

GLOBAL JOURNAL OF

**Community Psychology Practice**

PROMOTING COMMUNITY PRACTICE FOR SOCIAL BENEFIT



## **Moving Beyond “Better Safe Than Sorry”: Realizing Community Potential to Transform Approaches to Psychiatric Hospitalization**

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Jessica Nalani Lee successfully defended her dissertation, *Too Much Information: Agency and Disruptions of Power in Personal Narratives of Mental Illness and Suffering*, for a PhD in Rhetoric, Composition, and the Teaching of English from the University of Arizona. She will be joining the University of Houston as a Writing Fellow/Visiting Assistant Professor in Fall 2014. Email: [JessicaNalaniLee@gmail.com](mailto:JessicaNalaniLee@gmail.com)

**Keywords:** mental health consumers/survivors, biomedicine, recovery-oriented care, psychiatric hospitalization, rhetorical agency

**Recommended Citation:** Lee, J.N. (2014). Moving Beyond “Better Safe Than Sorry”: Realizing Community Potential to Transform Approaches to Psychiatric Hospitalization. *Global Journal of Community Psychology Practice*, 5(1), 1-8. Retrieved Day/Month/Year, from (<http://www.gjcpp.org/>).

## Moving Beyond “Better Safe Than Sorry”: Realizing Community Potential to Transform Approaches to Psychiatric Hospitalization

### Abstract

This essay is composed of three parts to analyze how the field of community psychology can help transform aspects of psychiatric hospitalization that may inadvertently reify oppressive social constructs. I begin by describing approaches to treatment in psychiatric hospitalization that can unintentionally objectify the consumer/survivor and reinforce a standardized approach to treatment that disallows the empathy needed for an efficacious relationship between a healthcare professional and a consumer/survivor. In the next section, I examine how community psychology commitments are achieved through recovery-oriented care that challenges oppressive social constructs. In the final section, I consider the ways in which the rhetorical concept of agency might be enacted in the context of psychiatric hospitalization to create an environment that advances recovery-oriented care.

*Keywords: mental health consumers/survivors, biomedicine, recovery-oriented care, psychiatric hospitalization, rhetorical agency*

The negative ramifications of psychiatric hospitalization are often justified with the reasoning that it is “better to be safe than sorry.” However, in a society that values independence and self-respect, the disempowering of the individual inherent in psychiatric hospitalization can work against the goal of preventing danger, with the “greatest risk for seriously mentally ill patients [being] not while they are in inpatient treatment. . . but *after discharge* [original emphasis]” (Warner, 1995, p. 248). This essay is composed of three parts to analyze how the field of community psychology can help transform aspects of psychiatric hospitalization that may inadvertently reify oppressive social constructs. In the section that follows, I begin by describing approaches to treatment in psychiatric hospitalization that can unintentionally objectify the consumer/survivor and reinforce a standardized approach to treatment that disallows the empathy needed for an efficacious relationship between a healthcare professional and a consumer/survivor. In the next section, I examine how community psychology commitments are achieved through recovery-oriented care that challenges oppressive social constructs. In the final section, I consider the ways in which the rhetorical concept of agency might be enacted in the context of psychiatric hospitalization to create an environment that advances recovery-oriented care.

### Defining Roles and Biomedicine

This paper focuses on the hospitalization of psychiatric consumers/survivors, understood in this context as individuals who experience or have experienced intense mental distress. When referring to people struggling with mental health issues, I use the term

“consumer/survivor,” the meaning of which is informed by Nelson, Lord, and Ochocka (2001). Nelson et al. (2001) described language and discourse as sociopolitical, explaining that those with mental health issues who have had experience with the mental health system often name themselves as consumers, survivors, or consumers/survivors, as opposed to using the terms “patient” or “client.” By referring to those who experience or have experienced intense mental distress as “consumer/survivors,” I seek to contribute to their empowerment. My critique of hospitalization for those undergoing mental suffering is not meant to advocate for the complete elimination of psychiatric hospitalization. Rather, I seek to expand upon the ways in which psychiatric hospitalization works to minimize risk and aid mental health consumers/survivors in the recovery process. This paper responds to Segal’s (1994) call for further study of the connections among compliance, persuasion, and rhetoric. I demonstrate the value of rhetorical appeal in the treatment of psychiatric consumers/survivors, arguing that consumers/survivors can be most effectively treated when knowledge informed by research as well as knowledge informed by personal experience are equally valued. Advocating validating the opinions and perspectives of psychiatrically hospitalized consumers/survivors may seem unrealistic when one assumes these people are “irrational” due to an acute psychotic or manic episode. I would argue, however, that acute psychosis or mania in some psychiatric consumers/survivors is not a viable reason for precluding open communication with psychiatric consumers/survivors as a whole (Rose, 2008). Moreover, such open communication is suggested with a particular type of psychiatric

consumer/survivor in mind—those who can speak to issues of power in their daily experiences, and in retrospect comment on their experiences during acute episodes.

In-patient psychiatric care can inadvertently objectify the consumer/survivor and reinforce a standardized approach to treatment that disallows variations on therapy plans as determined by an individual healthcare provider's best judgment of the situation. In particular, in-patient treatment for psychiatric consumers/survivors can, unintentionally or deliberately, dichotomize understandings of experiences and situations as either objective or subjective. The dichotomization of knowledge as either objective or subjective is in part explained by Foucault's (1975) exposition of privileged forms of knowing and being. Foucault (1975) analyzed medical discourse, tracing the ways in which the field's approach to the concept of the individual as a relational being has evolved. Specifically, Foucault's (1975) delineation detailing the medical field's separation of knowledge regarding pathology from the individual characterizes the separation of objective versus subjective knowledge. In this instance, subjective knowledge refers to an individual's perception of his or her experience, in contrast to objective knowledge understood as viewing the "overall" picture from a distance thus enabling unbiased and detached pronouncements. Foucault's exposition of the subjective and the objective also involves recognizing the medical field's appreciation of the objective—detached and therefore scientific and closer to the "truth"—*over* the subjective—biased towards a particular viewpoint built upon mercurial emotions and therefore unreliable.

According to Cohen (2008), mental healthcare often echoes a favoring of the objective over the subjective as a result of its foundation in biomedicine. Cohen (2008, p. 179) asserted that although options may appear to exist for the mental health consumer/survivor in terms of choosing a type of treatment, his/her level of engagement with staff, his/her acceptance of a particular diagnosis, and the specific health professionals he/she will work with, the reality remains that mental health consumer/survivor's overall treatment will be informed by biomedical treatment. Biomedical treatment is similar to a regard for the detached over the personal, as Segal explained (1994). Segal (1994) portrayed biomedicine as centered around, in part, the belief that illness and the illness experience are most effectively assessed and treated by focusing on the particular illness' pathological characteristics that are organic in nature and that perform an intervention that cures the illness (1994, p. 93). This characterization of biomedicine highlights how the position of being a mental health patient necessarily requires assuming a

generalized, "medicalized" identity, as disease is ultimately understood in terms of a pathological entity, translating the individual person's experience of illness into medical discourse.

Derkatch's (2011) explication of Burke's (1966) concept of terministic screens can be used to explain how the dichotomy between objective and subjective knowledge is reinforced in mental healthcare discourse. Derkatch (2011) analyzed how Burke's (1966) concept of terministic screens, or the idea that the terms people use are inherently biased and thus taint their interpretations of the world around them, can be applied to recognizing and therefore accounting for the different priorities and perspectives that biomedical scientists and consumers/survivors, along with the practitioners who work beside them, bring to the healthcare encounter. Derkatch (2011) explained that terministic screens for biomedical scientists are heavily influenced by language that pathologizes, as such healthcare professionals are predisposed by their training to translate patients' and their practitioners' subjective experiences of illness into the so-called objective medical terms of diagnosis (p. 136). In contrast, consumers/survivors' and their practitioners' terministic screens are mostly impacted by their personal experience with an illness (Derkatch, 2011, p. 136). Thus the disconnection between biomedical scientists and consumers/survivors and their practitioners affects communication down to the sentence-level, as differing priorities and perspectives can create a separation between groups even before they meet.

Terministic screens that both cause and reinforce the distance between the biomedical perspective and the subjective consumer/survivor and practitioner viewpoint also result in the invalidation of knowledge informed by personal experience. In Rose's (2008) commentary clarifying the involvement of mental health consumers/survivors in research, Rose pointed out that the term "researcher" often screens, or excludes, mental health consumers/survivors, described as "users and survivors" by Rose. In particular, Rose (2008) contended that mental health users and survivors' rational attempts to speak for themselves are thwarted by authority figures who see such users and survivors as a threat. Rose accused such authority figures as primarily focused on the potential of mental health users and survivors to be "crazy, dangerous, unpredictable, [and] irretrievably mad" precluding any kind of wide-spread, generalized practice that would assume the dignity of those whose knowledge of mental health issues is rooted in personal experience. Consequently, users and survivors who attempted to incorporate their personal perspectives into research and thus become "user researchers" (p. 640) were

subject to being viewed as contradictions (p. 642). Moreover, the understanding of the user researcher as containing two disparate elements can be perpetuated by the consumer/survivor him/herself. Rose (2008) revealed that many consumers/survivors could not trust their own accounts of past experience, believing that the fact they had undergone psychiatric treatment made them too ill to think rationally (p. 643). The connotations surrounding terms that perpetuate the dichotomy between objective and subjective knowledge are thus seen as pervasive, influencing the consumer/survivor to doubt his/her own self.

Parallel with biomedicine's objectification of the consumer/survivor is the suppression of the subjectivity of the healthcare professional. Returning to Segal's (1994) citation of Stein's (1990) characterization of biomedicine, Segal also pointed out how biomedicine advances the belief that "medical science is and should be based upon rational, scientific, dispassionate, objective, professional judgment" (p. 93). The healthcare professional's role is thus defined to embody rationality that is equated with detachment that itself is viewed as objective and therefore scientific. This separation is often purported to protect the mental health of those whose careers place them in direct contact with the pain and suffering of others on a regular basis. Yet a consequence of this separation, Segal (1994) contended, is a disparity between the healthcare professional and the consumer/survivor that remains even when both parties are friends and the consumer/survivor is him or herself a healthcare professional (p. 95). The consumer/survivor's separation from the healthcare professional is integral to the biomedical model. The belief that a personal account of one's illness must be measured against supposedly objective psychiatric diagnostic criteria aligns with Foucault's (1975) description of authorized forms of knowing. In particular, forms of knowing that view a situation from a distance are believed to enable unbiased conclusions, and are thus authorized over personal, subjective, and therefore biased ways of knowing. Thus, complementary to the objectivity of the consumer/survivor, the subjectivity of the healthcare professional is effaced.

An objective, or neutral, approach to healthcare is often believed to be necessary in order to reinforce standardized treatment. Attempts to be detached, however, can cause healthcare professionals to become preoccupied with accounting for and suppressing any personal biases that may taint their objectivity. This preoccupation, in turn, can suppress the empathy needed for an effective healthcare professional and consumer/survivor relationship. In their narrative analysis of physician case reports detailing problems related to certifying a patient's sickness, Engblom,

Alexanderson, and Rudebeck (2011) discovered that healthcare professionals' attempts to remain neutral in content and form in their case reports made acknowledgment of the problem at hand less likely (p. 22). Thus the healthcare professional foremost concerned with appearing impartial was more prone to employing unproductive interventions that primarily focused on the illness rather than the individual patient. Engblom et al. (2011) concluded that further research on the impact of varying narrative structures on the perceptions of healthcare providers might promote additional reflection to challenge the prioritization of objectivity in clinical encounters.

### **Enacting Community Psychology Commitments: Recovery-Oriented Care**

The field of community psychology is advancing, in part, a more empathetic relationship between healthcare professional and consumer/survivor in its commitment to (1) collective action that works to disrupt inequality in the status quo and (2) the belief that the mental health of the individual is necessarily impacted by his or her social context (Campbell & Cornish, 2014). Thus community psychology can be seen as set apart from other sub-disciplines of psychology in its active awareness of how the general discipline of psychology rarely considers and sometimes actually reinforces issues of power.

Similar to the distinction of community psychology from academic and professional psychology is the divergence between the concept of recovery according to the biomedical perspective versus that adopted by mental health consumers/survivors and psychiatric rehabilitation practitioners. From the perspective of biomedical clinical research, recovery from mental illness "is an absence of something undesired, such as illness or symptoms, or the removal of something that was not part of a person's life prior to that illness, like medications or hospitalization" (Davidson et al., 2005, p. 483). In contrast, mental health consumers/survivors and psychiatric rehabilitation practitioners believe recovery "remains possible even though a person's condition may not change" (Davidson et al., 2005, p. 483). This view of recovery most often involves "some component of acceptance of illness, having a sense of hope about the future, and finding a renewed sense of self" (Davidson et al., 2005, p. 483). These fundamentally different notions of recovery seem to be based on a different conception of a person's relationship to illness. In particular, I would characterize consumer/survivor and psychiatric rehabilitation practitioner literatures as representing the subjective, praxis component of mental health treatment. Freire (1970/2010) explained "praxis" as theory in action, that is, reflection *and* practice (p. 125).

Freire noted that such reflection and practice were not to be understood as separate parts of a whole—rather, the processes of reflecting and doing happen simultaneously when enacting praxis (p. 128). Praxis is therefore the simultaneous process of acting and reflecting. The continuous process of considering the ramifications of one's behavior starkly contrasts with biomedical ways of knowing and being that frame healthcare in terms of generalization to fit a known pathology at the exclusion of the individual consumer/survivor's unique understandings of his or her experiences. Thus knowledge informed by biomedical, clinical research is separated from knowledge informed by the experience of both consumer/survivor *and* psychiatric rehabilitation practitioners who are conscious of the assumptions, practices, and technologies they apply to the clients they encounter.

Attempts to balance appreciations for both praxis and biomedical-oriented knowledges are enacted through recovery-oriented care. Kidd et al. (2014) defined recovery-oriented care as “individually tailored, respectful of rights” and grounded in a consumer/survivor's particular strengths in order to promote their involvement and give them hope (p. 221). Kidd et al.'s (2014) characterization of recovery-oriented care emphasizes the concept of recovery articulated by consumers/survivors. In particular, Kidd et al.'s (2014) description of recovery-oriented care and consumers/survivors' concept of recovery both advocate treatment informed by consumers/survivors' and practitioners' subjective experience of mental illness. Applications of recovery-oriented care through processes such as shared decision making balance praxis and biomedical-oriented research by advancing the collaboration between biomedical researchers and consumers/survivors and mental health practitioners. In particular, information technologies such as decision aids and electronic decision support programs combine knowledge gained through biomedical research and the knowledge of consumers/survivors and mental health practitioners. Combining both sets of knowledges through such technologies, in turn, help busy healthcare professionals provide the kind of individualized treatment consumers/survivors desire (Drake, Deegan, & Rapp, 2010, p. 7).

A study on recovery-oriented care by Kidd et al. (2014) demonstrates how such care advances these commitments of community psychology. Kidd et al.'s (2014) research took place in the in-patient psychiatric setting and involved partnering individuals who had previously been inpatient clients of a large psychiatric treatment facility located in a Canadian urban center with the staff of those inpatient units. The consumers/survivors of the psychiatric inpatient units

delivered a yearlong series of talks to the staff. In addition to revealing information on how to best educate in-patient staff about recovery-oriented care, Kidd et al.'s (2014) study was significant for the ways in which it empowered the consumers/survivors who served as speakers to the in-patient staff. Kidd et al. (2014) noted that consumers/survivors described their role in the research as “a process of growing confidence, as they successfully engaged staff at a ‘human level,’ in effect recalibrating a relationship that had been characterized by a marked power differential” (p. 224). Kidd et al.'s efforts to employ recovery-oriented care in in-patient settings thus enacted community psychology's commitment to disrupting the “unequal status quo” as consumers/survivors became sources of knowledge for in-patient staff.

Recovery-oriented care can also be seen as enacting community psychology's sensitivity to the ways in which a person's nature is influenced by his or her social environment. Kidd et al.'s research also revealed the ways in which recovery-oriented care necessarily involves the collaboration of biomedical research and praxis, as opposed to therapy solely focused on change rooted in the individual. Kidd et al. (2014) recounted that:

Many staff members were struck by how the speakers regarded seemingly “insignificant things” as critical elements of recovery-facilitating care. These included having a “human” connection with staff, having staff taken even a small amount of time to listen to a request or discuss a challenge, and having conversations with staff that extended beyond questions about medications and symptoms. (p. 224)

Consequently, staff members reported greater attempts to be more responsive to consumers/survivors' concerns and noted positive outcomes from their efforts. Such positive results included a decrease in actions taken by consumers/survivors due to frustration and the empowerment of consumers/survivors through treatment that directly acknowledged their concerns (Kidd et al., 2014, p. 224). Thus the implementation of recovery-oriented care involved the alteration of the in-patient psychiatric environment, as staff learned to engage consumers/survivors who were current in-patients in new, more collaborative ways.

#### **Enacting Community Psychology Commitments in Psychiatric Hospitalization: Agency to Advance Recovery-Oriented Care**

In order to work toward a more collaborative engagement between biomedical research and the subjective experiences of the mental health care professional and the psychiatric consumer/survivor, it is

necessary to recognize such collaboration as taking place between unequal speakers. In particular, recognizing the marginalization of praxis-informed, subjective knowledge of both consumers/survivors and practitioners allows us to understand the nature of the authority imbued upon biomedical-oriented, objective research. Correcting for the disparity between praxis-informed, subjective knowledge and biomedical-informed, objective research, however, means resisting perpetuating the dichotomy between such knowledges. Specifically, the theory of agency advanced by Herndl and Licona (2007) provides a framework through which to understand how the collaboration between unequal interlocutors might honor a praxis-oriented notion of recovery. This praxis-oriented notion of recovery that combines action and reflection, in turn, can implement recovery-oriented care that enacts community psychology's commitments.

As noted earlier, I believe the field of community psychology to be advancing, in part, the belief that the mental health of the individual is necessarily impacted by his or her social context (Campbell & Cornish, 2014). I see recovery-oriented care's attempts to balance appreciations for both praxis and biomedical-oriented knowledges as enacting community psychology's sensitivity to the intrinsic social factors of a single individual. Herndl and Licona's (2007) theory of agency can be used to outline how praxis and biomedical-oriented knowledges might work together in its efforts to correct an understanding of agency that situates power within the individual and overlooks the myriad of material and textual influences that necessarily compose agency (p. 139). In order to enact this correction of the individual-social dichotomy, Herndl and Licona (2007) proposed three essential actions:

First, we must sever the metonymic identity of agent and agency, as well as the metonymic identity of author with authority. Second, we must reverse the order in which we think of these relationships; agency phenomenologically precedes the agent and authority phenomenologically precedes the author. Specifically, we contextualize agents and authors as sites of an agency function and an authority function. . . . Third, we must reveal the necessary, if also shifting, relationship between agency and authority. (p. 138)

Taken together, these actions serve to compose Herndl and Licona's (2007) rhetorical theory of agency that works against the reification of the individual as the creator of agency or the specific holder of authority. Herndl and Licona (2007) argued that empowerment for individuals only occurs when such individuals engage relationally with others (p. 141). In particular,

agency and authorship are interrelated, as with the knowledge of institutional or organizational practices comes the possibility to practice and formulate authority and agency through relationships (Herndl & Licona, 2007, p. 148). Thus the collaboration of biomedical-oriented research and knowledge gained through personal experience can imbue each party with the knowledge necessary to "speak with authority and act with a potential for change" (Herndl & Licona, 2007, p. 148).

Given the complexities and inequalities inherent between knowledge based in biomedical research and knowledge based in personal experiences, what would long-stay in-patient treatment that balanced both research and praxis-oriented knowledge entail? Based on my research of interventions in psychiatric hospitalization, I propose that in-patient treatment can balance both biomedical and praxis-oriented knowledge through open communication and an appreciation of the expertise of both the biomedical framework and praxis. These two characteristics, in turn, each fulfill components of the consumer/survivor, praxis-oriented notion of recovery: some component of acceptance of illness, having a sense of hope about the future, and having a renewed sense of self (Davidson et al., 2005, p. 483).

Open communication can balance both biomedical and praxis-oriented knowledge. Priebe et al.'s (2009) research on the impact mental health consumers/survivors' experiences as in-patients can have on their overall prognosis demonstrated the impact open communication between mental health professional and consumer/survivor can have on the consumer/survivor's acceptance of illness. In particular, Priebe et al.'s (2009) research indicated a causal link between a consumer/survivor's initial perception of his/her treatment and long-term outcome. Priebe et al. (2009) conducted their research by collecting socio-demographic data and readmissions for 1,570 involuntarily admitted patients (p. 49). 50% of the involuntarily admitted patients were interviewed within one week of their initial admission, and of those 50%, 51% were re-interviewed after one year (Priebe et al., 2009, p. 49). After one year, 40% of the re-interviewed sample felt their initial admission was warranted (Priebe et al., 2009, p. 50). Within the one-year follow-up period after the index episode, 234 patients, i.e., 15% of the total initial sample of 1,570 involuntarily admitted patents, were involuntarily readmitted and an additional 169 patients (11%) were voluntarily admitted within the same period (Priebe et al., 2009, p. 50). From their interviews, Priebe et al. (2009) determined that higher involuntary readmission rates seemed to be the result of patients who were initially less satisfied with their treatment, received government benefits, lived

with others and had an African and/or Caribbean background (p. 49). Conversely, involuntary psychiatric hospitalization was viewed more favorably in the long-run by those who were initially more satisfied with their treatment, were admitted when functioning at a lower level over all, and living alone (p. 49). Priebe et al. (2009) concluded that, in involuntary psychiatric in-patients, consumers/survivors' initial satisfaction with treatment affects their long-term prognosis (p. 49). Priebe et al.'s (2009) findings are significant to understanding key points of intervention in psychiatric hospitalization, pointing out areas where reform might most positively impact a consumer/survivor's recovery. In particular, when a consumer/survivor's "initial level of satisfaction" is understood as directly related to his/her acceptance of having an illness, open communication between the mental health professional and the consumer/survivor can be viewed as a way to advance a consumer/survivor concept of recovery. Priebe et al. (2009) have concluded that consumers/survivors should be asked to evaluate their treatment at the beginning of their hospitalization in order to foster an environment of open communication (p. 53). While Priebe et al. (2009) acknowledged that there is little information on what, particularly, will help consumers/survivors better adapt to psychiatric hospitalization, they also noted that observational studies imply that such actions as "procedural fairness, comprehensive information, respect, empathy" and including consumers/survivors in treatment decisions correlate with consumers/survivors' higher satisfaction with their treatment

(p. 53). Given that communication as early as admission can affect the overall perception, and therefore prognosis, of the consumer/survivor, the mental health practitioner's prioritization towards communicating the biomedical-based research behind his or her treatment decisions with the consumer/survivor can thus contribute to an atmosphere conducive to a praxis-oriented notion of recovery that leads to an acceptance of illness.

An appreciation of the expertise of both biomedical and praxis-oriented knowledge can also facilitate collaboration between them. Drake et al. (2010) explained that the biomedical-based health care professional, or team of professionals, bring(s) expertise related to observing the mental health issue as a whole, keeping in mind multiple variables including "the health problem, the possible interventions, potential benefits[,] and risk of alternatives" (p. 8). The praxis-based consumer/survivor and practitioner, in turn, bring expertise through their personal experiences, "values, goals, supports, and preferences" (Drake et al., 2010, p. 8). Valuing experientially-based knowledge in conjunction with biomedical research can consequently

imbue consumers/survivors with a renewed sense of self through the validation of their interpretations and experiences, thus leading to a sense of hope about the future.

Achieving a balance between praxis and biomedical oriented knowledge is not without its complexities, including, but not limited to, the complications of achieving agency in healthcare grounded in a biomedical framework. Segal (2006) critiqued as oversimplified alternatives to the paternalistic biomedical framework that claimed to move from a "compliance" model to a "concordance" model. Segal (2006) declared "concordance" to be merely "compliance" in disguise, accusing concordance theorists of being primarily focused on persuading consumers/survivors to follow the advice of their doctors, rather than creating space for consumers/survivors' health preferences to be respected (pp. 82-83). While Segal (2006) acknowledged that following the advice of doctors is necessary, she pointed out that this was not what concordance theorists such as Marinker et al. claimed to be addressing:

In advocating "concordance". . . Marinker et al. said they were "not simply offering an alternative, more politically acceptable way of talking about a technically difficult, and morally complex, problem"; rather, they said, they wanted "to introduce and urge a distinct change in culture, in researching and teaching about the relationship between prescribing and medicine-taking, between patient and prescriber." (pp. 81-82)

Segal's (2006) assessment of concordance ultimately judged the concept to be contradictory and deceptive in its intent for compliance (p. 81). Consequently, Segal (2006) called for more discourse on the relationship between "concordance and commerce, a frank view of strategies of patient persuasion, and a recognition that the taking and not taking of medical advice occur in a larger field of health beliefs, health economics, and health mores" (p. 92). By acknowledging the parallels between the proposal for balancing biomedical and praxis-oriented knowledge and moving from compliance to concordance, I recognize the need for further research on how recovery-oriented care might promote agency in the context of psychiatric hospitalization. In particular, I echo Drake et al.'s (2010) observation that "barriers to shared decision making. . . need to be clarified by further research and addressed at many levels" including, but not limited to: "basic decision making science, clinician training, structural implementation, electronic infrastructure, [and] patient empowerment" (p. 11). This article invites more progressive/critical perspectives on the ways community psychology can advance

consumer/survivor empowerment in long-stay psychiatric hospitalization.

Integral to the healing process is the recognition that approaches to mental health treatment can be enriched by the intertwining and clear communication of biomedical-based and experientially-informed knowledge. Analyzing the ways in which biomedicine's designation of distance between objective and subjective knowledge pervades the rhetoric of mental healthcare reveals power dynamics that can unintentionally disempower psychiatric consumer/survivors and accordingly prohibit alleviation of their distress. Mental health services are vital and therefore need to continue to be held to a high standard. Psychiatric hospitalization does not have to consist of being locked up, treated as "other," and deprived of agency. The field of community psychology is committed, in part, to (1) collective action that advocates for the rights of marginalized peoples, and (2) the belief that the mental health of the individual is necessarily impacted by his or her social context (Campbell & Cornish, 2014). These commitments advance treatments that move beyond the dichotomy of objective and subjective experiences, instead advancing an attitude towards care that enables coexistence.

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