Chapter 6

THE RADICAL PSYCHIATRIST AS TRICKSTER

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INTRODUCTION

Psychiatric practice is dependent on particular social, cultural and moral judgements about the ways in which individuals grapple with 'being human' (Jenner et al, 1993). This is one reason why it is important to develop and defend spaces in which psychiatric judgement and practice can not only be contested and challenged, but also where we can seek more genuine forms of open dialogue with, and about, 'madness', to ensure we move towards greater forms of democratic engagement and practice. However, there is always a push to close down these spaces and insist upon closure of debate and routinised practice. For example, attempts at greater democracy in mental health services and experimental 'anti-psychiatric' initiatives have often been written off as 'radical failure' (Spandler, 2006).

Drawing on recent attempts to utilise the notion of the 'trickster' as a positive force in challenging health and social care practices (e.g. White, 2006), this chapter explores how tensions and contradictions in the mental health system might be creatively explored. I argue that cultivating a 'trickster sensibility' is one way of ensuring that the conflicts, uncertainties and ambiguities, inherent in both decisions about mental health care *and* stories about radical innovations, are foregrounded in our discussions. This could help ensure that such discussions are not artificially and prematurely closed down.

I use the idea of the 'trickster' in three related ways. First, to refer to ways in which dominant psychiatric discourses and practices have been challenged *by* particular trickster-like figures, especially psychiatrists themselves. Second, to refer to the ways in which particular stories or narratives *about* tricksters circulate in particular social contexts to describe or explain a series of real or imagined historical events, as *radical failure*. Finally, I introduce a third way of viewing the creative potential of the trickster in the modern context. This explores the idea of a 'trickster politics of tensions', a politics that is not dependent upon the limitations of individual charismatic figures, but is developed and suffused through various 'paradoxical social spaces' (Rose, 1993). As a vehicle to explore these issues, I draw on the history of Paddington Day Hospital, a libertarian therapeutic community in west London (Spandler, 2006). The history of Paddington Day Hospital, and its legacy in *Asylum to Anarchy* (Baron, 1987), might be regarded as a quintessential 'trickster story' in mental health.

THE RADICAL PSYCHIATRIST AS TRICKSTER

Some commentators have, at least in passing, described radical psychiatrists, like R.D. Laing, as 'tricksters' (Burston, 1996; Doty & Hynes, 1993; Mezan, 1972; Hynes & Doty, 1993). [1] However, the potentiality of this concept in illustrating some of the opportunities and limitations of such figures in the psychiatric field has not been explored in any detail. Moreover, although the idea of the 'trickster healer' has been briefly alluded to as a possible way of viewing the role of spontaneity and mischievousness of the psychotherapist in gestalt psychotherapy, the focus was on the potential individual therapeutic value of their character and responses, rather than their wider social or cultural impact (Zimberoff & Hartman, 2003; Kopp, 1976).

The trickster is a figure from world mythology (Hyde, 1998). It is a contradictory force, both constructive and destructive, a figure that challenges dominant thinking and social conventions. On a positive level it can be an agent of change and renewal, forcing us to confront unpalatable truths, raising awkward questions and challenging our conceptions of normality and acceptability. On the flip side, this maverick figure can produce unpleasant and shocking effects, and can be experienced as destructive. The trickster is a figure that embodies and acts out various social tensions, pushing the limits of what is both possible and desirable, often through subversion and humour. The trickster can be seen as 'the mythic embodiment of ambiguity and ambivalence, doubleness and duplicity, contradiction and paradox' (Hyde, 1998: 7).

Radical psychiatrists have often either been romanticised as heroic counter-leaders or demonised and psychopathologised (Leitner, 1999; Mosher, 1991; Burston, 1996). Whilst there are many exceptions to this, I argue that the notion of the trickster is a particularly useful concept for understanding the role and impact of the radical psychiatrist, precisely because it draws our attention to their paradoxical role.[2] Moreover, unlike some commentators who have argued that the trickster represents an important but *primitive* or *infantile* stage in human evolution in terms of cultural and individual development (see for example, Jung, 1955; Radin, 1955), I argue that the paradoxical nature of the trickster means that it has both positive and negative effects in the world. It important to note that the 'trickster' is an abstraction. Actual embodied individuals are always more complex than the archetype (Hyde, 1998). I am not necessarily arguing that particular characters were *in fact* tricksters, rather that there are particular historical moments which specifically created spaces for trickster-type practices to emerge through

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1. Incidentally, Laing himself apparently made reference to the importance of 'trickster stories' in facilitating his understanding of 'schizophrenia' (Hynes & Doty, 1993).

2. The therapeutic community movement utilised the notion of the 'charismatic leader' as a way to explain the key role of the Medical Director or Psychiatrist in developing and shaping an egalitarian and collectivist therapeutic community practice which is often at odds with the surrounding psychiatric and social culture. This notion of 'charismatic leadership' is also useful because it recognises the positive and negative consequences of such leadership on the survival of such communities (Kennard, 1991; Hobson, 1979). The idea of the trickster I discuss here could be used to complement such ideas.

the behaviour of particular individuals. These individuals, by virtue of their being sufficiently inside *and* outside the dominant psychiatric culture, were able to express this sensibility at particular times. Neither do I want to make the claim that archetypes such as the trickster necessarily represent something transcendental and universal in the human psyche (Radin, 1955; Jung, 1955). Whilst recent commentators (e.g. Hynes & Doty, 1993) have explored wide-ranging *cultural manifestations* of trickster figures, rather then their origins or essence, I want to explore their social manifestations within the specific context of psychiatric practice.

Whilst the trickster belongs to the periphery and is thus usually a marginal figure, one of the paradoxes of the trickster figure is that they require some power and influence on the 'inside' in order to have sufficient space to be able to exercise their trickster-like qualities, and to have an impact (Hyde, 1998). In this context it is worth noting that probably the most sustained and rigorous attack on the foundations of the psychiatric profession has risen from within its ranks, through the work of the psychiatrist Thomas Szasz, especially through his 'myth of mental illness' thesis (Cresswell, 2008). The social situation usually occupied by the trickster might be one of the reasons why they are usually portrayed as male figures.[3] Moreover, trickster archetypes tend to emerge in patriarchal mythologies, where the 'prime actors, even at the margins, are male' (Hyde, 1998: 8). It could be argued that the medical establishment has traditionally been male-dominated and more generally and historically, women have had a lot less actual 'freedom of movement' than men. It is precisely this quality that is a necessary defining character of the trickster who requires sufficient space, status and command to be taken seriously (Tannen, 2007). Similarly, this might also help us to understand how male *psychiatrists* have often occupied this role, at least in particular historical contexts, due to their position as simultaneously on the *inside* (of the medical profession) yet on the *outside,* by virtue of their contrary ideas and identification with seeking to make sense of the ultimate experience of exclusion (madness).

Whilst there probably has always been resistance to psychiatric practice ever since its inception (Crossley, 1999; Campbell, 1996), it wasn't until the late 1960s and early 1970s that we witnessed a sustained period of psychiatric contestation. It is often said that tricksters appear at key points of growth and change in society and represent future possibilities (Hynes & Doty, 1993). This period was beginning to see changes in the psychiatric arena itself. For example, growing unease at psychiatric hospital practice and emerging critiques of institutionalisation (e.g. Goffman, 1961) helped to energise the re-emergence of therapeutic communities as radical alternatives to the mental health system. These changes took place within a wider context of high employment and increasing demands for labour which may have spawned a new therapeutic optimism and a renewed interest in social rehabilitative psychiatry (Warner, 1994). This period

3. Some have argued that the trickster could be an androgynous figure as s/he might be able to transcend the boundaries between male and female. In a recent Jungian feminist account it is argued that postmodernism has enabled the development of female tricksters figures (Tannen, 2007). Nevertheless, unfortunately, as Hyde has argued, the typical trickster, at least in our cultural imagination, remains male (Hyde, 1998).

was also characterised by a heightened *political* as well as *therapeutic* optimism and activism, in the aftermath of 1968 (Brown & Hanvey, 1987).

The rise of new social movements, especially the 'New Left' and the women's liberation movement brought to the fore issues of identity, subjectivity, freedom and oppression and this made the politicisation of the field of mental health and psychiatry increasingly possible (Crossley, 1999). The convergence of progressive social forces and radicalised individuals combined with an emergence of new ideas and organisations (Freeman, 1999). The impact of wider social innovations and prefigurative practices that were developed from within the social movements were often taken up in the mental health field. For example, the emerging counter-culture supported communal living, social experimentation and innovation and this helped enable a greater toleration of madness or psychological disturbance (Crossley, 1999; Spandler, 2006). It also provided the context for greater attempts to understand distress within its wider social context. For example, perhaps the ultimate 'anti-psychiatrist'[4] and trickster, David Cooper, succinctly argued that 'madness is the expression of social contradictions against which we must struggle as such' (Cooper, 1978: 166). In typical trickster fashion, the 'anti-psychiatrists' drew our collective attention to the reality of these social conflicts (Makarius, 1993).

Therefore, the social context in this period was ripe for the emergence of trickster figures who helped bring into question certain widely held assumptions about madness and psychiatry. The lack of an organised patients' movement meant that challenge often came from within the ranks of psychiatrists and mental health professionals themselves. Such figures had sufficient power and status to challenge the role of psychiatry in social control and regulation from *within* (Crossley, 1998). Thus, despite the paradox of *psychiatrists* actively challenging psychiatric assumptions and pursuing the acceptability and intelligibility of madness, it was precisely their role *as* psychiatrists that allowed them some freedom to experiment with new ideas and practices, a freedom rarely afforded to other professionals (or non-professionals).

As the social movement theorist Alberto Melucci[5] argues, such figures often play an important part in the development of social movements by picking up and embodying a number of emerging contradictions and tensions in the social world. Contemporary social movements 'move in to occupy an intermediate space of social life where individual needs and the pressures of political innovation mesh' (Melucci, 1994: 102). These pressures or conflicts and contradictions in the social world are 'carried forward by temporary actors who bring to light the crucial dilemmas of a society' (ibid). Such figures personally occupy and command social spaces available for social innovation. However, in creating the conditions for social change and making challenges which rub against the grain of acceptable practice and ideas, they create resistance and controversy.

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4. It was Cooper who, after all, coined the term 'anti-psychiatrist' and was probably the only radical psychiatrist to have actually identified themselves with it (Cooper, 1967).
5. Whilst Melucci used the term 'innovative counterleaders' (Melucci, 1996: 338) it could equally apply to the trickster figure.

JULIAN GOODBURN AS TRICKSTER

In this section I use some examples from my research into Paddington Day Hospital, and Julian Goodburn in particular, to demonstrate some of the features that have been attributed to trickster figures (see Hyde, 1998; White, 2006). This study offers us a unique, but lesser-known, example of the trickster and associated trickster mythologies. Goodburn was the Medical Director in charge of Paddington Day Hospital during the early 1970s. A conventionally trained psychiatrist and psychoanalyst who tried to develop a more informal, egalitarian and libertarian approach to practice. He had little contact with the famous 'anti-psychiatry' figures like R.D. Laing and David Cooper, although he was often associated with them because of his increasingly radicalised thinking and ideas.

Paddington Day Hospital was an important communicational 'node' in the UK radical psychiatric community (Spandler, 2006). It operated as a 'space of convergence' (Routledge, 2001) of various progressive counter-cultural forces that were a feature of the period, bringing together radical mental health workers who were attracted to therapeutic communities as an alterative to the conventional psychiatric hospital, ideas of anti-psychiatry, and key figures in the emerging patients' movement. As a result, Paddington Day Hospital offered a rich context for innovation.

The trickster reminds us that we need to question our underlying assumptions, rules and values about what is right and wrong; they ultimately 'shake up' our thinking (White, 2006). There are a number of examples of Goodburn's role in challenging accepted psychiatric, psychoanalytic *and* therapeutic community thinking at the day hospital. He not only challenged the ideologies of the prevailing 'psy' professions but he also challenged patients' own perceptions of themselves in relation to the world and their place within it. Rather than seeing individuals as victims of 'mental illness', like the other 'anti-psychiatrists', Goodburn saw patients as carriers of wider social tensions:

> There is a correlation between the contradiction, or disquiet that they're experiencing, and the contradiction or disquiet that everybody ought to be experiencing a propos some factor of society at large, which, you know, they are, through circumstances of their particular experience, the bearer of—the victim of, you might even say—and will subsequently manifest this as if it were something solely going on in them, when in fact it is going on in them, but as a consequence of the fact that these issues are not resolved in the world at large, and it just happens that they are the person standing on that particular street corner at that particular time who've copped it, as it were. (Goodburn, cited in Spandler, 2006: 33)[6]

6. It is possible to apply similar logic to the situation of the trickster or radical innovator. In other words, a particular constellation of social, cultural and personal forces is required to radicalise the psychiatrist at this time, such that they become potential innovators i.e. it is not purely a matter of historical inevitability or personal psychology (or pathology).

He challenged the notion of the role of the Medical Director (the consultant psychiatrist) in a psychiatric setting by refusing to take 'medical' responsibility for the day hospital and carry out official mental health assessments, give out diagnoses, hand out palliatives or sign their medical certificates which would designate patients as 'mentally ill'. Not wanting to perpetuate their role as helpless victims and as 'mental patients', staff challenged their need to be designated 'sick'. As a result the staff queried the need to sign medical certificates. Goodburn had a confrontational therapy style, pushing issues to their limits in an attempt to force personal and political awareness. Some of this style was developed from his long-time association with the group psychoanalyst, Henry Ezriel, although Goodburn radicalised Ezriel's approach in the more politically aware context of the day hospital, following a politicised campaign to save it from closure.

Humour was an important and often under-recognised trait of both Ezriel and Goodburn, who presented their ideas and experiences with case studies, stories and self-mocking jokes (Thomas, 2002). However, despite the difficulty of relaying the potency of humour in text, humour is a crucial feature of the trickster. Goodburn used psychoanalytic interpretation and humour in an attempt to reveal underlying interpersonal, social and political dynamics which were impacting on the situation at Paddington, in what could be considered as a form of 'metaplay' engaged in by the trickster. Metaplay is a sort of 'inversionary logic that probes and disassembles the most serious rules of "normal" social behaviour, or the behaviour expected of a person in a particular role or position' (Hynes, 1993: 30). On one occasion Goodburn was reported as being found under a table refusing to make decisions on behalf of the patients, forcing them to take responsibility for their own lives and actions; on another occasion as barricaded into one of the therapy group rooms for refusing to sign patients' medical certificates (Spandler, 2001).

The trickster also reminds us that we actively participate in the shaping of this world and challenges the prevailing belief that any social order is absolute, objective and unchallengeable (Hynes, 1993; Hyde, 1998). Goodburn wanted to allow the day hospital patients to develop their own freedom without external constraints and was intent on trying to create the best conditions through which people could take charge and shape the world as they saw fit, by challenging their notions of themselves as sick or in need of external leadership:

> We desperately need a religion, a belief system, a sense of being overburdened, overpowered, oppressed with it, in order to lull our anxiety that we're actually in a position to take charge of the situation, and shape it as we see fit. (Goodburn, cited in Spandler, 2002: 136)

Distinctions between the 'outside' and the 'inside' and the 'mentally well' and 'ill' were frequently put to question, not only by Goodburn, but by patients and staff at the day hospital. For example, the power structure of the day hospital and the distinctions between patients and staff were often questioned. Questions were asked such as 'why are the staff paid salaries while the patients have to survive on social security?' (Durkin,

1972: 14). In addition, Goodburn tried to give keys to patients of the day hospital and record proceedings of the official inquiry which proceeded into the functioning of the day hospital, so patients could know what was going on. Although both of these attempts were thwarted (and condemned) it was illustrative of the ways in which the boundaries of acceptability were continually questioned.

The trickster actively 'troubles' accepted and comfortable distinctions and boundaries (Hyde, 1998). Goodburn challenged many of the accepted boundaries of traditional psychoanalytic and psychiatric practice, for example by experimenting with turning the day hospital into one 'large group' session through which personal, institutional and political processes could be reflected upon. His position within a therapeutic community setting, with its emphasis on shared collective understandings, democratisation and 'cultures of enquiry' (Norton, 1996) enabled opportunities for the trickster to 'create lively talk where there has been silence', 'speak fresh' and 'tickle the imaginations of his kinsfolk' (White, 2006: 36).

> Reflective practitioners need to tell stories about themselves and others … that defend the openness of human conversation and raise possibilities that *things could be otherwise*—not because they necessarily *ought* to be, but so that they *might* be. (White, 2006: 27)

In this context, the trickster is able to expand the realm of thinking possibilities which, in turn, allows the space behind them to expand (at least for a while). For example, the libertarianism fostered by Goodburn and his colleagues at Paddington contributed to the conditions in which the mental patients' unions (MPU), the first network of organised patients' groups in the UK, were able to form.[7] Although it cannot be argued that Paddington or Goodburn played an active part in the development of the MPU, the early MPU activists clearly felt that Goodburn's libertarianism was practically as well as theoretically important, for example one activist pointed out that 'without his opening the doors we would never actually have met' (Douieb, cited in Spandler, 2006: 58).

LIMITATIONS OF THE PSYCHIATRIST AS TRICKSTER

Whilst the radical psychiatrist as trickster can be seen as a positive force for change in contributing to emerging radical mental health movements, it inevitably expresses a number of limitations and problems. Indeed, radical psychiatrists occupy a 'paradoxical space' in which they simultaneously subvert, and yet often also reproduce, prevailing power relations. In other words, as the actual embodiment of paradox, the trickster psychiatrist often reproduces the very contradictions they reveal, precisely because of their inside/outside status. The contradictions that the radical psychiatrist exposes are

7. It is important to recognise that other mental patients' unions were forming around this time (the Scottish Union of Mental Patients was probably the first). However, the national network of patients unions in England really took off following a meeting at Paddington Day Hospital in 1973.

often merely mirrored back through their actions, rather than ultimately challenged. For example, some have argued that the domination of therapeutic communities by psychiatrists, however well-meaning, ultimately limits the progress and innovation of alternative community practices (Haddon, 1979). This is the limitation of the trickster; if 'it only mirrors the thing it opposes, it discovers no secret passage into new worlds' (Hyde, 1998: 271).

In addition, tricksters can become so *marked* by what they oppose, that their challenges often fold back on themselves and become part of the problem (Parker et al, 1995). In part, this is because, as Audre Lorde famously put it, 'the master's tools will never dismantle the master's house' (Lorde, 2000). In other words, even though the radical psychiatrists frequently used 'alternative' psychiatric discourse, they ultimately had more power to do so than patients, or other workers. Their 'alternative' could still be considered in the broader lexicon of the 'psy' disciplines, which tries to impose particular forms of expert psychological knowledge (Miller & Rose, 1986).

For example, Goodburn's use of psychoanalytic understandings both provided important insights into the dynamics within and beyond the day hospital, but was also experienced by many as not only limited, but also oppressive. Some patients and staff viewed psychoanalytic interpretation as being wielded round as a new regime of psychological truth, however seemingly democratic (Baron, 1987). Indeed, one of the dangers of the trickster's subversive use of humour is the possibility of offending or humiliating others. Baron's book is littered with many possible examples of this, for instance, what appear to be far-fetched and mocking interpretations of patients' motives. This is one way in which the trickster is seen as walking a fine line between creativity and destructiveness (Hynes & Doty, 1993).[8]

Furthermore, whilst boundary crossing and subversion may be a necessary condition for creating challenging 'lively talk', it is not sufficient. Moreover, it often excludes others (White, 2006). For example, it appeared that many women patients felt considerably less safe within the informal and libertarian atmosphere at Paddington (Baron, 1987; Spandler, 2006).

Similarly, many feminists have criticised the anti-psychiatrists for their disregard of sexual politics and, as a result, reproducing gender inequalities in their practice (Burstow, 2005; Showalter, 1987). Indeed the 'tyranny of structurelessness' became a well-known (feminist) critique of much libertarian organising, which often left the oppressed and powerless even more silenced and marginalised, through unacknowledged power structures (Freeman, 1974/1984). In addition, whilst such charismatic figures may prove inspirational in provoking challenges which form the basis of initiatives that welcome change, uncertainty and risk (Alaszewski, Manthorpe & Walsh, 1995), they are less adept at providing the security, support and sustainability that such initiatives require (Hinshelwood, 1987).

The lack of serious attention to power relationships and dynamics, especially race and gender, was an important critique of anti-psychiatric alternatives more generally

8. This tension is summed up by the subtitle of Mullan's edited collection of commentaries about Laing: *RD Laing: Creative destroyer* (Mullan, 1997).

(Showalter, 1987; Parker et al, 1995). Of course, the more obvious point that the radical psychiatrists tended to be white, middle class and male can be been seen as limiting their effectiveness as social innovators. It could also be argued that dissent *within* the ranks is a more acceptable form of protest and can be more effectively co-opted and contained. In this way, threats can be more successfully reincorporated, not least because the challenge doesn't threaten other, more fundamental, aspects of the status quo.[9]

In sum, the concept of the trickster is useful because it recognises both the possibilities and limitations of the radical psychiatrist as an 'agent provocateur' within psychiatry. The limitations outlined here draw attention to the paradox at the heart of the subversive trickster figure, that in breaking the rules, they confirm the rules (Hynes & Doty, 1993). That the history of Paddington Day Hospital was so clearly riddled with these tensions and paradoxes marks it as an important moment in history. Not only did patients and staff struggle to collectively defend the progressive elements of the day hospital, they were also vociferous in resisting its practices when it failed to meet their expectations. However, rather than the history of Paddington Day Hospital being seen as an important lesson in revealing and reflecting on these tensions, it became a 'trickster story' *par excellence*, through Claire Baron's highly influential book *Asylum to Anarchy* (Baron, 1987).

TRICKSTER STORIES OF RADICAL FAILURE

Asylum to Anarchy is a well-known, influential and anonymised account of Paddington Day Hospital. It describes how a radical experiment in mental health democracy and liberty turned into anarchy, chaos and tyranny through the control of a manipulative and ultimately dangerous psychiatrist and analyst, 'Adrian' (Goodburn).[10] Baron argues that under his leadership, the staff operated implicit psychoanalytic rules which acted as a coercive regime of truth in the day hospital. The pursuit of these ideas ultimately led to a situation in which some patients felt neglected, mistreated and eventually led to an official enquiry and the eventual sacking of the medical director and the closure of the day hospital.

The term *asylum to anarchy* can be used, not only to refer to Baron's account of Paddington Day Hospital, but also more generally as a narrative that has been drawn upon to describe and analyse 'failed' radical initiatives, and most particularly the fall from grace of the radical innovator (Spandler, 2006). Such 'stories of radical failure' can also be referred to as trickster stories. Trickster stories have been described as moral tales of radical failure which reveal and re-affirm the very norms, belief systems and rules that are being broken and subverted (Hynes, 1993). In many ways, these stories actually serve as a model for the sanctity of the rules, because they vividly demonstrate what

9. It could be argued that some ideas from 'anti-psychiatry' have been effectively co-opted, thus reducing its more fundamental challenge to the legitimacy of psychiatric knowledge.

10. Goodburn has entered folklore through two trickster narratives. Not only through the dangerous psychoanalyst in *Asylum to Anarchy,* but also the charming but ultimately flawed 'Adrian Goodlove' in Erica Jong's *Fear of Flying* (Jong, 1974). In both narratives he signified the disappointment and false hopes represented by individual men and psychotherapy, however seemingly 'radical'.

happens if these rules are broken (Hynes & Doty, 1993). In these stories, the trickster figure ends up being banished from the community because he takes it upon himself to break the rules upon which the social order depends:

> Sooner or later the violator must pay a price for his violations ... Therefore, he must be depicted as falling into his own traps, the victim of his own ruses, and that can be expressed narratively only as being a result of silly and awkward comportment ... he appears as a being who lacks common sense, acting inconsistently and absurdly. (Makarius, 1993: 84)

Baron's *Asylum to Anarchy* is littered with many possible illustrations of this; for example, what appear to be far-fetched and mocking interpretations of patients' motives in the day hospital. Whilst convincingly argued, Baron's account can be criticised for being an ahistorical account which portrayed a one-sided view, both of the radical psychiatrist, who is portrayed predominantly as a destructive, infantile figure, and the day hospital itself, which is portrayed as a disastrous experiment in democracy. In particular, it did not take into account some of the positive developments and innovations that were initiated and supported at the day hospital, such as the development of the Mental Patients' Union (Spandler, 2006).

Moreover, her account has functioned as a trickster story because it seemed to demonstrate that attempts at subverting dominant (psychiatric) norms and values merely reinforces the necessity of these norms (Hynes & Doty, 1993). Thus such stories serve to maintain the status quo by making it appear self-evident and necessary. For many mental health workers, particularly those in the therapeutic community field, *Asylum to Anarchy* seemed to justify the need to bring greater conformism into practice. Specifically, it suggested that the challenges to psychiatric convention that the day hospital set in motion might be dangerous, and therefore practices of permissiveness and libertarianism should be curtailed, and greater structures and rules implemented (Spandler, 2006). Indeed, Baron herself argues that her analysis seemed to 'illustrate the … irrationality of more democratic psychiatric methods' (Baron, 1984: 157). In addition, despite there being no serious consequences or catastrophes in the day hospital under Goodburn, *Asylum to Anarchy* operated as an 'atrocity story' which played into the hands of a growing conservatism in the 1980s which made innovation and experimentation more difficult.[11] It has been noted how 'atrocity stories' often function in society as a way to silence or close down spaces for debate and possible innovation in thinking (White & Featherstone, 2005; White, 2006).

Although I call this a 'trickster story of radical failure', I do not necessarily argue that it is completely 'untrue', nor that such radical practices actually 'succeeded' in any simplistic way. However, I do argue that these accounts overplay the element of failure at the expense of a genuine attempt at a serious and critical appraisal of radical innovations

11. Although another paradox of this period was that increasing consumerism helped pave the way for a stronger 'service user' movement in the 1980s (Campbell, 1996; Rogers & Pilgrim, 1991).

in and against mainstream psychiatry. It is too easy to either discard radical innovations into the dustbin of history of a more optimistic and radical past, or to romanticise such developments as a sense of nostalgia for things past.

Rather, it is important to try and develop accounts which re-inscribe the trickster with their essentially paradoxical qualities, both positive and negative, constructive and destructive. Indeed one of the ultimate paradoxes at the heart of the Paddington Day Hospital story was that it was a group of patients, those who the day hospital had sought to 'empower', who initiated a complaint into the functioning of the day hospital which eventually led to Goodburn being sacked and the day hospital closing down. Goodburn represented and re-created the aspirations and disappointments of radical psychiatry. Despite this, the radical psychiatrist as trickster has played an important role in challenging psychiatric thinking and practice. Whether this remains to be true is discussed in the next section.

CULTIVATING TRICKSTER SENSIBILITIES

Whilst it can be argued that figures such as Laing, Cooper and Szasz, as well as Goodburn, could be referred to as tricksters, it is harder to find examples of female psychiatrists who could be described in this way. It would, of course, be a bitter irony if the ultimate challenge to psychiatry was limited to white, male and middle-class psychiatrists. This is another paradox of the psychiatrist as trickster. More generally, as we have already noted, there is a lack of women tricksters in cultural mythologies and narratives, which might serve to limit its effectiveness as a concept with which to understand resistance and innovation. It would be too simplistic to assume that this lack refers to any 'essential' gender differences between men and women. It may be that the idea of the trickster is too narrow and misses its female expression (i.e. we need to look more widely to find them), or that when 'trickster energy' is manifested in a female body they are not viewed as tricksters. In part, this is because culturally and historically, women have been legally and socially excluded from particular roles in society and from our collective consciousness (Tannen, 2007). In other words, it is actually harder for women, not only to command such roles in societies that are riddled with gender inequalities, but even to be created in this role in our collective cultural imagination.

Therefore, one of the many limitations of the individual 'charismatic leader' or 'trickster' is that it touches on the old myth of the 'great man'. If, as Radin argues, 'every generation occupies itself with interpreting trickster anew' (Radin, cited in Hyde, 1998: 3), then we need to consider new expressions of tricksters in the modern context. For example, Sue White has argued that the reflexive social work practitioner can operate as a trickster in order to challenge the underlying assumptions and contradictions inherent in their profession. She argues that health and welfare work in general (and the case could be argued particularly strongly in psychiatric practice) is riddled with ambiguity and it needs trickster figures to ensure that these ambiguities are confronted:

> The important message about the trickster myths ... is that they are a celebration and a reminder of the need to open up dialogue and reflective spaces *within one's own culture*, to be anthropological about one's own suppositions. It is easy to spot the flaws in the practices of others, but the capacity of cultures to act as sustaining media for established forms of thought means that for us all, as members of cultures many of our own taken-for-granted distinctions never receive scrutiny. (White, 2006: 24)

Thus tricksters are necessary in order to open up (and keep open) reflexive spaces to challenge hegemonic practices, to 'spot a new orthodoxy and trouble its unintended consequences' (White, 2006: 30). Rather than seeing the trickster as an individual crusader we should look instead at the variety of ways in which it is possible to express trickster sensibilities within mental health practice. This requires us to consider the current spaces that are available for the expression of the creative and innovative energies which are necessary to challenge orthodoxies in theory and practice.

Ultimately this 'democratises' the notion of the trickster, seeing it as a position that might be available to different people at different times. Thus, rather than looking for new trickster *figures*, we might need to look at ways of engendering new trickster *sensibilities*. As White has argued, this is important in order to keep open important debates and paradoxes in professional practice, rather than prematurely close them off, or deny their existence. Whilst the idea of a truly *democratic* psychiatry (or society) might always be more aspiration than facticity, a 'trickster politics of tensions' keeps alive the question of democracy's *possibility*, by broadening and deepening spaces for durable radical democratic engagement in practice (Coles, 2006: 557–9). Cultivating a trickster sensibility would entail:

> [T]he ability to craft vision, practice, and power by sustaining a series of important tensions. This construction of democracy-in-tension promises a responsiveness, suppleness, and mobility that might just develop the power to help bring forth a better world. (Coles, 2006: 547)

CONCLUSION

On a number of different levels the notion of the trickster helps us to understand how we might confront the various tensions or troubled relations that are apparent in the struggle for more democratic mental health services. Ultimately it might help generate a greater understanding of the conditions of possibility for present and future sites of contestation, within and beyond psychiatric contexts. Cultivating a democratised 'trickster sensibility' might be one way of challenging current thinking and practices, keeping open our ability to question and not enforcing premature 'solutions' to our necessary and profound uncertainty in the field of mental health care.

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