT'S FICTION debut describes a world that is bleak, lawless and savage.

But in the flesh, Elliott is affable, garrulous and commendably generous with his supply of cigarettes. The 27-year-old writer comes across as some kind of happily overfed mathematics undergraduate, in exhaustibly pleased at the novelty of the world that's placed before him and always delighted at every new suggestion - no matter how poorly expressed or counter-intuitive - that's put to him about his book. Every suggestion, that is, except one.

"This [book] is not autobiographical in any way," he emphasises about The Pilo Family Circus, which won the inaugural ABC Fiction Award for a first novel in April.

It's a ritual caveat, of course, but Elliott has a specific reason for making the point: he suffers from schizophrenia. Since the book tells the story of how one man's personality essentially splits in two whenever he piles on the face paint to become a circus clown, there will inevitably be those who read it as a metaphor for schizophrenia.
"I've had people say that the face paint is meant to be representative of the illness," Elliott acknowledges. "But that's not at all the way I see it. At the time I wrote the book, I was thinking more about alcohol, which does have a transforming effect on people. But no, this is nothing like the experience [of schizophrenia]. You don't change personality if you contract the illness, you don't suddenly turn into someone else - instead, it's basically the world that changes around you ... This is just a piece of fantasy."

Elliott might like to stress its disjunction from reality but there's little doubt that his book taps into a dominant strain in the representation of the carnival. From the gruesome homicidal stylings of American John Wayne Gacy, the clown turned serial killer, to the thousands of scary clown websites that litter the internet, the figure of the clown has come to be subverted by a kind of poisonous cruelty. Where it once would have scandalised, the notion that a man in garish face paint could be capable of great evil today seems almost truistic.

Elliott's book charts that shift in popular perception. Jamie, the protagonist, a recent arts graduate with a predictably non-existent long-term employment future, is sucked into the brutal parallel world of the Pilo circus after picking up a sack of discarded powder one night on the streets of Brisbane. The powder, it turns out, belongs to a bunch of clowns from the circus and they are determined to get it back. In the process, they ransack Jamie's rancid sharehouse, turn the sewers loose on his existence and force him to become one of them.

The clowns are Stravinskyesque skeletons of menace, humans shorn of all the things that make humans good - generosity, empathy, the impulse to civility and self-improvement - and catapulted into a violent endgame with the dwarves, acrobats and various other forms of pondlife that share the funfair with them. A quick five minutes under the Pilo family big top and Charles Darwin would never have had to spend all those years on the Beagle.

"The idea was very much to mix realities," Elliott says. "At the start, the violence is almost comic - it's a kind of slapstick, the kind of violence that clowns and other inhabitants of the circus world have traditionally existed to perform."

"But it gradually gets more sinister and, eventually, the main character, Jamie - with whom the reader hopefully sympathises - starts behaving this way, as well. He turns. I guess the intention was to create that effect. That was really my whole motivation for writing the book - not to make some comment about society or life or our world being a violent place but to create that effect or that shift."

Elliott says he came to writing as a kind of recovery mechanism after he was diagnosed with schizophrenia at the age of 19 but claims to have been writing "seriously" for only the past four years. His list of prose heroes takes in writers as different as Mervyn Peake, Stephen King, Robert Drewe and Steve Waugh ("Great tour diaries," he says, laughing). He refers to the job as an "apprenticeship", as if it's carpentry or sheep husbandry, a regular trade like any other.

That sleeves-up approach may be motivated, in part, by Elliott having had little else to divert him. He dropped out of a law degree - "technically I'm still enrolled" - and now works one day a week in a regular job. "I work in a law firm as a file grub, pushing
paper around," he announces with heavily ironic pride. "But I've done other jobs - I've been a pizza delivery boy, for instance."

It's hard not to get the impression that he goes about the business of writing in exactly the same manner that he would have once gone about the business of delivering pizzas: with an air of busy, if modest, efficiency, ticking off the deliveries - whether of pizzas or of words - one by one.

The reality is far more messy. Elliott lived, alone, in an apartment on the outskirts of Brisbane as he was writing The Pilo Family Circus. It's a place he describes as a "hole" - and one in which he developed an appropriately insalubrious working routine.

"I've led a monk-like existence over these four years," he says now. "I was keeping bizarre hours. I'd wake up from a 16-hour sleep, a medicated sleep, feeling like a zombie. It takes a long time for your mind to start up again after that kind of treatment. But then, once it does, you don't want to go to bed and waste the energy, so you stay awake for 36 hours or more and work the whole time.

"You take breaks - short ones - and by about the 20th hour, cabin fever starts to hit. I didn't try to alleviate the cabin fever, I tried to use it, to incorporate it into the writing. Caffeine was my friend then. It was weird - I was keeping, like, 40-hour days."

It's perhaps no surprise, then, to hear that Elliott has since moved back in with his parents. "The routine's a lot more sedate now," he says. But there's still no guarantee of a strict nine-to-five regime. "That's the intention but old habits die hard."
1.2 In the mind's eye

IN Australia we have recently developed a strange mania for trying to use art to solve social problems. Why this is, I can't say. Perhaps, wanting to believe in art but being surrounded by relatively little in the way of true greatness (we have no Louvre, no Prado, no Metropolitan Museum) we are eager to find other purposes for it. Or perhaps, when it comes to social and political issues, we are just naive.

Aboriginal art is the classic example of good intentions being funnelled through art towards a higher social and political purpose. But you find the principle at work elsewhere, too. Whenever rips in the Australian social fabric start to show, people look to art -- in the form of exhibitions, festivals and so on -- to provide a solution.

Something like this has happened in the sphere of multiculturalism. And it is happening again in mental health.

As with Aboriginal issues, government policy in mental health has been botched so badly and for so long that it may be no surprise to find people looking outside the political arena for a miracle cure. But why, time and again, art should get the guernsey is beyond me.

An exhibition called For Matthew and Others: Journeys with Schizophrenia, hosted jointly by Sydney's Ivan Dougherty Gallery and Campbelltown Arts Centre, is the latest example of the tendency.

In truth, there is much to admire about the show. It is named in honour of Matthew Dysart, a young man who struggled with schizophrenia for 15 years before taking his life.
It displays artworks by people with schizophrenia alongside work by artists who do not have the illness but have been affected by friends or relatives who do, or are in sympathy with them. The show also uses wall texts, letters, poems and a remarkable catalogue to tell in words the stories of those who have been affected, directly or indirectly, by schizophrenia.

Altogether, spread across two far apart venues, it may amount to a bit of a mess (it was put together by committee, and is trip-wired with good intentions). Yet it manages to be level-headed and very moving. It doesn't, for the most part, make exaggerated claims for the aesthetic quality of the work on display. Rather, its purpose is explicitly to raise consciousness and to remove the stigma attached to what is, according to the catalogue, "a brain disease that directly affects one in 100 Australians".

Art here is seen as a way for certain categories of people to "have their voices heard" and the "values of their insights examined". This, though it may put an art critic in an invidious position, is no bad thing. It is certainly better than the alternative, which is to make inflated claims for work by the mentally ill, as recently happened in London in an exhibition called Inside Worlds Outside. That put so-called "outsider art" (art by the psychotic, the autistic, the criminally insane, or the merely untrained) together with work by modernist giants such as Pablo Picasso, Jean Dubuffet, Francis Picabia and Antoni Tapies.

The London show suggested that work by these two sorts of artist could be seen as equivalent. The longer I think about it (and this has been a slow-burning issue in art for 100 years), the more I am convinced that it cannot and should not.

Yes, mainstream artists of various stripes have been affected and inspired by outsider art throughout the past 100 years. And yes, many great artists have themselves been affected by mental illness. But it is important to draw a distinction.

When we say that great artists are touched by madness, we mean neurosis, not psychosis. Neurosis is a shorthand way to describe what happens when a person's ability to deal effectively with disturbing memories or impulses is impaired, but not wholly absent. It is very widespread. It seems to be particularly common in artists, who may sublimate their disturbing memories or impulses and channel them into disciplined creativity.

Psychosis is different. It is severe. It involves a serious loss of touch with reality. It entails the kind of loss of control that is antithetical to the production of great art because it is involuntary.

When mainstream artists talk about not knowing what they are doing, or operating according to the dictates of their unconscious, it is a completely different thing. These artists are free to emerge from such induced states and resume a healthy, functioning life. People suffering from severe mental illness are not.

Schizophrenia is complicated because the disease is episodic and it varies greatly in its symptoms and severity. But if you stand back and look at some of the typical symptoms -- delusions, auditory hallucinations and thought disorder (that is to say, forms of psychosis); the loss of normal traits or abilities; flat, blunted or constricted
affect and emotion; poverty of speech and lack of motivation -- it would seem that not much about the illness is compatible with creative excellence.

I stress, however, that these are only symptoms affecting some people with schizophrenia some of the time. Many people with the illness are extremely articulate and live rich emotional lives, and it is this exhibition's noble purpose to make us aware of this. But it is also true that vast numbers of accountants and zoo-keepers are extremely articulate, emotionally rich and so on. So we should not confuse this exhibition's purpose with the idea that people with schizophrenia are naturally wonderful artists.

But wait: isn't it true that artists with schizophrenia see things that the rest of us don't? Aren't they more likely to have insights into emotions and states of consciousness that are otherwise repressed, factored-out and thwarted in our ever-more standardised world?

This common and plausible enough idea is lent some weight in the exhibition catalogue. But only some. It's a real bind: on the one hand, stigmatising those who are affected by schizophrenia is the most crushing problem many of them face on a daily basis, and championing their creativity can seem like a good way to counter this. But on the other, romanticising their suffering -- as is almost unavoidable when their artworks are spotlighted and celebrated -- can be almost as bad. According to Alan Rosen, a professor of psychology and a practising doctor, champions of outsider art have lamented the use of medicines to relieve the distress and suffering of the mentally ill because they blunt the mind and dull artistic expression.

Here we can see exactly how pernicious it can be to romanticise art by the mentally ill. Get too carried away by the idea and people with actual illnesses may be denied effective treatment because it "interferes with their creativity".

This evil idea is linked, of course, with the disastrous policy of de-institutionalising huge numbers of mentally ill people without following up with adequate support and funding.

In the past, the medical profession used to treat artworks by the mentally ill as potential tools of diagnosis. The content and form of artworks were interpreted as indicators of types and degrees of illness. To some extent, this approach has trickled down to the general public: people will often look at outsider art and try to guess what illness the maker had.

Quite rightly, the organisers of For Matthew and Others want to get away from this. The process is bound to be inaccurate and it can be terribly condescending. That is why, in this exhibition, works by 22 artists with schizophrenia have been hung alongside works by 15 artists who do not have the illness, without us being told the difference.

I can see that this refusal to differentiate between the healthy and the ill may help in the process of removing the stigma attached to schizophrenia. And I can see that some (not many, just some) of the artists with schizophrenia have talents comparable to artists free from the disease. But I would also say that if an artist continues obsessively to draw unidentified flying objects and monsters or to write the same
word or sentence again and again, we can probably conclude that they are in a dark place. And being in a dark place is not the same as being a great artist.

This issue of whether people with schizophrenia have an innate artistic talent is fudged slightly by the organisers. Anne Loxley, who was in charge of choosing the artworks, talks about the "charisma of schizophrenia". It's a notion that cannot be dismissed entirely, but I would question how helpful it is. Anthony White, an art historian, interprets works in the exhibition by artists with schizophrenia using traditional methods of art criticism. On the whole, I found his piece well-meaning, but tendentious and unconvincing.

Dinah Dysart, whose son Matthew was an art student and painted some fascinating images, nevertheless admits in the catalogue: "It would be ridiculous to assume that everybody with a mental illness is innately creative, yet that does not mean that they do not have something important to say."

True. But art, finally, is not about "having something important to say" in the sense that I suspect Dysart means it (social consciousness-raising). Nor, at its best, is it primarily about empowering certain categories of people.

The same sort of mistake has been made with Aboriginal art. One sees either an assumption, fed by a combination of romanticism and guilt, that all Aborigines are somehow innately creative (just put a brush in their hands and watch them go!). Alternatively, one encounters a complete disavowal of aesthetics in favour of a frankly political purpose, using art, almost arbitrarily, as the medium. Both approaches seem hopelessly naive to me.

We need to get real about mental health issues, not sublimate them into other areas, such as art. It's the same with Aboriginal issues: art may have a role to play, but it is absurd to look to it as a panacea for issues that require a hard-headed, sympathetic, society-wide approach.

To their credit, most of those involved in For Matthew and Others realise this. I would recommend anyone interested in this issue to see the exhibition, for it is by turns thought-provoking, sobering and extremely moving.

Don't just look at the art. Read some of the accounts by the families of those with schizophrenia or by professionals in the mental health field. Read, in particular, the essay in the catalogue by Allan Fels, the former chairman of the Australian Competition and Consumer Commission, whose daughter, Isabella, was diagnosed with schizophrenia nine years ago "after a prolonged period of disturbing, distressing, bizarre behaviour".

Fels writes about the burden placed on families by de-institutionalising those with mental illness. He quotes E. Fuller Torrey, the author of Surviving Schizophrenia: "Family members, especially mothers, are often expected to simultaneously be the person's case manager, psychotherapist, nurse, landlord, banker, janitor, cook, disciplinarian and best friend."

"Families," writes Fels, "cannot be all these things and especially they cannot be psychiatric hospitals." They need back-up, and back-up is too often lacking.
After years spent living in denial over her brother's mental illness, Georgia Blain says her mother's courage in writing a book about his life helped her deal with his loss.

WHEN my brother Jonathan died, I thought the absence of his physical presence would bring an end to the considerable pain we had felt for so long. His life was over, and with this ending I expected the space he had once occupied to cease to exist. It was, I know now, a strange and foolish expectation, one that was born out of years of struggling with sadness and anger. Shortly after Jonathan's death, my mother told us she was going to write a book about him. "It is about schizophrenia, really," she said at first, though soon this changed. It was to be more than just a text about the illness. It was to be a book about his life, and as such, it would, in part, be a book about us.

I was living in Adelaide when Jonathan took the overdose that killed him. He was in Sydney, and so was my mother. She would keep me updated as to his whereabouts whenever she rang. He was usually in the Cross, sometimes out on the streets, other times re-appearing at the Matthew Talbot Hostel for men. She would be anxious when she had lost track of him, relieved when he was found again, and I would listen, wishing we could have another type of conversation, one that didn't involve my brother. I couldn't ride the ups and downs of his life any more. To allow myself truly to imagine the way in which he was living would be to immerse myself in a despair so enveloping, I had to keep away.

Cutting off from my brother was a gradual process, although it was precipitated by an event when I was forced to face the reality of who he was and what our relationship had become. The experience made me realise that it wasn't possible just to step in and save him.

We were living by the beach in Adelaide. I was in my second last year of school, and had a bedroom on the middle floor of the house. I kept it immaculate; my bed made, my books in shelves and my desk carefully arranged for study. Jonathan was living in a squat. He wrote on the walls, warnings to himself, reminders that he must not hurt either my mother or us. I never went there but my mother visited him regularly and he sometimes came home, returning to sleep in a room at the bottom of the house.

I'm sad to say I dreaded his presence. I would smell him before I saw him, the cigarette smoke, the sweat, the layers of dirt pressed into clothes that had been worn for weeks. Often he had friends with him, young men in varying states of madness, all
with matted hair, nicotine-stained fingers and eyes that failed to focus. They would emerge from the basement, laughing to themselves, or perhaps talking about Jesus or the end of the world. One, I remember, had a book of graph paper, and he spent hours colouring the squares in intricate patterns that he believed held solutions to all the problems of life. He was the most lucid of Jonathan's friends. Most of the time, I stayed in my room. My diary was filled with schoolgirl longings for a boyfriend, tales of jealousy and insecurity, classroom dramas; all interspersed with feeble attempts at recounting how difficult I found my brother. I didn't have a language for what was happening to him. I didn't know how to understand his madness, or how to incorporate his existence into my own life.

One night I wrote a poem. I described what he had become and how much I missed the person he used to be. I wrote it because I thought there was some way of fixing everything. There was no physical evidence of a sickness that I could see. He had just travelled too far off the rails. Surely he could come back if we let him know how much he meant to us? Filled with hope, I showed my poem to him one night when we were alone in the house. It didn't occur to me that he would find my depiction of the state he was in distressing.

He sat out the back in the courtyard. It was a cold Adelaide night and he crouched against the wall of the house, shivering as he smoked and read. I waited just inside the door, expecting an epiphany, I suppose. He dropped his cigarette to the ground, leaving it smouldering on the winter damp bricks.

"You think I'm filthy," he said. I backed into the kitchen. "And mad." He wiped at his nose with his hand, and shook his head, his lank hair falling across his eyes. "F--- you." Stunned, I wanted to explain that he'd misread what I was trying to say. It was about love, I wanted to tell him, but he just spat on the ground and left, walking straight out the gate to the street without looking back at me.

'The book is changing," my mother told us as she struggled with the work in the years following Jonathan's death. "I can't just write about the illness." She tried to explain and I listened with dread. "I need to write about him. I need to write about us." I didn't understand. I would look at the piles of paper on her desk, divided into different categories: times in Jonathan's life, theories about the illness, interviews with psychiatrists. She would start typing in the first light of morning, continuing through to the darkness of evening, and I would resent the hold he still had on us.

When she first started to write, she spoke to us about her book helping others. A lay person's guide to schizophrenia, it would demystify the illness, it would help families struggling like we had; this was the justification she gave us. As the work became personal, she maintained this argument, never faltering in telling us that she believed this was the best way to achieve her aim. At that stage, I didn't understand how writing about oneself could ever amount to more than a purely personal exercise. If this was what she needed to do, then so be it, but there was no point in publishing it. Believing you could effect a change through such a book was, as far as I was concerned, foolish. Why couldn't my mother see that remaining submerged in his life wasn't only painful for her and for us, it was also futile?

Writing about his death she found unbearably hard. "I can't put it down on paper," she told me. When the police rang to tell her they'd found Jonathan, she had to identify his body. He had overdosed again. He'd been doing it regularly, always taking himself off
to emergency to have his stomach pumped. This time he didn't make it. They found him outside the elevator of the hostel where he was living. My mother does not know if he was trying to get to the hospital or not. It doesn't really matter. He had been hovering on that line between life and death for a while, uncertain as to which side to stay on, until eventually, on that day, he simply couldn't make it back.

Soon after my mother had identified Jonathan's body, she flew to Adelaide to tell me. She didn't call first, and when I opened the door to find her standing right in front of me, I had no idea why she was there. She didn't speak and as she drew me close and hugged me, I knew something was wrong. That afternoon I left her lying on my bed and I walked around the suburb. The streets were flat and empty, bordered by neat bungalows built in the '40s. I wished I lived in one of them, that I was someone other than the person I was. I wanted to go home to one of those ordinary houses I'd imagined as a child; a place where the furniture was brown and faded; the television was on; a floating of days that came and went, pleasant and unremarkable. I tried to work out what I was feeling. Grief, yes. Relief? That was harder to acknowledge. It had been enough to live through his life. It was simply too much now to deal with the aftermath. I continued living my life as I had always lived it. He was gone, and just as I had not known how to deal with his existence, it seemed there was no easy way to understand the space now occupied by his absence.

Five years later, when my mother finally finished her manuscript, she gave me a copy in a red folder. She was sending it off to the publishers. She wanted me to read it first. I held it, flicking at the edge of the pages with my thumb. I opened it randomly and read a few sentences. I closed it again. It was summer and I was living in a two-roomed flat on the southern clifftops of Bondi. This was my sixth home in five years. After leaving Adelaide for Sydney, I had moved from house to house. I had been depressed and now I was happy. Life was opening up before me, and the folder in my hands took me back to a place I did not want to revisit.

Outside my window, sharp white light skimmed and skipped across the surface of the ocean. With pillows propped up behind me, I sat on my bed and began to read. I didn't stop. Through the heat of the day and into the early evening, I stayed where I was, immersed in a story I knew well, but that still seemed strangely new. I was gripped, wanting to know what happened next, even though the ending would not bring any surprises. I remembered how I'd loved my brother as a child. I remembered the despair and the distress, and I saw my mother as she had been all those years, chasing after him, running, running, never quite catching him, never able to bring him back.

When I came to the last few pages, I wept. I rang her crying and I could only tell her it was good. My mother had given Jonathan back to us, and not just a sentimentalised version of who he had been. It was all there, but in being able to read about it rather than having to directly experience it, I could allow myself to love him and grieve for him.

But it was more than just a private gift. It was going to be read by friends, acquaintances and people I had never met, and I felt fear. It was not shame of Jonathan that breathed heat onto my anxiety. I had gradually come to understand that he had been ill and that this illness was not something that had to be hidden. My fear was more to do with revealing the impact he had on our lives. I felt vulnerable at the prospect of my sorrow being out there for others to see.
So, when the first few people tried to talk to me about the book, I barely responded. "I had no idea what you went through," friends would comment. Soon people I barely knew began to tell me how much the book had meant to them. I had an aunt, they would say. She was always odd; or, my cousin, he was like your brother. It seemed the world was filled with those of us who had lived with a mental illness.

With each conversation, I became more adept at discussing our life. I found I could recount various episodes when Jonathan's illness had been bad without wishing I'd never begun to speak. I'd used so much strength in keeping a distance between Jonathan and myself; letting go of that hold was an immense relief.

But strangely, this slow acceptance of my mother's book and eventual pride in her work didn't mark an end to my grieving. Instead, it signalled the start. There were now two quite separate stories. There was the story of our family in the book. This was public property. And then there was the person who had grown up in this family and who had tried for years to deny all that had happened.

Removing this denial in such a public sense finally opened the way for me to begin to understand Jonathan and the impact he had on my life. I peeled my gloves back, fingers outstretched, finally ready to touch, only to find that it was a process of tentatively lifting layers of emotion.

Like shedding skin, I let go slowly, dropping the hot tightness of my grief to reveal a heavy sadness; peeling that back to find moments of sharp pain for the brevity of his life; lifting that to reveal the ache of missing what he might have been.

I came to realise that these layers were infinite. The trick was not to drown in them, but to know them for what they were and to let myself experience them one by one as they emerged.

This is an edited extract of Writing About Us by Georgia Blain, taken from the Best Australian Essays 2006 edited by Drusilla Modjeska, Black Inc., RRP $27.95, out now. The essay will also form part of a forthcoming collection, Births Deaths Marriages, to be published by Picador in 2007.
Dale Hull spent years trying to get treatment for her mentally ill son. But no one would listen and a tragedy was inevitable, writes Richard Guilliatt.

On a blazing hot Sunday afternoon near the end of 2004, Nathan Hull set off on foot from the home he shared with his mother in the outer suburbs of Wagga Wagga, heading towards town. It was not unusual to see the big, amiable, troubled 26-year-old ambling around Wagga, in southwest NSW, for it helped to quieten his mind. On this day, though, his mind would not be stilled and the sweat pouring off his brow was not just caused by the 40C heat. Nathan was agitated, his eyes were glassy and his thoughts swirled around one objective: to get to Wagga Base Hospital and confront the psychiatrist, Dr Greg Weppner, who nine months earlier had suggested that a spell in jail might fix his problems.

Of all the rebuffs Nathan had endured as he tried to get help over the previous nine years, Weppner's burnt strongest in his memory. It seemed to sum up how indifferent people were to his troubles. Yet amid his jumbled thoughts, he also knew this plan to confront the psychiatrist made little sense, because Weppner didn't work on weekends. Psychiatrists rarely do, which is one reason police and hospital emergency staff have learnt to dread the long, spooked interlude between Friday evening and Monday morning when the damaged and troubled are left to fend for themselves.

It was shortly after lunchtime when Nathan turned up at the reception desk of Gissing House, Wagga's only mental health facility, where he was told Weppner was not in. It appears no one offered him assistance, because soon after Nathan turned up in the adjacent hospital emergency department, where he asked for a drink. The receptionist was typing, and told him to use the water cooler. A nurse walked up and asked if she could help. Perhaps out of nervousness in the presence of this sweating and agitated young man, the two women exchanged a smile that Nathan noticed and did not like. He reached over the counter and pushed the receptionist's computer keyboard, which is when she called for a security guard. Nathan then reached out and grabbed a woman called Carol Lyons, standing near him, and all hell broke loose.
Months later, after he'd been arrested and charged with two counts of attempted murder, Nathan would try to explain the violent events that followed inside that crowded emergency room. He recalled trying to keep calm but feeling a building sense of anger. He kept thinking about all the doctors, psychiatrists and nurses who had failed him over the years, insisting there was nothing wrong with him. An idea popped into his head to stage a siege as a protest. A protest about what?

"I was protesting," he said, "against the fact that no one cared."

A YEAR LATER, NATHAN'S MOTHER, Dale, is standing outside Wagga's brick-and-timber Federation courthouse, awaiting her son's appearance in the main courtroom. "I feel like I've spent a lifetime around here," she says, glancing around anxiously. Wagga is a relatively big town - 60,000 people - but gossip still follows you like a shadow when your son is charged with attempted murder. "You know," she adds, "a year ago I couldn't have imagined any of this happening to me. Catching the train at seven in the morning to go and stand outside some prison in the sleet and hail, waiting to see my son ... It's like some nightmare that you think you'll wake up from."

A plump 50-something woman with soft brown eyes under a thatch of jet-black hair, Dale has a nervy, flustered manner enlivened by flashes of sharp humour. "I'm his mad mother," is how she sometimes introduces herself to the many lawyers, politicians, psychiatrists and government bureaucrats she has lobbied about her son's case. For most of that time, Nathan has drifted through the NSW prison system, from Junee to Parklea to Silverwater to Long Bay to Goulburn to Wagga lockup and back.

His mother has visited most of them, become familiar with their dingy waiting rooms and the dismal routine of seeing her son through scratched Perspex or across a bolted-down table.

Today we discover the court hearing has been postponed and Nathan is being shunted back to Junee, so we head over to Dale's house, where she keeps the history of her son's case in a bulging folder of clippings, correspondence and psychiatric reports. On the drive over, she tells me the story of one of her visits to see Nathan at Long Bay psychiatric hospital, on a morning when the cramped, low-ceilinged waiting room was filled with other parents whose mentally ill children had been locked up as criminals. "Suddenly they announced there'd been a suicide - this young fellow had hanged himself somewhere in the hospital," she recalls. "We didn't know who it was - I thought it might have been Nathan. Everyone had this terrible haunted look in their eyes. Some poor bugger had lost a son or a husband, and no one wanted to look at each other."

She never did find out who had died, but looking at all the other stricken faces in that waiting room sparked a flash of recognition. "You sit there thinking you're the only one going through all this. But you talk to other people visiting the jails and it's the same story over and over."

The disintegration of the mental health system has been so well documented over the past 15 years that the scale of the problem seems to defy solutions. Voluminous government reports have been compiled, judges and coroners have cried out for action, parliamentary committees have exhaustively examined the issue, strategies have been proposed and funding promises have been made, yet the jails continue to fill up with the psychotic and the disturbed. The head of the NSW prison system, Ron
Woodham, told ABC-TV's Four Corners last year: "In my 40 years in the job, I've never seen the damaged product like it is now that's coming off the street. It's unbelievable. In our big remand jails, particularly of a Friday night, it's like a casualty ward."

It's not until you talk to someone caught up in the nightmare that it snaps into focus. I'd first spoken to Dale a couple of months after her son's arrest, and the story she told seemed hard to believe. Her son - a "lovely, big, gentle thing" who'd been an A-level student - had spent seven years trying to get treatment for his increasing mental problems, but psychiatrists in Wagga had insisted he wasn't mentally ill. Hospital staff had rebuffed him. The courts had treated him as a common criminal. Eventually, he had snapped, although she preferred not to talk about what exactly had happened. There had been "an incident" at the hospital, and people had been hurt.

Over the ensuing months, Dale would call with updates on Nathan's movements: he was in Wagga for his committal hearing, drugged with antihistamines to help him sleep; he was in a cell with a broken toilet at Silverwater, having "lost his spot" at the Long Bay psychiatric hospital; he'd been transferred to Junee and his file had gone missing in transit, so nobody knew what drugs to give him. She had spent interminable hours on trains and buses getting out to see him at these places. "My main purpose now," she said more than once, "is to keep him alive and stop him from committing suicide in jail."

Dale lives in a cluttered but clean two-bedroom Housing Department home on Wagga's fringe. Photos around the lounge room trace her son's development from a pudgy primary school student to a prematurely bald, overweight man in his early twenties. A clipping from the local paper shows Nathan at 13, grinning and holding up his certificate of distinction for maths and science.

That was 1991, when he'd again been ranked among the brightest students at Mount Austin High School. It was an achievement made all the sweeter by the hurdles he'd overcome. Nathan and his mother had been forced to move to Wagga 11 years earlier after his father developed a heroin habit in Sydney, and in the years up to his dad's death they'd had little contact. The experience made both mother and son virulently anti-drugs, but it also left Nathan caring for his mother, who suffered a debilitating back condition.

The glowing school reports ended just before Year 10, when he dropped out of school and began to withdraw into a curious lassitude. His pastimes marked him as a loner - word puzzles, TV quiz shows, betting on the trots.

"That's when I started to see it happen," says Dale. "I used to say to him: 'Are you all right, Nathan?' He complained that the teachers were dumb. But there was something wrong."

Quick-witted and funny - his favourite television show is Little Britain - Nathan started to become unpredictable. An argument with his mother at a bus-stop ended as a brawl with police who were called to the scene.

A psychologist's report noted his very high intellectual abilities but "marked peculiarities in thinking". He was experiencing hallucinations and belief in magical
events, combined with rapid mood swings and paranoia-like feelings consistent with "schizotypal personality disorder".

It was 1997, and Dale was about to discover how inadequate mental health services can be in rural Australia. More than 100,000 people live in Wagga Wagga and its surrounds, yet there have rarely been psychiatrists resident in the town. Instead, psychiatrists are flown in from Sydney or drive from Canberra twice a week to treat patients; the local mental health crisis unit, Gissing House, has only 18 beds available and is primarily staffed by nurses. Hence, Nathan had to see a psychiatrist in Wodonga, 195km south.

"I took Nathan down to see this doctor in Wodonga," recalls his mother, "and he said Nathan had schizophrenia. He really wanted to help, and asked if we would keep coming back." But the train ride from Wagga and cab fares to and from Albury train station made treatment financially punitive, so Nathan ended up back in Wagga's overworked, understaffed mental health system.

Schizophrenia creeps up on its sufferers, its symptoms ebbing and flowing in a way that can make diagnosis difficult. In a country town, where psychiatrists fly in on lightning visits, the chances of getting appropriate treatment are low. Nathan saw several psychiatrists in Wagga, but none thought he was mentally ill. One of them, Dr Murray Wright - now director of mental health for the local Area Health Service - recommended anger management. A nurse suggested his mother needed counselling.

"I pushed to get help and they told me I was too anxious," she recalls. "I used to see Nathan's funny little turns when he would go into a psychotic state, but no one would listen to me. I accompanied him to the outpatients department at the hospital once and the nursing staff were laughing at him. The doctor came to me and said, 'That bloody kid of yours is on drugs - we're getting these bloody druggies here every Friday!' They sedated him and took a blood test and the doctor came out later and apologised, admitted that Nathan didn't have any drugs in his body. But when I asked whether he would be admitted to Gissing House, they said: 'No, you can take him home.'"

In August 2003, Nathan was again arrested for assault after an argument with a shopkeeper. Yolande Lucire, a forensic psychiatrist, assessed him in Albury six weeks later and reported that he was wary, antisocial and may have schizophrenia. He had succumbed to strange and uncontrolled giggling and talked of strange coincidences in which "I think of a thing and then they show it. I think that I caused it."

Lucire wrote to Wagga's local health service recommending enforced treatment. But two months later, a psychiatrist employed by Wagga's Community Mental Health Service, Dr Greg Weppner, wrote an assessment of Nathan that shocked both him and his mother.

"Mr Hull presented as a young man who has not undergone quite a number of maturation tasks, and has not obtained skills appropriate for living in the adult community," Weppner wrote. "... I do not believe that there is anything this service can offer him at this point in time. Perhaps a short period in gaol might help him understand that there are more consequences to his violent actions other than the inconvenience of attending court..."
Dale shows me the letters of complaint she fired off to Weppner's superiors, the College of Psychiatrists and the Health Care Complaints Commission. Lucire also wrote to Weppner, warning that "Nathan is potentially dangerous, and could again assault. Going to jail will not fix the problem."

Despite the warnings, nothing was done. Local Health Department officials told Dale that Weppner had reviewed the case and confirmed that Nathan "does not display any risk factors". The NSW Health Care Complaints Commission refused to investigate, saying Weppner's report was "appropriate". The College of Psychiatrists told her they did not conduct their own investigations.

In June 2004, Nathan was found guilty of assault, placed on another good behaviour bond and told by a magistrate to seek help from his doctor. The doctor, however, had received a letter from Weppner stating that Nathan was not mentally ill.

"That's when Nathan was deteriorating," his mother says. "I could see it; the episodes were getting more frequent. He said: 'Mum, I'm sick, aren't I? I know what I am - I'm mad.' That's the scary thing - he knew he needed help. I think he was hearing voices more often. He would say: 'Mum, it's not your fault you've got a big, mad son.'"

On November 26, a Friday, he became highly agitated after hearing his parole officer would no longer be supervising him; the following day, his mother overheard him muttering "No, I'm not going to do it" repeatedly to himself; the day after that, he became irrationally angry about a bet he'd failed to place on a horse race, and stormed out of the house after shouting at his mother.

"I swear on my mother's grave," Dale says, "that I didn't know he had a knife. If I'd known he'd taken that knife from the drawer, I would have called the police."

IT'S APRIL 2006 and Nathan's case is finally reaching its long-delayed conclusion inside Wagga's wood-panelled courthouse. Sitting in the corral-like dock, Nathan resembles a shrunken version of his old, overweight self; his billowing khaki pants are held on with a belt winched halfway around his back, and his upper body swims inside a pale blue, short-sleeved shirt. His broad-browed face has lost its round chubbiness, and advancing baldness makes him look older than 27. After 16 months in half a dozen different jails, he has lost 32kg.

Over that long stretch of time, three psychiatrists have examined Nathan and concluded that he is, in fact, mentally ill - either from schizophrenia or a recurring psychotic disorder - contradicting the assessment of nearly every psychiatrist he has consulted in Wagga Wagga over the previous seven years. Despite this, Nathan has agreed to plead guilty to charges of malicious wounding and wounding with intent. The alternative - pleading not guilty by reason of mental illness - is a course defence lawyers in NSW often don't recommend, because such prisoners can be confined indefinitely until the minister for corrective services orders their release.

On the morning of the sentencing, Dale takes a walk down to the nearby Murrumbidgee River and sits at a concrete bench, staring upstream. "The night it happened, I thought about coming here and throwing myself in," she says. "I knew something was going to happen if he didn't get treatment. I just never imagined it would be so bad." Nathan always told her he wasn't sure he could take more than five years in jail, she says; today he faces a maximum penalty of 25 years.
In the courtroom, she takes a seat in the press gallery a few metres to the right of her son. Behind him, the old courtroom is deserted apart from a handful of security guards. Sixteen months ago his crimes hogged the evening news and the front page of the local paper for days; today, only two local reporters are here to record the denouement. Five minutes into Judge Stephen Norrish's remarks, the prosecutor begins to quietly nod off.

It's unclear, from Judge Norrish's description of events, exactly when Nathan first brandished a 13cm kitchen knife at the people gathered in the emergency department of Wagga hospital. The judge sticks carefully to the undisputed events of that day: an agitated and angry Nathan trudging through the heat to the Gissing House mental health unit, demanding to see Dr Weppner, and being turned away; his arrival at the nearby Emergency Department; his argument with the receptionist and his impulsive decision to grab Carol Lyons with the apparent intention of starting a siege. And then, the intervention of Mrs Lyons' 53-year-old husband, Garry.

"Mr Lyons not unnaturally grabbed the arm of the offender in an attempt to free his wife," recounts the judge. "The offender then lunged towards Mr Lyons and stabbed him in the left side of his neck." The judge pauses. "It was a miracle that Mr Lyons was not killed, in my view, in light of the location of the injury." In the dock, Nathan flushes slightly, staring at his hands with a downcast mouth, frowning as if trying to solve some tricky puzzle.

The judge has left out some details - the nurse shouting for security as Garry Lyons staggers around clutching his neck, the women and children screaming in terror at one end of the emergency area, where there is no exit door. Instead, he jumps straight to the arrival of the security guard, Jason Schurr.

"Mr Schurr heard the distress calls from nearby and very bravely, I must say, ran to the area. He saw Mr Lyons holding his bloodied neck and also noticed a number of people grouped together at one end of the reception area, obviously endeavouring to get away from the prisoner. While Mr Schurr was looking in that direction, and unaware of the presence of the prisoner, he was stabbed to the left side of his back by the prisoner. After being stabbed, Mr Schurr fell to the ground. Police officers who were nearby ... entered the reception area to assist and apparently subdued the prisoner by ordering him to throw the knife on the floor."

Schurr suffered a punctured lung in the attack and was administered his last rites by a priest as emergency doctors tended to him; he subsequently suffered severe post-traumatic disorder and has been unable to return to his regular job. The knife wound in Garry Lyons' neck narrowly missed his carotid artery.

But Judge Norrish notes that Nathan had a serious mental illness, which was left untreated largely because of Weppner's "rather surprising" and "somewhat less than sympathetic" assessment of him nine months earlier. Had he received treatment, says the judge, the stabbing of Garry Lyons and Jason Schurr might not have occurred. He asks Nathan to stand and sentences him to seven years' jail with a non-parole period of three, making him eligible to apply for release in November 2007. Nathan nods mutely and is led back down into the prison system. Throughout the entire 16 months of court hearings, he has barely uttered a word.
NATHAN HULL'S LETTERS FROM jail sometimes read like dispatches from a kid at a substandard school camp. "The dinner I got last night was called SWEET AND SOUR CHICKEN," reads one, "but it was a misnomer as there was only one tiny piece of chicken in the whole tray."

For the most part, he talks about events outside the prison walls - political scandal, the television Logie Awards, race results. Sometimes he adds amusing, scribbled caricatures. Only in passing does he allude to the grimness of his situation. "It's real One Flew Over The Cuckoo's Nest in here, as there is some sort of excitement nearly every night," he wrote to his mother from one jail.

In prison, ironically, Nathan has finally received the medical treatment he was denied in the health system. After several months at Long Bay psychiatric hospital, he was prescribed anti-psychotic medications and released into the general prison system. But the drugs are sometimes administered haphazardly, their side-effects can be unpredictable, and he rarely gets to see a psychiatrist.

Late last year he told his mother he felt he was suffocating from the effects of drugs, and on several occasions he has blacked out and fallen in his cell.

Last year the Australian Council on Healthcare Standards identified Wagga Wagga's mental health services as among the worst in the country. The NSW government body that governs the area - the Greater Southern Area Health Service - acknowledges the inadequacy of the town's mental health facilities in its latest annual report. But the service's director of mental health operations, Dr Murray Wright, defends its handling of the Nathan Hull case, saying the service was "vigilant" in its care for him, and made a number of attempts to arrange follow-up psychiatric appointments.

Weppner, who now works in private practice, refused to comment for this article. The NSW Health Care Complaints Commission is now reviewing its earlier finding that Nathan Hull's care was adequate.

Meanwhile, a group of enterprising Wagga citizens has refurbished an abandoned building for use as a support centre for schizophrenia sufferers, but it remains unused because the NSW Government refuses to provide $250,000 to hire staff. The cost of keeping Nathan in jail, even for the minimum three years of his sentence, will be at least $200,000, although that does not take into account the cost of the injuries to his victims, the lengthy police investigation and 16 months of court proceedings.

In all his years of troubles, Nathan was never once deemed ill enough for admission to Wagga's mental health ward, Gissing House, and it's unlikely now that he ever will be, because his mother is considering a move back to Sydney. That way, once he gets out of jail, she hopes he will be able to get regular treatment. In the meantime, her life still revolves around the same daunting task.

"It's keeping him alive. I'm realising now that my fight for Nathan is only just beginning."

Richard Guillliatt is a staff writer. This is his first story for the magazine.

[TAM_T-20060527-1-030-285918 ]
1.5 Jailed in body and mind

MENTALLY ILL prisoners are routinely locked in isolation, writes Elisabeth Wynhausen.

TONY Bull has lost count of the number of times he went to prison. What he hasn’t forgotten is the times he was locked up in solitary confinement in Hobart’s Risdon Prison. On one occasion following what he calls a set-to with an officer, Bull barricaded himself in his cell. He was gassed and dragged away. "I got put in solitary in Division 8 for 40 days," he says.

Bull, a former amphetamine addict, had been given the wrong "psych medication", an antidepressant called Luvox, and was unbalanced. When he was put in solitary, he set fire to the cell.

"The officers don't recognise mental illness," he says. "They see you as being a troublemaker and put you in solitary. I'm not the only one it's happened to. It can send you mad if you aren't to start with."

Risdon is due to close later this year, but many other prisons lock up mentally ill inmates in solitary confinement, or what's called segregation, for 22 or 23 hours a day. If prisons are in lockdown, inmates stay in their cells around the clock.

There are more than 25,000 people in prisons in Australia. Many have been affected by the critical shortage of in-patient and community-based mental health services across the nation. Mental illness is so prevalent in the general prison population that a large-scale study in NSW in 2003 found the rate of psychosis was 12 per cent, 30 times the rate in the general population. Since the study was carried out there has been an explosion of drug-induced psychosis.

Estimates of the number of mentally ill inmates in the general prison population range from about one-third to more than two-thirds, says Helen Connor, executive director of the Australian Mental Health Consumer Network.
In 2003, NSW's Corrections Health Service (now Justice Health) found that "almost half of reception inmates and more than one-third of sentenced inmates ... had suffered a mental disorder in the previous 12 months".

A study of all female prisoners in Victoria by psychiatrists Christine Tye and Paul Mullen published this year in the Australian and New Zealand Journal of Psychiatry indicated that if drug-related disorders were excluded, 66 per cent of the women met the criteria for a mental disorder. Victorian Supreme Court Chief Justice Marilyn Warren has condemned the lack of access to psychiatric care for women in Victoria's prison system in two judgments in recent months.

Barrister Greg Barns, legal adviser to Tasmania's Prison Action Reform group, says: "Solitary confinement is routinely used for prisoners who have mental illness. Hundreds of prisoners around Australia are in solitary confinement."

Last month at the inquest into the death of Scott Simpson, the NSW State Coroner recommended that prison inmates who were mentally ill should be put into solitary confinement only as a last resort. Simpson, a paranoid schizophrenic, committed suicide in 2004 in his cell after being locked up 22 hours a day for 26 months. Nurses testifying at the inquest said his medicines were pushed through a slot in the door of his segregated cell in the multi-purpose unit at Goulburn prison. He was then transferred to the High-Risk Management Unit at Goulburn, a prison within a prison known as the supermax.

NSW Corrective Services Commissioner Ron Woodham has the power to have any inmate designated "extreme high risk" held there. When Simpson's mother, Terri, wrote to the commissioner about the effects of the intense isolation in the supermax, Woodham wrote back: "I can advise that Scott's placement at the HRMU is considered to be beneficial to him and his future management."

Found not guilty of murdering a cellmate by reason of mental illness, Simpson was in isolation on the day he died. The Human Rights and Equal Opportunity Commission has stated that the conditions of his imprisonment constituted cruel, inhumane and degrading treatment under the UN's International Covenant on Civil and Political Rights.

Forensic psychiatrists at the inquest testified that mentally ill inmates were likely to deteriorate if held in solitary confinement for extended periods.

"If you put someone who is paranoid and agitated and greatly distressed in a solitary confinement setting for 23 hours a day, you cannot expect that to have a calming effect," said Robert Lewin, a forensic psychiatrist for 20 years. He told Deputy Coroner Dorelle Pinch that being in solitary confinement was bound to have made Simpson worse. "There is no circumstance in which that is appropriate in the care of a mentally ill person," Lewin said. "That it is used in the prison system in my opinion is an absolute abomination."

Solitary confinement of mentally ill inmates is archaic, according to Alvin F. Poussaint, professor of psychiatry at Harvard medical school. Poussaint says solitary makes psychotic prisoners "more psychotic" and prisoners who are already depressed likelier to commit suicide.
Australian human rights advocate Charandev Singh has investigated more than 25 deaths in custody and detention, including what he describes as "a disproportionate number of deaths of mentally ill prisoners held in segregation". Though the use of solitary confinement has been widely condemned for 40 years, Singh says, "experts say the mentally ill people least able to handle the isolation are most likely to be locked up in solitary. They are being punished for behaviour that is part of their mental illness."

No one knows for sure the numbers involved because solitary confinement isn't called solitary any more. In NSW, where Simpson died in isolation, it is officially illegal to hold prisoners in solitary confinement.

Solitary doesn't exist in Tasmania either, according to the Tasmanian Yearbook for 2000: "Three solitary confinement cells located in Risdon Prison were in use until the mid-1970s, when the attorney-general ordered that solitary confinement be discontinued."

Bull, 41, now working as a brickie's labourer, was released from Risdon eight months ago. His last time in Division 8 was a few years ago. "Men are still going around there for trivial offences," he says. "Speak out about the system and you're taken from your cell in the nighttime and put in solitary. I know seven were taken out of yard only the other week."

Fellow inmate Mick Marlow spent three years in Risdon's Division 8 in solitary. "He was locked up 23 hours a day. He didn't see sunlight," says a nurse who worked in Risdon. PAR's Caroline Dean says: "He went into solitary on a one-month charge and didn't come out for three years."

One thing has changed in Tasmania since solitary confinement was officially discontinued. Prison authorities talk about segregation in terms that suggest inmates are being managed or protected rather than punished.

A report on women in prison by the Anti-Discrimination Commission of Queensland notes that prison staff "often fail to recognise manifestations of mental disorder and respond with restraint or disciplinary action".

Before being wrongly placed in immigration detention, Australian citizen Cornelia Rau was imprisoned in Queensland. Though seriously mentally ill, she was repeatedly placed in the prison detention units used to "segregate prisoners for breaches of discipline", the report said.

A 2002 survey of female prisoners in Queensland revealed that almost two-thirds reported speaking to a doctor or psychiatrist about mental health issues. Debbie Kilroy of Sisters Inside, which advocates on behalf of women in prison, says in Queensland: "Women with a serious mental illness are held in crisis support units, which means they are locked in isolation 23 hours a day."

The anti-discrimination commissioner's report describes the environment: "The cells contain very little -- a bed with a suicide-proof mattress -- and no personal property of any kind is allowed. The lights in the cells are on 24 hours a day and while they are in the cells women wear a suicide gown. Suicide gowns are loose cotton garments, similar to the gowns worn in operating theatres. They have fastenings down the back,"
which routinely gape and provide little allowance for modesty or dignity as no underclothes are allowed to be worn beneath the gowns. Women who are detained in the padded cell in CSU are generally held in a totally naked state ... Each time a woman exits and re-enters her cell, she is strip-searched."

When the report was released, Queensland Police and Corrective Services Minister Judy Spence said the strip-searching "regime ... has cut drug use from almost 20 per cent of prisoners six years ago to now around 5 per cent". The minister said strip-searching in the crisis support unit had been reduced by "50 per cent in the last 12 months".

Nevertheless, the anti-discrimination commission report noted that women elsewhere in the prison "related their fear of showing any emotion that may be noticed by prison officers". They were frightened they would be placed in a crisis support unit.

When Queensland doctor and state Liberal leader Bruce Flegg visited the prison a few weeks ago, he was shown the padded cell. It had with nothing in it, not even a mattress, Flegg tells The Australian. Prison staff "admitted to the use of restraints, body belts and so forth", he says.

Susan Hayes, head of the Centre for Behavioural Sciences in Medicine at the University of Sydney, says mentally ill prisoners are often held in conditions of solitary confinement, "because it's easier to lock them in their cells than to deal with them in the general prison population". "The obvious alternative is have them in a forensic hospital, where they're in a clinical rather than a custodial environment and where all the staff are trained to deal with mental illness."

Other experts insist the mentally ill shouldn't be in prison in the first place. "That would mean a much greater investment in community mental health services and sexual assault counselling," Singh says. "There needs to be a total prohibition on solitary confinement for the mentally ill. That's what they're bringing in in New York state."

[AUS_T-20060828-1-010-683133 ]
1.6 At 15, Kylie killed her mother. The demons are gone, but she's still a prisoner of her past

SHE is so gentle and polite as she offers tea and biscuits in a child-like voice that it defies imagination Kylie Fitter helped kill her mother in a crime of biblical proportions.

Seated in the living room of an inner-city terrace, the willowy, 20-year-old spun-sugar blonde, sweetness itself, is out on weekend leave from jail. But in the view of her many supporters, Kylie is a political prisoner.

Neither the neighbours who tried to save Kylie's mother as she ran into the street on October 16, 2001, nor the man walking his dog, the woman watering her garden, nor the two girls on their way to school could forget the horror that unfolded before them.

In the quiet, semi-rural community of Glossodia, near Richmond, Fiona Fitter, 35, was running for her life. In pursuit were her 18-year-old son, carrying a large knife in each hand and screaming incoherently, her husband, and her 15-year-old daughter.

Some neighbours went to call police, others tried to intervene as the husband cried: "She deserves it." Onlookers watched in horror as Mrs Fitter raced into a neighbour's house, only to see her son smash down the front door, and Mrs Fitter re-emerge, screaming in terror.

It was almost 9am, when Mrs Fitter, in her nurse's uniform, having returned home after night shift at Westmead Hospital, was chased and tackled to the ground by her son. She broke free and ran her last few metres. The young man fended off neighbours with the knives. Then, husband, son and daughter dragged Mrs Fitter into the front yard of a house, where the two men finished her off.

As she lay moaning, they plunged the knives several times into her body, and drove surgical needle holders through her nostril into her brain. The older man shouted that his wife was Satan; that she was going to die.

Kylie Fitter, the NSW Supreme Court found a year later, had taken part in the "concerted attack on the quarry with no less an intent than to kill". Justice Graham
Barr said she had dragged her mother and "kicked her, punched her and held her legs as the attack was carried out".

None of the many traumatised witnesses saw everything. Kylie admitted later only to having held her mother's legs down for a few seconds, and denied having punched or kicked her, but a neighbour's account was accepted as the more accurate. To Kylie, it was a demon, not her mother on the ground.

It didn't matter in the end: Kylie was found not guilty of murder on the grounds of mental illness. Her father and brother were also not convicted of any offence because of their state of mind at the time.

In such cases, mentally ill people in NSW found to lack the capacity to understand the wrongfulness of their act are detained as forensic patients. They are held in the psychiatric wards of jails or similar facilities. The court does not impose a sentence. They can be held indefinitely, in the old term, "at the governor's pleasure". In detention, they receive the medication and treatment many failed to get in the community from the state's impoverished mental health service.

And every six months their condition is reviewed by the Mental Health Review Tribunal. The tribunal is an independent, quasi-judicial body of three members, whose new president is a former Supreme Court judge, Greg James.

It gathers evidence from the treating experts, assesses the patient's progress, and determines whether, at any stage, they are no longer a serious danger to themselves or others, and could progressively, under the strictest conditions, be released into the community.

However, the tribunal can only make recommendations. In NSW, the power to release a forensic patient lies with politicians, who are subject to lobbying and voter backlash. Officially the Health Minister, John Hatzistergos, makes the decision, but effective power resides with the Minister Assisting the Health the Health Minister, Cherie Burton. And Ms Burton is taking a tough stance. This year she rejected all six recommendations for conditional release, insisting on more conditions, and more information.

Kylie is one of the prisoners. The Mental Health Review Tribunal has found her to be no serious danger three times now. Its fourth recommendation, that she be freed from Juniperina Juvenile Justice Centre under strict conditions, is due soon. "It is more than satisfied ..."

Kylie is not on medication, not even for the depression that dogged her early teen years, and has no symptoms of mental illness. She has had no recurrence in 4½ years of the one-off psychotic episode she experienced on October 16, 2001.

There is no upside for the Government, especially a year away from an election, in releasing forensic patients. It is politically expedient to keep forensic patients incarcerated no matter how strong the evidence of their recovery. Robert Hayes, former president of the tribunal, says: "Applicants for conditional release are not advised why they are knocked back. The only possible rationale can be in a law-and-
The order environment is battening down against any possible risk even when experts have given assurances the risk is minimal."

In 2000, the Government released on strict conditions 70 per cent of those recommended by the tribunal; last year it freed only 30 per cent.

Reviews in 1992, 1993 and 1996 recommended the health minister lose the discretion to keep forensic patients locked up indefinitely. Other states have placed the power with a court or similar tribunal so that political considerations can play no part.

ROBERT and Janice Johnston met Kylie Fitter for the first time in a counselling room at the Juniperina detention centre. Amid the clutter, the chaplain, a youth worker, and a psychologist with clipboard were present to observe the interaction. "She was 17 by then," Mr Johnston says, "but seemed like a 14-year-old."

The Johnstons have four grown children. One of them, Anna, lived near the centre, and had been asked by the chaplain to visit a timid young girl who seemed entirely without friends or family.

The Johnstons - intelligent, down-to-earth, committed Christians - passed the test, and took Kylie under their wing. When she was eventually allowed out for a day, then a weekend, it was to their empty nest she flew.

Wary at first, the Johnstons looked closely for signs of instability. "I wondered what the triggers might be," Mrs Johnston says. "The first time she helped me in the kitchen I wondered what she felt about knives. I asked her to cut a carrot, and she had no idea. Her mother had done everything for her."

Eventually they grilled her about "the incident". They were grappling to understand her acquiescence in the horror. Why? Like others they have come to believe Kylie was as much a victim as her beloved mother.

A victim three times over: of an upbringing that made her unfit for the world, of a psychotic father and brother, and now of political expediency.

Kylie, born three months premature, already remained to her parents fragile and vulnerable. Sheltered from life, she was an introverted girl with no friends, or self-esteem, and little ability to think for herself. Her mother waited on her. Her father filled her head with extreme Christian beliefs. He was domineering, passionate about his God and his family. He suffered mild psychosis, it is now believed, for many years. But he was not unintelligent. Against the odds of a terrible upbringing, he gained a degree and became a youth counsellor.

Both Kylie's parents suffered abuse as children. Out of love for their children, they kept them close and fiercely protected. They moved a lot; there were several schools, and charismatic churches. By 13 Kylie was on Prozac. She left school at 14, a social misfit, believing she was stupid, and in isolation filled her days playing computer games. Her brother was spiralling into schizophrenia, hearing "demons' voices" and becoming fixated on harming his mother. Eighteen months before the murder he spent three months in hospital. Her parents were her world. She loved them both. And when her world began to fall apart, she had no outside reference point.
KYLIE'S paternal aunt - who does not want to be named - says the unravelling began in 1999. Kylie's father hurt his back at work, lost his job, and his self-esteem. He suffered such bad pain he turned to cannabis for relief. For a devout Christian his heavy drug use was bizarre and it triggered outlandish behaviour. He shared joints in the back shed with his son; he began to collect knives. There were good days and bad. Kylie was still "his little princess". Eventually, a year before the murder, he too, was admitted to a psychiatric hospital after he tried to choke his wife. "Fiona's last two years were hell," Kylie's aunt says. The couple separated, Fiona took out an AVO, and contemplated moving to Queensland, where her sister lived. Yet Kylie's mother encouraged her daughter to visit Katoomba, where her father and brother lived in their shared world of demons, angels and paranoid delusions. Shortly before the murder, Kylie visited her father. He showed no sign of illness and, because her mother shielded her from the truth, she did not fear him. It was a pleasant visit. Soon after he was admitted to hospital again, and on leaving it, headed with his son to the family's old home in Glossodia.

It was by all accounts an extraordinary night for Kylie. Not a moment's sleep could be snatched, with her father and brother ranting for hours about demons and angels. And when her father recounted a truly bizarre story, all Kylie's vulnerabilities conspired to make her believe, rather than resist. Her mother was evil, and drank babies' blood, her father said. God had told him her mother would die in a car crash but her evil spirit would come back to haunt them all.

Kylie was thrilled God, whom she loved, was speaking through her beloved father. In the opinion of the doctors who testified at the trial, Kylie lost capacity for rational thought and came to share the delusions of her father and her brother. When she later held her mother down, she believed her mother was already dead, and that it was a bad spirit the pair was slaying.

The young woman serving tea and biscuits gives credit to the Johnstons and the Juniperina staff for helping her become what she is today. The girl once considered incapable of making her own bed was dux in year 11 of distance education students and was accepted to study at University of Western Sydney. She hopes to become a dietician. A relay team of psychologists and psychiatrists has helped her gain insight. Her delusional state lasted only a few days - until her father told her the truth in a phone call - but coming to grips with what she did has taken longer. "I cried non-stop for weeks," Kylie says. "I was devastated by what had happened."

She has passed through many phases, fury at her father for having tricked her, anger at the mother she idolised for having left her so vulnerable. But gradually the murder has become less a focus, and the retelling has taken on a mechanical quality. She has become more discerning, and she wants to get on with her life. She is locked up every afternoon after university, and wants to leave the strip searches and security cameras behind. The Johnstons are willing to provide a home. The Mental Health Review Tribunal finds no reason to keep her locked up. It has laid out pages of detailed conditions around her release, including regular psychiatric check-ups. She must not associate with "extreme religious groups or groups with interests in the unusual, bizarre or paranormal".

Kylie says: "No one can get over something like that. I'll be very sad or very angry but I definitely think there's a future out there for me, and I'm motivated."
There are two aunts pivotal to this story, paternal and maternal. The paternal aunt, after initial shock at Kylie's involvement, has been reunited and wants her niece to have another chance. She is one of the few people to have had contact with the family over years, and who was so close to her sister-in-law, she was asked to identify the body. Kylie "is no longer the depressed, naive and isolated young girl that was living in a horrific situation", she says. "Kylie deserves to move on ... There is a point at which you have to get on with your life despite the terrible memories, and this is what I believe Kylie is trying to do. I find this to be quite appropriate."

But Ms Burton has sided with Kylie's maternal aunt, who lives near Cairns and who had not seen her sister for 20 years. The maternal aunt is a registered victim under the Victims Rights Act, and with the support of the powerful NSW Homicide Victims Support Group, has opposed Kylie's release. She believes Kylie to be a threat and insists on a mediation session between the two of them to persuade her of Kylie's insight. Ms Burton has agreed to this demand but the Johnstons have been told by the Department of Juvenile Justice such mediation as a condition of release is unprecedented. It could take two years to arrange. Kylie's lawyers are wary of giving her maternal aunt such power.

Even Martha Jabour, the executive director of the victims support group, who describes Ms Burton as "having worked very closely with our group", believes ministers have too much power in forensic cases. "I personally don't believe the minister should be making these decisions," she says. "It should be the Supreme Court or a special mental health court."

In response to questions about the influence of political considerations in decisions to release forensic patients, a spokeswoman for Ms Burton issued this statement. "Decisions ... are made with the aim of achieving the best prospect for a forensic patient being successfully rehabilitated. The criteria considered ... include the level of insight, assessment of risk, level of compliance with the rehabilitation program, and victim impact statements." The Government is completing its review of the Mental Health Act, including ministerial power over forensic patients.

Kylie Fitter, not guilty by reason of mental illness, is a new woman, and experts say, poses no danger to herself or others. Her paternal aunt says: "Keeping her locked up will stunt her. I can't see it being of any benefit to Kylie or to the community."
1.7 Lighting a dark prison

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Ruth Pollard.
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Scientists are seeking to unlock the causes of schizophrenia by focusing on it as a developmental disorder, writes Ruth Pollard.

SHE watched as her twin disappeared into the deep pit of mental illness. No longer competing for the top grades in maths and science, he withdrew from their world and entered his own, often terrifying, parallel universe.

It took several years and a run-in with police over a stolen car to produce the diagnosis that to many is a life sentence: schizophrenia.

And while her brother struggled, Cynthia Shannon-Weickert studied.

At first, medicine seemed the ideal way to help David Shannon, who by now had been institutionalised with adult psychiatric patients.

Dr Shannon-Weickert realised that medicine was limited by the treatments that were available, and for patients with schizophrenia, these were widely recognised as less than perfect.

"I decided the best way to help was to understand what was causing the disease so that we could come up with therapies and treatments to deal with the root of the problem, rather than just treating the symptoms.

"That has been a quest that I have been on for the last 20 years."

The 43-year-old neurobiologist - formerly from the National Institute of Mental Health in the US - has just been appointed to Australia's first professorial chair of schizophrenia research, based at the Prince of Wales Medical Research Institute in Sydney.

Working with the Neuroscience Institute of Schizophrenia Research and Allied Diseases and the University of NSW, Dr Shannon-Weickert will continue her research on molecular biology and brain development as part of a NSW Government-funded five-year, $8 million research program.
Viewing the disease through the prism of a developmental disorder, she studies the molecular and cellular development in the post-mortem brains of babies, toddlers, children, adolescents, teenagers, young adults and adults and compares them to those who have schizophrenia.

"There is a developmental program that unfolds in the normal human brain as we grow, mature and come into adulthood, and what happens to the brains of people with schizophrenia is that process gets derailed, truncated or terminated.

"Those things that are part of becoming a mature adult, learning to navigate social situations, planning for our future, are the very things that people with schizophrenia cannot do."

She likens schizophrenia research to investigating a plane crash. "Before we were just looking at the debris on the ground and trying to piece together what was the cause."

With research focusing on neurobiology, genetics and environmental factors, scientists are hoping to unlock the mystery of the causes of schizophrenia.

"My brother was sick during high school but we didn't really recognise it as a family - he withdrew socially, he became very volatile at times, he was very difficult for my mother to handle. It is just so awful to see someone robbed of their life at such an early stage."

The past two decades of schizophrenia research had been dominated, and hampered, by a simplistic genetic hypothesis, says the director of Sydney University's Brain and Mind Research Institute, Professor Ian Hickie.

"It was thought that if we could find the gene we could find the cause ... that has failed; it is now clear that there are a whole range of genes, each contributing to the causal path."

He says understanding brain development is crucial, but the focus should also turn to factors that make people vulnerable - viral illnesses affecting the brain, drug exposure in adolescent years and other pressures.

Between 5 and 10 per cent of cases of schizophrenia can be explained by the interaction of a gene with cannabis use - that leaves 90 per cent of cases unexplained, he says.

"It is increasingly likely that we will identify environmental agents, and that could certainly include infectious agents such as viruses. It might be that a vaccine becomes plausible.

"People said 'you will never be able to vaccinate against cancer', and there's Ian Frazer [Australian of the Year] saying 'yes you can' - we may be, in five or 10 years' time, in a situation with schizophrenia that cervical cancer is now in."

The head of the school of psychiatry at the University of NSW, Philip Mitchell, says that 20 years ago most experts believed psychotic disorders such as schizophrenia would be understood in a decade.
"We are more sanguine now," he says. "But there are now good indications that we are on the threshold of really understanding this. Once we understand one of the cellular or genetic pathways, we will very quickly be able to develop better treatments."

He says the promise, in the long term, is that new treatments will reduce the enormous disability caused by the disease.

Much of the significant clinical work in Australia is focused on "early intervention" - detecting the signs of schizophrenia and other psychotic disorders before the person experiences an episode so severe they are taken to hospital or, as is often the case, jailed.

Professor Vaughan Carr is the scientific director at the Neuroscience Institute of Schizophrenia and Allied Disorders in Sydney. He also runs a clinic in Newcastle that treats patients at high risk of developing schizophrenia, typically teenagers from 14 to 18, when the telltale symptoms most often reveal themselves.

"The aim is to learn better means of early detection and intervention, stalling the onset [of schizophrenia] or preventing it all together," Carr says.

"We identify people we think are at risk, either on the basis of family history of schizophrenia or who have the early signs of non-specific distress such as anxiety."

It is thought that without early intervention, 40 to 50 per cent will go on to develop schizophrenia or other psychotic disorders, he says.

The institute is working with experts in NSW, Queensland, Victoria and Western Australia to establish a large schizophrenia research bank that would be available to scientists around the country to use as part of their research.

The plan is to build a sample size of 2000 people with schizophrenia - their clinical and cognitive profile and brain scans will be entered into the brain bank and their blood will be collected for a DNA bank.

A control group of 2000 people without schizophrenia will also be established.

"It is a resource that will be there in perpetuity so people can test particular genetic hypotheses," Carr says.

Shannon-Weickert once believed she could save her brother.

"It's sad, to think that I was going to fix my brother was very naive, I was a young girl," she says.

"Now I realise it may be that, in my generation, all we do is figure out what causes the disease. It is going to take the next generation of scientists to come up with the cure."

Diagnosis schizophrenia

200,000 Australians are affected by schizophrenia.
* It can be characterised by psychosis, hallucinations, delusions, paranoia, altered perceptions of senses, disorganised thoughts, behaviour and speech, and withdrawal from family and friends.

* One in six schizophrenics will take their life, more than 40 per cent will attempt suicide and 70 per cent will regularly contemplate ending their life.

* The lost earnings from people unable to work because of schizophrenia totalled $488 million in 2001, with a further $88 million in carer costs.

* Direct costs to the health system were $661 million.

* More than 70 per cent of people with schizophrenia do not work at all and nearly half have no school qualifications.

* The typical age for the onset of schizophrenia is 18 to 25. - Access Economics, Schizophrenia Costs: An analysis of the burden of schizophrenia and related suicide in Australia
1.8 Teens at most risk from dope

Tackling misconceptions about cannabis use is the key to reducing the harm it causes, writes Ruth Pollard.

WHEN tetrahydrocannabinol, the active ingredient in cannabis, collides with the growing brain of a teenager the results are dangerously unpredictable.

Some use cannabis socially for a time then dump it as they take on the responsibilities of adulthood, suffering no serious effects.

But for a significant number of others, psychosis, schizophrenia and other mental illnesses develop and a vicious cycle of self-medication and worsening symptoms is amplified by torrid teenage emotions.

In 1920, when Australia first outlawed cannabis, there was little evidence of its use here.

Now it is the country's most widely used illicit drug: at its peak in 1998, 60 per cent of 20- to 29-year-olds reported having used cannabis.

Once viewed as a bit of harmless fun, it is now recognised as the third most prevalent drug of dependence after alcohol and tobacco. About 10 per cent of people who try cannabis become dependent - this is 3 per cent of Australia's population, or 700,000 people.

Those most vulnerable are the young and those who use regularly. With the age when people first try the drug dropping from 30 to below 16, many young brains are at risk of harm from cannabis.

The key question for those in the field is not whether cannabis is associated with mental illness, but how to reduce the harm it causes.

The Mental Health Council of Australia says most of the effort must be directed at teenagers, many of whom do not associate their cannabis use with the negative feelings they are experiencing.
"Years ago I loved it [cannabis] but now I just think back to my symptoms and how bad it was and the problems it caused my life, and I just really think it's not worth it," says one young man who has recovered from psychosis.

Delays in seeking help are a big problem, with many people waiting until their 30s to try to find treatment.

"It is clear we need much more sophisticated interventions than currently used," a council report, Where There's Smoke, notes.

Yet experts also say it would be wrong to demonise the drug, or run a scare campaign that attempted to raise the level of fear about its side effects - after all, 90 per cent of users experience few or no long-term problems.

Indeed, most have stopped using the drug by their late 20s, as employment and family responsibilities kick in, the report, released yesterday, says. Since the peak of use in 1998, there has been a decline in the numbers of people aged 14-19 and 20-29 taking cannabis.

Yet, disturbingly, there has been a corresponding, albeit smaller, increase in the use of ecstasy and methamphetamine over the past six years, says the chief executive officer of the Mental Health Council of Australia, John Mendoza.

Investing money, and lots of it, is the first step for state and federal governments, he says.

The creation of centres of excellence around Australia to deal with cannabis interactions, as well as alcohol and other drug use, and provide an outreach service for young people, was vital and expensive - it would cost $300 million a year.

Beyond that, an additional $100 million a year is needed to deal with adults with problematic cannabis use, Mendoza says.

Then there is the issue of treatment.

"We have got a group of young adults who smoke and smoke regularly, and we have virtually nothing in the kitbag in terms of treatment programs for dependence," Mendoza says.

School-, university- and TAFE-based drug education is another area that needs significant investment to send consistent, strong prevention messages similar to those warning against smoking or drink-driving, he says.

"This is the period where people will experiment with illicit substances and the period when they will most likely experience their first episode of mental illness or psychosis; it is also when, if we intervene, we get the best results.

"It is coinciding with a time when brain development is undergoing fairly critical changes. It is a period where all sorts of things go a bit awry for individuals ... Throw in some chemical additives and things can go horribly wrong."

But Mendoza warns against punitive approaches.
"Experience from here and abroad is that if you ban those students who use cannabis and alienate them, it makes it more difficult to reach them with prevention messages.

"You will drive the drug use underground or drive students away from being able to access help."

Ten years ago the link between cannabis and psychosis was not clear. There is now a significant and growing body of evidence of the relationship between the two.

There is evidence of a genetic vulnerability to psychosis being, in effect, triggered by cannabis use, the council report says.

Cannabis use is also known to precipitate schizophrenia in people who have a family history of the illness. The incidence of psychotic symptoms is two to three times greater among those who have used the drug yet, in this case, cannabis has not been proven as a major causal factor.

While there is no clear causal link between cannabis use and depression, there is a link between early cannabis use and later depression, the report notes.

Patrick McGorry is a professor of youth mental health at the University of Melbourne and the executive director of the ORYGEN Youth Health, a mental health service that also provides education, advocacy and health promotion activities.

"We see a lot of young people with a lot of cannabis-related problems, and we see the subgroup who have really got into trouble," McGorry says.

"It is so freely available that I do not think there is any possibility of restricting the availability like you might with heroin."

Yet as the harm associated with cannabis use becomes better recognised, governments and services are at risk of losing credibility with those who smoke it if they try to demonise the drug, he warns.

The reason: most people who use cannabis do not get into trouble. "You cannot cry 'reefer madness', but it is important to say that it is harmful for a subgroup of people - it is a real balancing act."

In one program that McGorry runs, half of the young people with psychotic illnesses have had some exposure to cannabis and a quarter have significant current use that complicates their illness.

"Moderate to heavy use exacerbates their illness, impedes their recovery and increases their relapse rate," he says.

A lack of proven treatments also clouds the issue. There are no medications to treat cannabis addiction, and questions about the effectiveness of psychological interventions, such as cognitive behavioural therapies, alone.

McGorry conducted a trial involving the provision of basic education, support and information about the dangers of cannabis use and compared it to the provision of cognitive behavioural therapies.
The two arms of the trial had the same results, and showed that simple interventions such as education do work for some people.

"We need new treatments to treat the addiction ... and we need a lot more investment in research into cannabis use."

It was also vital to realign drug and alcohol services with mental health services so families and clients did not constantly bounce from one service to the other, or, worse still, fall through the cracks.

The executive director of the Black Dog Institute, Professor Gordon Parker, says there is little doubt he is seeing more and more young people with psychotic conditions where cannabis is involved.

More and more were ending up in acute psychiatric beds. "The in-patient services are now disproportionately weighted to those who have drug-induced psychosis, squeezing out other people with mental illness who used to occupy those beds," Parker says.

"It is not a very efficient use of the health dollar if you merely hold somebody for a few days or a week, and then they go back out and start taking the drugs again - the return on that investment is minimal."

Instead, Parker says, it is important to intervene early in the development of a psychotic illness, and to ensure it is properly diagnosed and treated and that follow-up support is provided.

"Adolescents are unlikely to identify drugs even if drugs are the culprit ... they will present with anxiety and depression but they will not link these feelings with cannabis."

Intervention at this stage can mean the difference between a low-level mood disorder and a teenager moving on to a more serious mental illness such as psychosis and, in many cases, harder drugs, he says.

The news in NSW is not all bad. The Government has opened four specialist cannabis clinics - in Paramatta, Sylvania, the Central Coast and Orange - and the early results from two of those centres is promising.

People who attend the clinics have reported an average reduction in use of more than 50 per cent, and 58 per cent were either abstinent or rare users, says David McGrath, the director of mental health and drug and alcohol programs at NSW Health.

"We are looking at rolling the model out on a broader basis ... [because] people who use cannabis didn't necessarily see themselves in the same demographic as people who use heroin or had problematic alcohol consumption."
1.9 They were young, troubled and dependent on a health system that let them die. Their parents are asking what went wrong.

Extra
LIZ PORTER
1871 words
21 May 2006
Sunday Age
First
20
English

BEN McFARLANE was 29 when he wandered off into bushland near Mount Baw Baw, barefoot and lightly clad, on a cold January night in 2001. Diagnosed with schizophrenia 10 years earlier, he had become psychotic when his medication was changed months before his disappearance.

When he was discharged by the local hospital's crisis and assessment team, his parents, Helen and Cyrus, were told that his problems - which included wandering from home and into traffic, and displaying fear and aggression towards them - were "behavioural" not psychotic. Unsurprisingly, they feel that the system let them, and their son, down. It is a feeling shared by the 24 members of the support group they joined in the wake of Ben's disappearance.

When the group gathers on a Saturday lunchtime in a Malvern restaurant, there are clues to the awful fate that binds its members. One woman suddenly puts an arm around another, who has tears running down her cheeks. On the table before them are coronial findings and submissions to Senate and Victorian parliamentary inquiries.

Each member has lost a child - and, in one case, a boyfriend - first to mental illness, then to death. Most of the deaths were by suicide, although some were from drug overdose or misadventure.

Today, 10 of the group's members are present - eight women and two men, each with a harrowing story to tell. Jeanne Solity's son, David, 26, an artist and performer, died under a train in 2003 while on an unsupervised outing. He died around the corner from the hospital where he was an involuntary patient being treated for schizoaffective disorder, which includes symptoms of schizophrenia, such as hallucinations and delusions, and a mood component, such as depression or mania.

Maria Hore-Lacy's son, Ricky, was diagnosed with paranoid schizophrenia at 21 and killed himself, aged 24, in 1995. The year before, as her son was discharged from hospital, a doctor told her: "One day your son is going to kill himself."

But the members of this group have more in common than their grief, pain and anger. They are here to lobby for more beds and better staffing in the mental health system,
and for high-quality support after discharge, which is the time when most deaths by suicide occur. Their hope is that such changes might save other parents from the pain they have experienced.

For Caroline Storm, whose daughter killed herself in 2002, the group meetings are the only place where she can relax in the knowledge that her companions genuinely understand how she is feeling.

"We are such different people," says Storm. "But we have all been through the same thing."

The group is also a place where members can express emotions unspeakable elsewhere. In October 2002, amid the outpouring of sympathy for the families of the Bali bombing victims, one group member said: "I'm so bloody sick of this Bali thing." Caroline Storm found herself nodding. "It was the first public tragedy after Ann died," she recalls. "And I was crying for the parents. But we wanted our children's deaths to be known and counted, too."

The group began in the late '90s when Joan Cusworth, a former Mental Illness Fellowship counsellor, started meeting with three other women who, like her, had lost a child to mental illness and suicide.

Schizophrenia robbed Stephen Cusworth of his happiness and his friends. As a teenager, he was a champion sportsman. By his 20s, he was lost, lonely and on medication. At 33, living in a flat attached to his parents' house, he disappeared after taking a walk down to the Yarra. His body was never found.

Joan Cusworth and her three companions called their mini-support group the "sticky bun group", after the now-closed cafe in Templestowe where they used to meet. The title stuck over the years as bereaved parents came from all over Melbourne to join. Meanwhile, as the venue changed to somewhere more central, the members found a second identity as a lobby group.

In 2003, Kathryn Brand's son, Lee, 27, died of a drug overdose several days after he was discharged from the Monash Medical Centre's psychiatric ward - without his GP being informed of his release or the fact that Lee had been taken off the medication he had been using.

Last year, Brand organised a visit to State Parliament to make a slide presentation about her son's life to MPs. Along with Storm and fellow group member Graeme Bond, she appeared last August before the Victorian Parliamentary Law Reform Committee's inquiry into the 1985 Coroner's Act, where the three argued for changes in the system, including an emphasis on the prevention of deaths, and the speedier introduction of improvements to the mental health system recommended by coroners over the past decade.

Bond has been campaigning for change in the system since his severely depressed 19-year-old son, Jason, committed suicide in 1993 after being discharged from a psychiatric hospital without either of his parents being informed. He has set aside his campaign to have the inquest into his son's death re-opened - but only temporarily.
Along with Brand, he also made submissions to the Senate select committee on mental health (which reported its recommendations for a nationwide network of mental health centres last month).

Today he is poring over the recent 37-page finding of the inquest into the death of Vivienne Lucas, daughter of fellow group member Pam Lucas.

Lucas attended her first meeting back in April 2003, only weeks after Vivienne, 33, took an overdose of her medication and died.

It was February 6, nine days after she had been discharged from The Alfred hospital, where she had been an involuntary psychiatric patient, and only three days after Lucas had phoned the head of the hospital’s crisis assessment and treatment team, appalled that its members had not been visiting her daughter, only making phone contact. A talented professional dancer, Vivienne was diagnosed with bipolar disorder (manic depression) at 20. The ensuing 12 years of her life were blighted by suicide attempts and multiple involuntary admissions to psychiatric hospitals in Melbourne and Sydney. Along the way, she made heroic efforts to "start again", finding new jobs in new places. At the time of her death, she had a BA in performing arts, had completed a diploma in drug and alcohol counselling and was in the process of applying for a job as a receptionist.

HER illness had patterns, of which her mother and sister were only too aware. One certain warning sign that her condition was deteriorating was the periodic announcement that she wanted nothing to do with her family.

Her file, Lucas says, contained a note, written while she was well, advising staff to listen to her family. But under the current privacy and mental health legislation, hospital staff were technically correct in carrying out their patient's expressed desire to cut contact with her family.

Lucas made her call to the CAT team manager on Monday morning, February 3, 2003, after a nightmare weekend in which her agitated daughter, suffering from paranoid symptoms, had made accusations about a neighbour entering her flat. A local locksmith had changed her locks but called police after Vivienne made irrational accusations against him. But Lucas could not convince the CAT team that her daughter was in danger. "I was screaming at him, saying 'How can this happen?' " The CAT team leader's notes of the conversation, obtained through FoI, showed his lack of interest in her views. "Mother allowed to ventilate" was his summary.

The inquest was told that on Wednesday, February 5, Vivienne Lucas had been acting strangely and making agitated phone calls to the local mental health clinic and to her consulting psychiatrist at The Alfred. The doctor made an appointment with her for the next day and recommended the CAT team visit.

But a team nurse phoned her that evening, recording in her notes that her patient "states everything is fine".

On Thursday, Vivienne didn't answer the phone when her psychiatrist tried to reach her. She had taken a fatal overdose of her medication either late the previous evening or early that morning.
Three years later, there is some satisfaction for Lucas in the fact that the coroner made recommendations that are implicitly critical of the treatment her daughter received in the last weeks of her life. One specifically suggests changes to privacy legislation so that psychiatric patients' families can be consulted about their care. Another is critical of The Alfred's psychiatry department, suggesting it "reconsider its hierarchical structures" so that CAT teams would, as a priority, attend to involuntary patients when asked to by the patient's consulting psychiatrist.

Others in the support group have endured the crushing disappointment of findings they have interpreted as a "rubber stamping" of the "whitewashed" version of events presented by lawyers for hospitals. Only months after her own daughter's death, Lucas accompanied Storm to every sitting of the 2003 inquest into the death of her daughter, Ann Cameron, who committed suicide on March 16, 2002, at the age of 40.

Storm felt she had every reason to hope for some criticism of hospital authorities in the coroner's findings.

Her daughter, a gifted photographer, had suffered from schizophrenia from the age of 30. She had twice attempted suicide before her final admission to The Alfred on February 6, 2002, suffering "rebound psychosis" - a florid psychotic state that can develop when a patient suddenly stops taking their medication. On March 14, Storm was horrified to discover that her daughter was being sent home, alone, to her flat. She knew Ann was still in the same state she had been before previous suicide attempts.

"I said, 'You can't do that'," recalls Storm. "But they don't listen to carers." The case manager told the worried mother that she had seen Ann that morning and she had denied being suicidal. Ann was discharged on Saturday morning. She killed herself 30 hours later.

While cross-examining a psychiatrist called as an independent expert at the inquest into the death, Storm's lawyer, Dr Ian Freckelton, elicited the admission that psychiatric hospitals regularly discharged "patients who are posing a significant risk to others or to themselves".

But the inquest findings brought the grieving mother no satisfaction. While the coroner made recommendations about clinicians listening to carers and being vigilant in cases of involuntary patients being given leave, Storm knew there was no body responsible for implementing them.

"We all lean on each other's shoulders," says Graeme Bond. "But it's not enough to say 'woe is me' and leave it at that.

"We are serious about forcing governments and bureaucrats to meet their obligations and to put accountability in the system."

For help or information, visit www.beyondblue.org.au, call Suicide Helpline Victoria on 1300 651 251 or Lifeline on 131 114. Mental Illness Fellowship Victoria helpline: 8486 4222.

Document SAGE000020060521e25l00025
Many carers of the mentally ill face unnecessary obstacles in helping their loved ones survive, writes Julie Robotham.

WHEN she saw the date on the appointment letter, Teresa Tremtiaczy slumped in despair. Her son, Darius, was unravelling before her eyes as increasingly terrifying delusions consumed first his mental and then his physical health. His life was ebbing away, as surely as if his condition had been cancer or organ failure.

The notification arrived in early November last year and the psychiatric assessment was to take place in January, but Teresa knew that 42-year-old Darius did not have that long.

Some time in the early hours of November 29, he slipped out of the Randwick flat where he had lived since childhood, poured petrol over his body and set himself alight. He died in the neat back garden, four metres from the bedroom where his exhausted mother had finally fallen deeply asleep after weeks of watchful nights.

The story of Darius Tremtiaczy - podiatrist, world traveller, didgeridoo player - has every classic element of the familiar crisis in NSW's mental health system. Through a succession of Sydney hospitals he waited endlessly for services, which he then received only sporadically. He experienced little continuity in the individuals supervising him, who might have noticed the depth and speed of his decline.

In early 2004 Darius's life began to fold in on itself. He was scared that someone - he could not explain who or why - was planning to kill him. He gave up his part-time job in a hospital because there were so many people there, in his mind all potentially murderous. The professional, who in his previous life had treated the feet of homeless people in inner-city hostels, was now sleeping rough, running up fines for fare evasion.

At home, his world contracted further. He became too frightened to sleep, even in his own bed, and made a nest on the balcony, where he lay, starving and dehydrated in the full sun.

It is terribly painful for Teresa to reflect on the last weeks of her only child, but one hurt stands apart. Despite being her son's constant carer during his two-year
downward spiral, she was excluded from key decisions on his treatment, informed that her involvement would breach his privacy.

On one occasion when a psychiatric emergency team visited the house at Teresa's request, the visitors called out to Darius upstairs, who replied that he was fine. Teresa was told they had no right to override his wishes and to conduct the assessment she desperately wanted.

When Darius was an in-patient at an acute mental health facility, Teresa was asked to leave when she arrived outside visiting hours, even though Darius's paranoia by this stage meant he was dependent on his mother for food, believing hospital meals had been poisoned.

Teresa said her questions about her son's medication were not answered. To this day, she does not know his diagnosis. "They thought I was a pushy mother," said Polish-born Teresa. "They said, 'How old is he? 42? Well, he's old enough to look after himself.' I needed them to listen to what I had to say, but it was like I was nobody."

At the recent premiers' conference, the Prime Minister pledged an invigorated focus on mental health, and the premiers emphasised new funding needed to go to community mental health services, to avert people becoming so ill that they need an in-patient bed.

But psychiatrists say treating more people in the community means more families will need to be able and willing to be the backstop for that care, shepherding loved ones through the system and advocating for them if their condition worsens.

Investment alone will not prevent tragedies like that of Darius Tremtiaczy, they say, unless it is accompanied by cultural and legal change that acknowledges the role of carers who frequently anchor the care of an adult child, sibling or parent.

"If we're going to expect family members and carers to take on such a big responsibility, such an emotionally draining task, then we need to support them in that," said Louise Newman, the director of the NSW Institute of Psychiatry. "Families play a pivotal role that [mental health] services would find it hard to match."

Doctors and nurses sometimes misunderstood privacy legislation, she said, and believed "they couldn't or shouldn't talk to significant others ... in [patient] management terms it's just unacceptable, really".

Cherie Burton, the NSW Minister Assisting the Minister for Health (Mental Health), said the State Government was committed to giving carers more support and had increased funding of family and carers' programs by $1 million to a total $3.6 million between 2005 and 2008. The money would be spent to improve the way mental health services worked with families and to support carers with training and other services.

"If carers are supported to maintain their caring role, they are better equipped to look after their loved one and to assist in their ongoing recovery," Burton said.

In 2002, Dr Brian Pezzutti completed a select committee inquiry into mental health services in NSW, identifying the role of carers and families as a key issue. He recommended the health minister "seek to amend the NSW Mental Health Act 1990
to allow limited disclosure of confidential information ... to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client".

In its response, the Government agreed to consider the issue as part of a wider review of the act, and released a discussion paper on privacy and carer issues two years ago. It included extracts of submissions to Pezzutti’s inquiry that pungently outlined the problem. "Unfortunately my experiences show that family are not taken seriously or included in the assessment yet they know the person better than any psychiatrist can through a one-hour interview," said one.

Another said: "At present, carers do not appear to have opportunities to either provide input or receive basic medical advice regarding the person they care for."

Burton said a draft bill was in preparation and would include proposals for improved information sharing and involvement of carers in the development of care plans for the mentally ill. Her spokeswoman said one aim was to make the revised act "more functional and written in plain English", which might extend the time needed to draft it.

Professionals are angry that the process has stalled despite the consensus for change. "I think there's a strong feeling in the field that the drafting of the bill needs to be expedited," said Professor Philip Mitchell, the chairman of the NSW Mental Health Priority Taskforce, convened last year to advise the health minister on how to manage the state's worsening mental health crisis. "There is a frustration that this has been a slow process."

For Professor Ian Hickie, executive director of Sydney University's Brain and Mind Research Institute, legal concerns are a fig leaf, hiding a treatment shambles. "Privacy's often an excuse for poor clinical practice," he said. The "very theoretical legal discussion" which had taken place as part of the review of the NSW Mental Health Act did not prevent mental health professionals from acting pragmatically when there was a clear case for involving relatives in care planning, Hickie said.

"There has to be a legal framework [but] already as it exists there is considerable flexibility," he said. "There are many situations where you can work with families in a productive way, but it takes time and clinical skill. Very experienced clinicians rarely invoke privacy as a significant excuse."

For Teresa Tremtiaczy, the discussion never came. "Darius understood his body was failing," she said. "I went to the GP and I cried and I said, 'I'm losing my son. Is there anything else you can do? Somebody has to help me.'"

"Where do you turn? What are you supposed to do? I was tearing my heart out. I knew I was losing him."

Document SMHH000020060302e2330005v
## Appendix 2- Overview of genre

<table>
<thead>
<tr>
<th>Headline and kicker</th>
<th>Newspaper and section of paper</th>
<th>Genre and rhetorical purpose</th>
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<tr>
<td>At 15, Kylie killed her mother. The demons are gone, but she’s still a prisoner of her past</td>
<td><em>The Sydney Morning Herald</em> News and features</td>
<td><strong>Media exposition</strong>: aims to convince the reader that Kylie Fitter should be released from prison</td>
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<td><strong>The fears of a clown</strong> Will Elliott talks to Aaron Timms  The popular transformation of the clown, from jester to psychopath, intrigues an award-winning first time novelist</td>
<td><em>The Sydney Morning Herald</em> Spectrum-books. The interview</td>
<td><strong>Interview/ review</strong>: summarises, discusses and evaluates a prize-winning book and gives some background on the writer and his working methods</td>
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<td><strong>In the mind’s eye</strong> In any exhibition of art by people with a mental illness there’s a danger of romanticising their suffering, writes Sebastian Smee</td>
<td><em>The Australian</em> Review-feature</td>
<td><strong>Media challenge</strong>: argues against the idea that people with psychotic illnesses are innately creative</td>
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<td><strong>A life revealed, a brother found</strong> After years spent living in denial over her brother’s mental illness, Georgia Blain says her mother’s courage in writing a book about his life helped her deal with his loss</td>
<td><em>The Age</em> Essays/ideas/comment</td>
<td><strong>Autobiographical narrative</strong></td>
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<td><strong>Jailed in body and mind</strong> Mentally ill prisoners are routinely locked in isolation, writes Elisabeth Wynhausen</td>
<td><em>The Australian</em> Features; feature</td>
<td><strong>Media exposition</strong>: aims to convince the reader that of both the existence and wickedness of the use of solitary confinement for people with psychotic mental illness in Australian prisons</td>
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<td>They were young, troubled and dependent on a health system that let them die. Now their parents are asking what went wrong</td>
<td><em>The Age</em> Extra: Sunday Age</td>
<td><strong>Media exposition</strong>: persuades that: the health system is responsible for the deaths of a number of young people with psychotic mental illness</td>
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<td><strong>Lighting a dark prison</strong> Scientists are seeking to unlock the causes of schizophrenia by focusing on it as a developmental disorder, writes Ruth Pollard</td>
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<td><strong>Media discussion</strong>: talks about some of the recent trends in schizophrenia research, in particular the work done by a researcher whose brother has schizophrenia</td>
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<td><strong>Teens at most risk from dope</strong> Tackling misconceptions about cannabis use is the key to reducing the harm it causes, writes Ruth Pollard</td>
<td><em>The Sydney Morning Herald</em> Health and Science</td>
<td><strong>Media challenge</strong>: addresses misconceptions about cannabis use and looks at some interventions by which young cannabis users can be prevented from developing psychotic illness</td>
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<td><strong>The fight to save Nathan</strong> Dale Hull spent years trying to get treatment for her mentally ill son. But no one would listen and a tragedy was inevitable, writes Richard Guilliatt</td>
<td><em>The Australian</em> Magazine; features</td>
<td><strong>Media exposition</strong>: argues that the failures of the health system are responsible for Nathan Hull’s crimes</td>
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<td><strong>Trapped in a system near collapse</strong> Many carers of the mentally ill face</td>
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unnecessary obstacles in helping their loved ones survive, writes Julie Robotham

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<th>News and Features</th>
<th>with psychotic mental illness and their families.</th>
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## Appendix 3- Subcategories of AFFECT

Table 3.2 Category of Affect - un/happiness

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<th>UN/HAPPINESS</th>
<th>Surge (of behaviour)</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>unhappiness</td>
<td>cry</td>
<td>grieving</td>
</tr>
<tr>
<td>misery [mood: ‘in me’]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>antipathy</td>
<td>abuse</td>
<td>hate</td>
</tr>
<tr>
<td>[directed feeling ‘at you’]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>happiness</td>
<td>laugh</td>
<td>thrilled</td>
</tr>
<tr>
<td>[cheer]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>affection</td>
<td>hug</td>
<td>love</td>
</tr>
</tbody>
</table>

Table 3.2 Category of Affect - in/security

<table>
<thead>
<tr>
<th>IN/SECURITY</th>
<th>Surge (of behaviour)</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>insecurity</td>
<td>twitching</td>
<td>anxious</td>
</tr>
<tr>
<td>disquiet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surprise</td>
<td>cry out</td>
<td>stunned</td>
</tr>
<tr>
<td>security</td>
<td>assert</td>
<td>confident</td>
</tr>
<tr>
<td>confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>trust</td>
<td>commit</td>
<td>confident in/about trusting</td>
</tr>
<tr>
<td></td>
<td>entrust</td>
<td></td>
</tr>
</tbody>
</table>
Table 3.3 Category of Affect- dis/satisfaction

<table>
<thead>
<tr>
<th>DIS/SATISFACTION</th>
<th>Surge (of behaviour)</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>dissatisfaction</td>
<td>yawn</td>
<td>bored</td>
</tr>
<tr>
<td>ennui</td>
<td></td>
<td></td>
</tr>
<tr>
<td>displeasure</td>
<td>screaming, shouting,</td>
<td>angry, sick of,</td>
</tr>
<tr>
<td></td>
<td>protesting</td>
<td>fed up</td>
</tr>
<tr>
<td>satisfaction</td>
<td>busy</td>
<td>fascinated,</td>
</tr>
<tr>
<td>interest</td>
<td>industrious...</td>
<td>interested,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>intrigued</td>
</tr>
<tr>
<td>pleasure</td>
<td>pat on the back</td>
<td>pleased,</td>
</tr>
</tbody>
</table>
## Appendix 4- Judgment in the texts

### 4.1 Kylie Fitter

<table>
<thead>
<tr>
<th>Mentally Ill Individuals</th>
<th>Institutions (State Government and representatives)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Judgment: social sanction : propriety and veracity</strong></td>
<td><strong>+</strong></td>
</tr>
<tr>
<td><strong>Prisoner</strong> of her past (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>Gentle</strong> (+ve prop)</td>
<td>concerted attack on the quarry with no less an intent than to kill&quot;. (-ve prop)-Kylie</td>
</tr>
<tr>
<td><strong>polite</strong> (+ve prop)</td>
<td>Kylie Fitter helped kill her mother (-ve prop)</td>
</tr>
<tr>
<td><strong>Child-like</strong> (+ve prop)</td>
<td>crime (Kylie) (-ve prop)</td>
</tr>
<tr>
<td><strong>sweetness itself</strong> (+ve prop)</td>
<td>held her mother down (-ve prop)</td>
</tr>
<tr>
<td><strong>not guilty</strong> (not –ve prop)</td>
<td>finished her off (-ve prop: father and brother)</td>
</tr>
<tr>
<td><strong>not convicted of any offence because of their state of mind at the time</strong> (not –ve prop)</td>
<td>plunged the knives several times into her body, and drove surgical needle holders through her nostril into her brain. (-ve prop: father and brother)</td>
</tr>
<tr>
<td><strong>not guilty by reason of mental illness</strong> (not –ve prop)</td>
<td>kicked her, punched her and held her legs (-ve prop)</td>
</tr>
<tr>
<td></td>
<td>tricked (-ve ver: father)</td>
</tr>
<tr>
<td></td>
<td>slaying (-ve prop: father)</td>
</tr>
<tr>
<td></td>
<td>a threat (-ve prop: Kylie)</td>
</tr>
<tr>
<td></td>
<td>he tried to choke his wife (-ve propriety)</td>
</tr>
<tr>
<td></td>
<td>fixated on harming his mother (-ve prop: brother)</td>
</tr>
</tbody>
</table>

---

21 All judgments in this table referring to mentally ill individuals refer to Kylie Fitter unless otherwise stated.
<table>
<thead>
<tr>
<th>Judgement : social esteem : capacity, tenacity, normality</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ poses no danger (not –ve norm)</td>
</tr>
<tr>
<td>+ no serious danger (not –ve norm)</td>
</tr>
<tr>
<td>+ not on medication, not even for the depression (not –ve cap)</td>
</tr>
<tr>
<td>+ has no symptoms of mental illness (not –ve cap)</td>
</tr>
<tr>
<td>+ has had no recurrence of the one off psychotic episode (not -ve cap)</td>
</tr>
<tr>
<td>+ more discerning (+ve cap)</td>
</tr>
<tr>
<td>+ motivated (+ve tenacity)</td>
</tr>
<tr>
<td>+ dux in year 11 (+ve norm)</td>
</tr>
<tr>
<td>+ insight (+ve capacity)</td>
</tr>
<tr>
<td>+ not unintelligent (not –ve cap: father)</td>
</tr>
<tr>
<td>+ no longer the depressed, naïve (not-ve cap)</td>
</tr>
<tr>
<td>+ and isolated young girl (not –ve norm)</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>+</td>
</tr>
<tr>
<td>+</td>
</tr>
</tbody>
</table>
mother (-ve cap: control: brother)

his heavy drug use was bizarre (-ve norm: father)

outlandish behaviour (-ve norm)

all Kylie’s vulnerabilities conspired (-ve cap)

a social misfit (-ve norm)

believing she was stupid (-ve cap)

lost the capacity for rational thought (-ve cap)

seemed like a 14 year old (-ve cap)

once considered incapable of making her own bed (-ve cap)

spiralling into schizophrenia (-ve cap: brother)

idolised (-ve cap)

<table>
<thead>
<tr>
<th>Kylie Fitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally ill individuals</td>
</tr>
<tr>
<td><strong>social esteem</strong></td>
</tr>
<tr>
<td>-ve cap (21)</td>
</tr>
<tr>
<td>+ve cap (2)</td>
</tr>
<tr>
<td>-ve norm (6)</td>
</tr>
<tr>
<td>+ve norm (1)</td>
</tr>
<tr>
<td>-ve ten (1)</td>
</tr>
<tr>
<td>+ve ten (1)</td>
</tr>
<tr>
<td>-ve prop (11)</td>
</tr>
<tr>
<td>+ve prop (4)</td>
</tr>
<tr>
<td>-ve ver (1)</td>
</tr>
<tr>
<td>+ve ver (1)</td>
</tr>
</tbody>
</table>
# 4.2. Jailed in body and mind

<table>
<thead>
<tr>
<th>Mentally Ill Individuals</th>
<th>Institutions (prison system, mental health system and proponents)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>social esteem: capacity, normality and tenacity</em></td>
<td></td>
</tr>
<tr>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td><strong>jailed in body and mind</strong> (-ve cap)</td>
<td><strong>it’s easier</strong> to lock people in their cells (-ve ten)</td>
</tr>
<tr>
<td><strong>unbalanced</strong> (-ve cap)</td>
<td><strong>given the wrong</strong> psych medication (-ve cap)</td>
</tr>
<tr>
<td><strong>not guilty by reason of mental illness</strong> (-ve cap)</td>
<td><strong>don’t recognise</strong> mental illness (-ve cap)</td>
</tr>
<tr>
<td><strong>likely to deteriorate</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>depressed</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>seriously mentally ill</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>least able to handle the isolation</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>extreme high risk</strong> (-ve norm)</td>
<td></td>
</tr>
</tbody>
</table>

*(social sanction)*

<p>| + | - | + | - |
|--------------------------|------------------------------------------------------------------|
| <strong>Propriety and veracity</strong> | |
| <strong>troublemaker</strong> (-ve prop) | <strong>gassed and dragged away</strong> (-ve prop) |
| <strong>set the cell on fire</strong> (-ve prop) | <strong>prisons lock up mentally ill inmates in solitary confinement,</strong> (-ve prop) |
| | <strong>condemned</strong> (-ve prop) |
| | <strong>locked up 22 hours a day for 26 months</strong> (-ve prop) |
| | <strong>cruel</strong> (-ve prop) |
| | <strong>inhumane</strong> (-ve prop) |
| | <strong>degrading</strong> (-ve prop) |
| | <strong>absolute abomination</strong> (-ve prop) |</p>
<table>
<thead>
<tr>
<th>Officially illegal (-ve prop)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Punished for behaviour that is part of their mental illness (-ve prop)</td>
</tr>
<tr>
<td>Wrongly placed in immigration detention (-ve prop)</td>
</tr>
<tr>
<td>Gowns which provide little allowance for modesty or dignity (-ve prop)</td>
</tr>
<tr>
<td>There is no circumstance in which [solitary confinement] is appropriate (-ve prop)</td>
</tr>
<tr>
<td>Solitary confinement has been condemned (-ve prop)</td>
</tr>
<tr>
<td>Locked up 23 hours a day (-ve prop)</td>
</tr>
<tr>
<td>Terms that suggest inmates are being managed or protected rather than punished (-ve prop)</td>
</tr>
<tr>
<td>Women with a serious mental illness are locked in isolation 23 hours a day (-ve prop)</td>
</tr>
<tr>
<td>Women who are detained in the padded cell in CSU are generally held in a totally naked state (-ve prop)</td>
</tr>
<tr>
<td>Prison staff &quot;admitted to the use of restraints, body belts and so forth&quot; (-ve prop)</td>
</tr>
<tr>
<td>Mentally ill prisoners are often held in conditions of solitary confinement, locked in their cells (-ve prop)</td>
</tr>
<tr>
<td>Solitary confinement isn't called solitary any more (-ve ver).</td>
</tr>
</tbody>
</table>
4.3 They were young, troubled and dependent on a system that let them die. Now their parents are asking what went wrong.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>acting strangely (-ve norm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>posing a significant risk to themselves or others (-ve norm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>schizophrenia robbed Stephen Cusworth of his happiness (-ve cap)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>irrational (-ve cap)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**social sanction : propriety and veracity**

<table>
<thead>
<tr>
<th>+</th>
<th>-</th>
<th>+</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>+</td>
<td>-</td>
<td>+</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>displaying aggression (-ve prop):</th>
<th>appalled that its members had not been visiting her daughter, only making phone contact (-ve prop)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a health system that let them die (-ve prop)</td>
<td></td>
</tr>
</tbody>
</table>

|                                                                                     |                                                                                     |
| one [recommendation] is critical of the Alfred’s psychiatric department (-ve prop) |                                                                                     |

|                                                                                     |                                                                                     |
| made recommendations that are implicitly critical of the treatment her daughter received in the last weeks of her life (-ve prop) |                                                                                     |

| whitewashed version of events (-ve ver) |                                                                                     |
|----------------------------------------|                                                                                     |

|                                                                                     |                                                                                     |
| she had every reason to hope for some criticism of hospital authorities (-ve prop) |                                                                                     |

| the year before, as her son was discharged from hospital, a doctor told her "One day your son is going to kill himself (-ve prop) |                                                                                     |

| admission that psychiatric |                                                                                     |
hospitals regularly discharged "patients who are posing a significant risk to others or to themselves (-ve prop) they don’t listen to carers (-ve ten) rubber stamping (-ve ten) technically correct (-ve ten) the system let them and their son down (-ve ten)

Young, troubled and dependent on a system that let them die

<table>
<thead>
<tr>
<th>Mentally ill individuals</th>
<th>Institution (hospitals, courts, lawyers)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>social esteem</strong></td>
</tr>
<tr>
<td>-ve cap (8)</td>
<td>+ve cap (0)</td>
</tr>
<tr>
<td>+ve cap (1)</td>
<td>-ve cap (0)</td>
</tr>
<tr>
<td>-ve norm (3)</td>
<td>-ve norm (0)</td>
</tr>
<tr>
<td>+ve norm (4)</td>
<td>+ve norm (0)</td>
</tr>
<tr>
<td>-ve ten (0)</td>
<td>-ve ten (4)</td>
</tr>
<tr>
<td>+ve ten (0)</td>
<td>+ve ten (0)</td>
</tr>
<tr>
<td></td>
<td><strong>social sanction</strong></td>
</tr>
<tr>
<td>-ve prop (1)</td>
<td>-ve prop (7)</td>
</tr>
<tr>
<td>+ve prop (0)</td>
<td>+ve prop (0)</td>
</tr>
<tr>
<td>-ve ver (0)</td>
<td>-ve ver (1)</td>
</tr>
<tr>
<td>+ve ver (0)</td>
<td>+ve ver (0)</td>
</tr>
</tbody>
</table>

4.4 Trapped in a system near collapse

<table>
<thead>
<tr>
<th>Mentally ill Individuals</th>
<th>Institution (mental health system)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Social esteem</strong></td>
</tr>
<tr>
<td></td>
<td>+</td>
</tr>
<tr>
<td>professional (before illness)+ve cap</td>
<td>trapped in a system near collapse (-ve cap)</td>
</tr>
<tr>
<td>un­ravelling (-ve cap)</td>
<td>family are not taken seriously (-ve ten)</td>
</tr>
<tr>
<td>In early 2004,</td>
<td></td>
</tr>
</tbody>
</table>
Darius’s life began to fold in on itself (-ve cap)

At home, his world contracted further (-ve cap)

his decline (-ve cap) no one would listen (-ve ten)

his two year downward spiral

so ill that they need an inpatient bed (-ve cap)

his body was failing (-ve cap)

poor clinical practice (-ve cap)

terrifying delusions consumed first his mental and then his physical health. (-ve cap)

Social sanction

unacceptable (-ve prop)

a fig leaf hiding a treatment shambles (-ve ver)

Privacy's often an excuse (-ve ver) for poor clinical practice

excluded from key decisions on his treatment (-ve prop)

her questions about her son’s medication were not answered (-ve prop).

Trapped in a system near collapse

<table>
<thead>
<tr>
<th>Mentally ill individuals</th>
<th>Institution (mental health and hospital staff and policies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>social esteem</td>
<td></td>
</tr>
<tr>
<td>-ve cap (10)</td>
<td>+ve cap (0)</td>
</tr>
<tr>
<td>+ve cap (1)</td>
<td>-ve cap (2)</td>
</tr>
</tbody>
</table>
4.5 The fight to save Nathan

<table>
<thead>
<tr>
<th>Mentally ill Individuals</th>
<th>Institution (mental health system and courts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social esteem: capacity, normality, tenacity</td>
<td></td>
</tr>
<tr>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>A-level student (+ve norm)</td>
<td>troubled (-ve norm)</td>
</tr>
<tr>
<td>certificate of distinction for maths and science (+ve norm)</td>
<td>jumbled thoughts (-ve cap)</td>
</tr>
<tr>
<td>ranked among the brightest students (+ve norm)</td>
<td>damaged (-ve cap)</td>
</tr>
<tr>
<td>an achievement made all the sweeter by the hurdles he’d overcome (+ve ten)</td>
<td>troubled (-ve norm)</td>
</tr>
<tr>
<td>very high intellectual abilities (+ve norm)</td>
<td>mentally ill (-ve cap)</td>
</tr>
<tr>
<td>psychotic (-ve cap)</td>
<td>his medication is sometimes administered haphazardly (-ve ten)</td>
</tr>
<tr>
<td>disturbed (-ve norm)</td>
<td>no one would listen (-ve ten)</td>
</tr>
<tr>
<td>damaged product (-ve cap)</td>
<td>rebuffs (-ve ten)</td>
</tr>
<tr>
<td>his increasing mental problems (-ve cap)</td>
<td>none thought (attribute: acknowledge) he was mentally ill (-ve cap)</td>
</tr>
<tr>
<td>glowing school reports ended (-ve cap)</td>
<td>admitted that Nathan didn't have any drugs in his body (-ve cap)</td>
</tr>
<tr>
<td>cap) began to withdraw (-ve norm)</td>
<td>Five minutes into Judge Stephen Norrish's remarks, the prosecutor begins to <strong>quietly nod off</strong> (-ve ten)</td>
</tr>
<tr>
<td>a curious lassitude (-ve cap)</td>
<td>mental health service says that the service was <strong>vigilant</strong> (+ve tenacity)-health system spokesman</td>
</tr>
<tr>
<td>loner (–ve norm)</td>
<td><strong>never once deemed ill enough for admission to Wagga's mental health ward, Gissing House</strong>, (-ve cap)</td>
</tr>
<tr>
<td>there was something wrong [with him] (–ve cap)</td>
<td></td>
</tr>
<tr>
<td>started to become unpredictable (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>marked peculiarities in thinking (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>funny little turns where he would go into a psychotic state (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>antisocial (-ve norm)</td>
<td></td>
</tr>
<tr>
<td>succumbed to strange and uncontrolled giggling (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>had a serious mental illness (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>hallucinations and belief in magical events (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>potentially dangerous (-ve norm)</td>
<td></td>
</tr>
<tr>
<td>sick (-ve cap)</td>
<td></td>
</tr>
</tbody>
</table>
mad (-ve norm)

hearing voices (-ve normality)

became irrationally angry (-ve cap)

sitting in the corral-like dock (-ve cap)

**Social sanction: propriety and veracity**

<table>
<thead>
<tr>
<th>+</th>
<th>-</th>
<th>+</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>amiable (+prop)</td>
<td>people had been hurt –(-ve prop)</td>
<td>mentally ill children had been locked up as criminals (-ve propriety)</td>
<td></td>
</tr>
<tr>
<td>lovely (+ve prop)</td>
<td>brawl (-ve prop)</td>
<td>The courts had treated him as a common criminal (-ve prop)</td>
<td></td>
</tr>
<tr>
<td>gentle (+ve prop)</td>
<td>his [Nathan’s] violent actions (-ve prop)</td>
<td>he had a serious mental illness which was left untreated largely because of Weppner’s surprising and somewhat less than sympathetic assessment of him (-ve prop)</td>
<td></td>
</tr>
<tr>
<td>violent events (-ve prop)</td>
<td>[Weppner] suggested that a spell in jail might fix his problems (-ve prop)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>charged with attempted murder (-ve prop)</td>
<td>drugged with antihistamines (-ve prop)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>found guilty of assault (-ve prop)</td>
<td>In prison, ironically, he has received the medical treatment he was denied in the health system. (-ve prop)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>crimes (-ve prop)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>offender (-ve prop)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>judge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stabbed (-ve prop)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stabbed (-ve prop)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The fight to save Nathan

| Mentally ill individuals | Institution (mental health system, courts and representatives) |
### Social Esteem

<table>
<thead>
<tr>
<th></th>
<th>+ve cap (17)</th>
<th>-ve cap (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve cap (0)</td>
<td>+ve cap (17)</td>
<td>-ve cap (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>+ve cap (0)</th>
<th>-ve cap (17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve cap (3)</td>
<td>+ve cap (0)</td>
<td>-ve cap (17)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>+ve norm (4)</th>
<th>-ve norm (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve norm (0)</td>
<td>+ve norm (4)</td>
<td>-ve norm (0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>+ve norm (4)</th>
<th>-ve norm (0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-ve norm (0)</td>
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### Social Sanction

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### 4.6 Fears of a Clown

#### Mentally Ill Individuals

<table>
<thead>
<tr>
<th>Social Esteem: Capacity, Normality, Tenacity</th>
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<tbody>
<tr>
<td><strong>Mentally Ill individuals</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th>+affable (+ve norm)</th>
<th>-feeling like a zombie (-ve cap)</th>
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<tbody>
<tr>
<td>+garrulous (+ve norm)</td>
<td></td>
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<tr>
<td>+award-winning first time novelist (+ve norm)</td>
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<thead>
<tr>
<th>Social Sanction: Propriety and Tenacity</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>commendably generous (+ve prop)</td>
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#### Institutions

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<tr>
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### Fears of a Clown

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4.7 A life revealed

<table>
<thead>
<tr>
<th>Mentally Ill individuals</th>
<th>Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social esteem: capacity, normality, tenacity</strong></td>
<td></td>
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<tr>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td><strong>struggled</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>matted hair, nicotine-stained fingers and eyes</strong> that failed to focus (-ve norm)</td>
<td></td>
</tr>
<tr>
<td><strong>laughing to themselves, or perhaps talking about Jesus or the end of the world</strong> (-ve norm).</td>
<td></td>
</tr>
<tr>
<td><strong>his madness</strong> (-ve norm)</td>
<td></td>
</tr>
<tr>
<td><strong>he’d read</strong> what I was trying to say (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>he simply couldn’t make it back</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>I had come to realize he was ill</strong> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td><strong>odd</strong> (-ve norm)</td>
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</table>

**A life revealed**

<table>
<thead>
<tr>
<th>Mentally Ill individuals</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>social esteem</strong></td>
<td></td>
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<tr>
<td>-ve cap (3)</td>
<td>+ve cap (0)</td>
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<tr>
<td>+ve cap (0)</td>
<td>-ve cap (0)</td>
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<td>-ve norm (4)</td>
<td>-ve norm (0)</td>
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<td>+ve norm (0)</td>
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<tr>
<td><strong>social sanction</strong></td>
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<td>-ve prop (0)</td>
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## 4.8 In the mind’s eye

<table>
<thead>
<tr>
<th>Mentally Ill Individuals</th>
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<tbody>
<tr>
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<td></td>
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<td>+</td>
<td>-</td>
</tr>
<tr>
<td>extremely articulate (+ve cap)</td>
<td>struggled (-ve cap)</td>
</tr>
<tr>
<td>live rich emotional lives (+ve cap)</td>
<td>psychosis…involves a serious loss of touch with reality (-ve cap)</td>
</tr>
<tr>
<td>people suffering from severe mental illness are not <a href="#">free to emerge from psychotic states</a> (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>some of the typical symptoms [are] loss of normal traits or abilities (-ve cap)</td>
<td></td>
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<tr>
<td>It entails the kind of loss of control (-ve cap) that is antithetical to the production of great art</td>
<td></td>
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<tr>
<td>because it is involuntary (-ve cap)</td>
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<tr>
<td>blunted or constricted affect and emotion (-ve cap)</td>
<td></td>
</tr>
<tr>
<td>poverty of speech (-ve cap)</td>
<td></td>
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<tr>
<td>lack of motivation (-ve cap)</td>
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</tbody>
</table>
his daughter was diagnosed with schizophrenia nine years ago after a prolonged period of bizarre behaviour (-ve norm)

Social sanction: propriety and veracity

the disastrous policy of de-institutionalising huge numbers of mentally ill people without following up with adequate support and funding (-ve prop)

<table>
<thead>
<tr>
<th>Mentally ill individuals</th>
<th>Institutions (mental health system, courts and proponents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social esteem</td>
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<tr>
<td>Social sanction</td>
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4.9 Lighting a dark prison

Mentally Ill | Institution (research): here appreciation is more relevant

<table>
<thead>
<tr>
<th>Social esteem</th>
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she watched as her brother disappeared into the deep pit of mental illness (-ve cap)

no longer
<table>
<thead>
<tr>
<th>competing for the top grades (-ve cap)</th>
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<tbody>
<tr>
<td>while her brother struggled (-ve cap)</td>
</tr>
<tr>
<td>the diagnosis that to many is a life sentence [schizophrenia] (-ve cap)</td>
</tr>
<tr>
<td>“My brother was sick during high school” (-ve cap)</td>
</tr>
<tr>
<td>He withdrew socially (-ve norm)</td>
</tr>
<tr>
<td>he became very volatile (-ve cap: control)</td>
</tr>
<tr>
<td>and difficult for my mother to handle (-ve norm)</td>
</tr>
<tr>
<td>More than 70% of people with schizophrenia do not work at all (-ve cap)</td>
</tr>
<tr>
<td>the enormous disability caused by the illness(-ve cap)</td>
</tr>
<tr>
<td>it’s awful to see someone robbed of their life (-ve cap)</td>
</tr>
<tr>
<td>it can be characterised by psychosis, delusions, paranoia, altered perceptions of the senses, disorganised thought, behaviour and speech (-ve cap)</td>
</tr>
<tr>
<td>and withdrawal (-ve norm) from</td>
</tr>
</tbody>
</table>
“Those things that are part of becoming a mature adult, learning to navigate social situations, planning for our future, are the very things that people with schizophrenia cannot do” (-ve cap)

More than 70 per cent of people with schizophrenia do not work at all (-ve cap)

the lost earnings from people unable to work because of schizophrenia totaled $488 million (-ve cap)

nearly half have no school qualifications (-ve cap)

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<th>social sanction</th>
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<tr>
<td>had been institutionalised with adult psychiatric patients (-ve prop).</td>
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Lighting a dark prison

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4.10 Teens at most risk from dope

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<th>Institution</th>
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<tr>
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<tr>
<td><strong>Social esteem:</strong></td>
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<tr>
<td>capacity, normality, tenacity</td>
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<tr>
<td>the most vulnerable are the young (-ve cap)</td>
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<tr>
<th>Teens at most risk from dope</th>
<th>Institutions (mental health system, courts and proponents)</th>
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<tr>
<td><strong>Social sanction:</strong> propriety and veracity</td>
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Appendix 5- Disclaim: counter invoking negative judgment of institutions in media expositions

5.1 *Disclaim: counter* invoking criticism of institutions

5.1.1 Kylie Fitter

| The demons are gone, | **but** (denial of expectation that she should be released once she is well) | she's **still** (denial of expectation) a prisoner of her past |
| Seated in the living room of an inner-city terrace, the willowy, 20-year-old spun-sugar blonde, sweetness itself, is out on weekend leave from jail | **But** (denial of expectation: she is in jail so she should be BUT in fact she shouldn’t) | in the view of her many supporters, Kylie is a political prisoner |
| It gathers evidence from the treating experts assesses the patient's progress, and determines whether, at any stage, they are no longer a serious danger to themselves or others, and could progressively, under the strictest conditions, be released into the community | **However** (denial of expectation that tribunal recommendations will be followed) | the tribunal can only make recommendations |
| the tribunal can | **only** (denial of expectation: they) | make recommendations |
Officially the Health Minister, John Hatzistergos, makes the decision but (denial of expectation that the ‘official’ version will be correct) effective power resides with the Minister Assisting the Health the Health Minister, Cherie Burton

She has had no recurrence in 41/2 years of the one-off psychotic episode she experienced on October 16, 2001. [but] (denial of expectation that she’s okay and should be released) There is no upside for the Government, especially a year away from an election, in releasing forensic patients.

The only possible rationale can be in a law-and-order environment is battening down against any possible risk even (denial of expectation that expert opinion will be respected) when experts have given assurances the risk is minimal.

But (denial of expectation that Cherie Burton will pay attention to people who actually know the situation of the Fitter family) Ms Burton has sided with Kylie’s maternal aunt who had not seen her sister for 20 years

Ms Burton has agreed to this demand but (denial of expectation that her agreement is legitimate) the Johnstons have been told by the Department of Juvenile Justice such mediation as a condition of release is unprecedented.

5.1.2 Jailed body and mind

Risdon is due to close later this year, but (denial of expectation that Risdon’s closure means the end of solitary) many other prisons lock up mentally ill inmates in solitary confinement

Though the use of solitary confinement has been widely condemned for 40 years, (countering expectation that condemnation should have an effect) Singh says, "experts say the mentally ill people least able to handle the isolation are most likely to be locked up in solitary

"Men are still going around there for trivial offences," (countering expectation that it shouldn’t be
<table>
<thead>
<tr>
<th>Prison authorities talk about segregation in terms that suggest inmates are being managed or protected</th>
<th><strong>rather</strong> (semantic opposition: protected vs. punished)</th>
<th>than punished</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Though</strong> seriously mentally ill (denial of expectation that seriously mentally ill people shouldn’t be in prison)</td>
<td>she was repeatedly (?) placed in the prison detention units [used to &quot;segregate prisoners for breaches of discipline&quot;]</td>
<td></td>
</tr>
<tr>
<td>The minister said strip-searching in the crisis support unit had been reduced by &quot;50 per cent in the last 12 months</td>
<td><strong>Nevertheless</strong> (denial of expectation that the reduction of strip searching will lessen fear of confinement)</td>
<td>the anti-discrimination commission report noted that women elsewhere in the prison &quot;related their fear of showing any emotion that may be noticed by prison officers.&quot; They were frightened they would be placed in a crisis support unit.</td>
</tr>
</tbody>
</table>

### 5.1.3 Young and troubled

<table>
<thead>
<tr>
<th>Her file, Lucas says, contained a note, written while she was well, advising staff to listen to her family</th>
<th><strong>But</strong> (denial of expectation that her wishes will be respected)</th>
<th>under the current privacy and mental health legislation, hospital staff were technically correct in carrying out their patient's expressed desire to cut contact with her family</th>
</tr>
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<tbody>
<tr>
<td><strong>But</strong> (denial of expectation that the CAT team would listen to her)</td>
<td>Lucas could not convince the CAT team that her daughter was in danger</td>
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</tr>
<tr>
<td>The doctor made an appointment with her for the next day and recommended the CAT team visit</td>
<td><strong>But</strong> (denial of expectation that the CAT team would do what was recommended)</td>
<td>a team nurse phoned her that evening, recording in her notes that her patient &quot;states everything is fine&quot;</td>
</tr>
<tr>
<td>&quot;I said 'You can't do that', recalls Storm</td>
<td><strong>But</strong> (denial of expectation: that the mental health team will listen to family)</td>
<td>they don't listen to carers”</td>
</tr>
<tr>
<td>While cross-examining a psychiatrist called as an independent expert at the inquest into the death, Storm's lawyer, Dr</td>
<td><strong>But</strong> (denial of expectation that Storm has reason to</td>
<td>the inquest findings brought the grieving mother no satisfaction</td>
</tr>
</tbody>
</table>
Ian Freckelton, elicited the admission that psychiatric hospitals regularly discharged "patients who are posing a significant risk to others or to themselves" be satisfied)

While the coroner made recommendations about clinicians listening to carers, and being vigilant in cases of involuntary patients being given leave, (denial of expectation that recommendations will lead to action)

Storm knew there was no body responsible for implementing them

5.1.4 Trapped in a system near collapse

The notification arrived in early November last year and the psychiatric assessment was to take place in January, but (denial of expectation that the time frame set for assessment is reasonable)

Teresa knew that 42-year-old Darius did not have that long

It is terribly painful for Teresa to reflect on the last weeks of her only child but (semantic opposition: painful vs more painful)

one hurt stands apart

Despite being her son’s constant carer during his two-year downward spiral (denial of expectation that her role warranted involvement)

she was excluded from decisions on his treatment, informed that her involvement would breach his privacy

When Darius was an in-patient at an acute mental health facility, Teresa was asked to leave when she arrived outside visiting hours even though (denial of expectation that the hospital staff will ensure he gets fed)

Darius's paranoia by this stage meant he was dependent on his mother for food, believing hospital meals had been poisoned.

“I needed them to listen to what I had to say, but (denial of expectation that her needs will be met)

it was like I was nobody."

At the recent premiers' conference, the Prime Minister pledged an invigorated focus on mental health, and the premiers but (denial of expectation that money and attention will fix)

psychiatrists say treating more people in the community means more families will need to be able and willing to be the backstop for
emphasised new funding needed to go to community mental health services, to avert people becoming so ill that they need an in-patient bed.

"Unfortunately my experiences show that family are not taken seriously or included in the assessment

Professionals are angry that the process has stalled

<table>
<thead>
<tr>
<th>5.1.5 The fight to save Nathan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dale Hull spent years trying to get treatment for her mentally ill son</td>
</tr>
<tr>
<td>Of all the rebuffs Nathan had endured to get help over the previous nine years, Weppner's burnt strongest intensify in his memory.</td>
</tr>
<tr>
<td>Voluminous government reports have been compiled, judges and coroners have cried out for action, parliamentary committees have exhaustively examined the issue, strategies have been proposed and funding promises have been made</td>
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<tr>
<td>Her son - a &quot;lovely, big, gentle thing&quot; who'd been an A-level student - had spent seven years trying to get treatment for his increasing mental problems</td>
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<td>More than 100,000 people live in Wagga Wagga and its surrounds</td>
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<td>Nathan saw several psychiatrists in Wagga,</td>
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<td>&quot;I used to see Nathan's funny little turns when he would go into a psychotic state</td>
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<td>They sedated him and took a blood test and the doctor came out later and apologized admitted that Nathan didn't have drugs in his body</td>
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<td>Lucire wrote to Wagga's local health service recommending enforced treatment.</td>
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<td>In June 2004, Nathan was found guilty of assault, placed on another good behaviour bond and told by a magistrate to seek help from his doctor.</td>
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<td>Schurr suffered a punctured lung in the attack and was administered his last rites by a priest as emergency doctors tended to him; he subsequently suffered severe post-traumatic disorder and has been unable to return to his regular job. The knife wound in Garry Lyons' neck</td>
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<td>narrowly missed his carotid artery</td>
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<td>After several months at Long Bay psychiatric hospital, he was prescribed anti-psychotic medications and released into the general prison system</td>
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<td>The NSW government body that governs the area - the Greater Southern Area Health Service - acknowledges the inadequacy of the town's mental health facilities in its latest annual report</td>
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<td>Meanwhile, a group of enterprising Wagga citizens has refurbished an abandoned building for use as a support centre for schizophrenia sufferers</td>
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Appendix 6 – Individual experience reconstrued as basis for modulation of obligation: examples from eight articles
<table>
<thead>
<tr>
<th>Individual experience</th>
<th>Experience represented as recurring</th>
<th>Modulation of obligation directed by experts</th>
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<tbody>
<tr>
<td>Lighting a dark prison</td>
<td>“Those things which are part of becoming a mature adult, learning to navigate social situations, planning for our future, are the very things that people with schizophrenia cannot do”</td>
<td>He says understanding brain development is crucial, but the focus should also turn to factors that make people vulnerable</td>
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<td>Young and troubled</td>
<td>While cross-examining a psychiatrist called as an independent expert at the inquest into the death, Storm’s lawyer…elicited the admission that psychiatric hospitals regularly discharged “patients who are posing a significant risk to others or themselves.”</td>
<td>The coroner made recommendations about clinicians listening to carers and being vigilant in cases of involuntary patients being given leave.</td>
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<td>Trapped in a system near collapse</td>
<td>Doctors and nurses sometimes misunderstood privacy legislation, she [Louise Newman, the director of the NSW institute of psychiatry] said, and believed “they couldn’t or shouldn’t talk to significant others</td>
<td>He [doctor Brian Pezzutti, who had completed a select committee inquiry into mental health services in NSW recommended the health minister “seek to amend the NSW Mental Health Act 1990 to allow limited disclosure of confidential information… to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client”</td>
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<td>In the mind’s eye</td>
<td>Art is seen as a way for certain categories of people to have their voices heard</td>
<td>We need to get serious about mental health issues, not sublimate them into art (author as expert)</td>
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<td>Kylie Fitter</td>
<td>In such cases, mentally ill people in NSW found to lack the capacity to understand the wrongfulness of their acts are detained as forensic patients. …. They can be held, in the old term, at the governor’s pleasure (author as expert)</td>
<td>Reviews in 1992, 1993 and 1994 recommended the health minister lose the discretion to keep forensic patients locked up</td>
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<td>Teens at most risk from dope</td>
<td>“This is the period [teenage years] where most people will experiment with illicit substances and the period they will most likely experience their first episode of mental illness or psychosis” [John Mendoza, CEO of mental health council of</td>
<td>The Mental Health council says most of the effort must be directed at teenagers</td>
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<th>Jailed in body and mind</th>
<th>Australia</th>
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<td>“I got put in solitary in Division 8 for forty days,” he [Tony Bull, prisoner with psychotic illness] says</td>
<td>A report on women in prison by the Anti-Discrimination Commission of QLD notes that prison staff often fail to recognise manifestations of mental disorder and respond with restraint or disciplinary action.”</td>
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<td>Other experts insist the mentally ill shouldn’t be in prison in the first place. … Singh says “There needs to be a total prohibition on confinement for the mentally ill. That’s what they’re bringing in in New York”</td>
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<th>Fight to save Nathan</th>
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<td>The head of the NSW prison system, Ron Woodham, told ABC’s Four Corners last year “In my forty years in the job, I’ve never seen the damaged product like it is now….. In our big remand jails… it’s like a casualty ward”</td>
<td>Voluminous government reports have been compiled, judges and coroners have cried out for action, parliamentary committees have exhaustively examined the issue, strategies have been proposed and funding promises have been made, yet the jails continue to fill up with the psychotic and the disturbed. (explicit demand for action plus implicit demand)</td>
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