CHAPTER 3

INSTITUTIONAL PRACTICES OF MENTAL HEALTH SERVICES

> A powerful identity will strive to constitute a range of differences as intrinsically evil, irrational, abnormal, mad, sick, primitive, monstrous, dangerous, or anarchical—as other. It does so in order to secure itself as intrinsically good, coherent, complete or rational and in order to protect itself from the other that would unravel its self-certainty and capacity for collective mobilisation if it established its legitimacy. This constellation of constructed others now becomes both essential to the truth of powerful identity and a threat to it. The threat is not posed merely by actions the other might take to injure or defeat the true identity but by the very visibility of its mode of being as other (Connolly, 1991 in Smith, 1998).

The previous chapter identified the reliance in psychiatry on 'mental illness' to explain symptoms. As we saw, this approach brought into question the competence of the patient as a person. As shall be discussed in the next chapter, chapter four, mental health law authorises mental health service providers to admit someone involuntarily on the grounds of 'mental illness'. This includes authority to use 'such force as may reasonably be necessary' to: restrain, administer, sedate, transport, detain and isolate a person. The purpose of this chapter is to consider the implications of this legally authorised treatment of a patient as mentally ill and therefore 'incompetent'. Though the consumer/survivor movement is a reaction against the coercive nature of these 'services', psychiatry maintains its conceptual integrity, in the manner quoted above, by the way patients are treated.

1. Understanding as diagnosis

The importance of psychiatry's theoretical and conceptual practices (outlined in the previous chapter) are delineated by Laclau (1979), who argues like Jaspers, that theory produces objects for knowledge. Though constructed and limited, theoretical concepts and their consequent methods have real effects. A theoretical approach introduces a paradigm or a way of seeing reality. A paradigm, in turn constructs a perception of reality, which is incommensurate with other paradigms. This is because a paradigm is a particular way of seeing: a perspective through which the world is viewed and through which it becomes a reality.

The test of the value of the theoretical, Laclau suggests, is the empirical. But the self-referential nature of knowledge means that the methods are necessarily self-verifying. That is, a point of view external to a paradigm, such as the consumer/survivor perspective of acute psychiatric services, are excluded. To identify theoretical problems, Laclau suggests like Touraine, the need to identify where the theory falls down in practice. That is, the internal contradictions of a theoretical approach are demonstrated in its practical limitations. For example, though Smukler (1994) argues that the clinician appreciates the person as a subject, not an object, this does not concord with the experience of patients.

What patients find, according to consumer/survivor research, as was discussed in chapters one and two, is that the reliance upon diagnostic categories to 'explain' behaviour has negative implications for patients in acute public mental health services. The practical implications of reliance on

the medical paradigm in psychiatry to respond to people in acute distress will be discussed further.

The problem is that the explanatory rationale utilised in psychiatry as identified in the previous chapter draws not just from established knowledge, but from a particular style of reasoning. That is to say, what is considered true or false emerges from a style of reasoning about things, not from the things themselves. Ways of reasoning, similar to paradigms, present different ways of investigating the world. An established rationality is not open to external evaluation 'because the very sense of what can be established by that style depends on the style itself' according to Hindess (1988: 79).

Hindess (1988) goes on to state, that an analysis of behaviour or practice requires identification of the style of rationality, rather than a judgement made from within the style itself. That is to say, the limitations of the usefulness of a style of reasoning utilised by a professional body, needs to be recognised and compensated for in practice. For instance, Hindess (1988) points out that the limited cognitive capacities of human beings means that the processing of gathering information is structured to simplify decision making by the use of techniques. Techniques are developed to limit searching for information from situations that yield results. Hindess' (1988) concept of the 'boundedness of rationality' applies to the limitations of the cognitive functions of professionals. Professionals do the best they can according to agree on 'standards of satisfactory performance'.

As explored in the previous chapter, in the field of mental health, psychiatrists are trained to identify and categorise behaviour as symptoms of mental disorders as set out in DSM IV (American Psychiatric Association, 1994). These categories simplify and define the practitioner's task as one of perceiving only information relevant to the diagnostic task. The diagnostic task thus becomes one of gathering information relevant to diagnose a disorder, whilst excluding other information that may aid in understanding. The usefulness of the theory and techniques practiced by medical professionals in mental health services in diagnosing mental illness will be considered henceforth in the light of the consumer/survivors who have experienced them.

Mental State Examination

Psychiatric disorders are considered to be primarily disorders of the mental state (Spitzer, 1994). The mental state examination is intended to elicit objective evidence of an underlying disorder, and is assumed to be equivalent to the physical examination in medicine. It is described in psychiatric texts in terms of an objective, empirical observation. But as Keks (1994: 68, 69) points out, the mental state examination is based on symptoms, not signs. That is, the description of the mental state is based upon the patient's account of their feelings, experiences, fears, and worries: that is, the patient's subjective experience. These reported 'symptoms' are not 'objective' signs but internal, personal experiences. Yet, psychiatrists are required to use explanatory rationality to 'objectively' describe the patient's experience (Dakis & Singh, 1994), which is a practical conundrum.

Additionally, this objective, scientific assessment presumes a biological causation, which informs the perspective on how symptoms are interpreted.

> The style and the content of a psychiatric interview are necessarily shaped by the interviewer's theory of psychopathology. Thus a biological theory of illness leads to an emphasis on signs, symptoms, and course of illness (Silberman & Corta, 1997: 19).

So although psychiatrists also look for disturbance in behaviour, which is also assumed to be related to biology, what is diagnosed is a disturbance in the patient's mental state: in mood, perception, thought, cognition, experience of the self and world, through indirect observation. This requires the psychiatrist to assess another person's mental state accurately (Kaplan, Sadock & Grebb, 1994). However, this requirement, carried out in the mental state examination, exposes the limits of the empiricist scientific perspective to know another's mind (Halasz, 1994; Mullen, 1984).

This type of assessment keeps concealed the question of how another's mind can be known. The reliance on an empirical scientific categorical methodology presumes direct and concrete knowledge, while the complexity of the philosophical question of mental state is rarely engaged with in psychiatric theory or practice. The lack of engagement with these problems is a failure to acknowledge the limitations of science, resulting in 'a tension between the need to define specific phenomena and the desire to do justice to the complexities of actual experience' (Mullen, 1984: 15).

Clayton (1998) while a psychiatric registrar, grappled with the limits of a scientific approach to deal with the experience of the patient and clinician. The presumption of the scientific model in psychiatry, Clayton points out, is

that the technical and procedural difficulties of the clinician can be overcome with experience. This means, she argues, that procedures themselves are not seen as intrinsically problematic for the clinician, but that the problems that arise from them are indicative of the limitations in the technician or patient. This leaves the methodology unquestioned and the problematics of the theory of the mental state examination invisible (Halasz, 1994). This is consistent with the empiricist theoretical view of the observation of phenomena.

Even though there is some recognition of the role of understanding or intuition of the psychiatrist in the mental state examination, the subsequent diagnosis is considered 'scientific' and 'objective'. Subsequently, the professional's account of the symptoms, though not the patient's, are considered to be reliable and 'true'. The frame or philosophy that is utilised to interpret symptoms or behaviour as objective evidence is not discussed. Diagnoses then are based upon subjective symptoms as reported by the patient and on patient's behaviour as observed and interpreted from the clinician's point of view.

Yet the problem of reliance on the subjective experience reported by the patient, and the subjective nature of the assessment and diagnosis and treatment made by the professional (often with the added burden of pressure from the patient's family to do so), is not addressed. The central role of the subjectivity of the patient and the examiner in the diagnosis as highlighted by Jaspers in the previous chapter are not adequately discussed in current theory and practice. Keks (1994: 67) claims that what is required to

overcome the practical limitations is that practitioners become aware of their emotional biases, liabilities and blind spots, so that their own subjective and hence observational biases may be minimised. [1]

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[1] The Understanding and Involvement study (Epstein & Wadsworth, 1994; Wadsworth & Epstein, 1996b; Wadsworth & Epstein, 1996c) found that there needed to be ongoing research or evaluation to provide an opportunity for some form of self reflection, as otherwise professional staff maintained a distance from patients. The project recognised that such change required incremental changes over time. But even so, this would require a fundamental shift in the way patients are conceptualised, which is what consumer/survivor activists are arguing for: 'fundamental changes in the way service providers see and are able to be with consumers' (Epstein & Shaw, 1997: 87).

Consumer/survivor activists (Wadsworth & Epstein, 1996b) argue that this can come through a 'comprehensive and systemic system of change', and a process of 'new forms of reflective practice'. Inquiries into the consumer/survivor perspective have been facilitated through the introduction of Staff-Consumer Consultants carrying the perspective of the consumer/survivor into the hospital culture (Epstein & Shaw, 1997). Rather than to blame or excuse, the Understanding and Involvement project suggests change through respect and not control, addressing the fears that result in dehumanising practices. It also involves strengthening positive practices through dialogue and communication. This means 'doing something about ensuring that fear and control responses are contained and do not get out of hand' (Wadsworth & Epstein, 1996b: 165).

The Understanding and Involvement Project is concerned with how to change current practices so that the services are more respectful. They found that central to a change in Mental Health Services was to address: 'How could staff get the chance to surface their own repressed undiscussables' (Wadsworth & Epstein, 1996b: 167)? The Understanding and Involvement Project argued that without emotional support, staff could not 'carry out their

work with maximum compassion and humanity' (Wadsworth & Epstein, 1996b: 167). They asked, how could:

Staff work to identify and support consumers' energies and happiness if their own loss of energies and unhappiness were unacknowledged and unsupported (Wadsworth & Epstein, 1996b: 167)?

Wadsworth and Epstein (1996b) found that without there being a willingness for practitioners to acknowledge and deal with their own emotions, there was no preparedness or resources to be able to be with anyone else's. Wadsworth and Epstein (1996b: 168) thought that the expectations of staff as 'all competent, all coping, all rational, tough and all-knowing' was unrealistic as was the expectation that consumer/survivors were 'all-incompetent, all-failing, all-irrational, weak and ignorant'. The Understanding and Involvement Project found for staff to be able to respect and listen to patients, and not reject or repress their expression, then staff also needed to support and resource each other, and to maintain a nurturing environment. Wadsworth and Epstein called this the missing site in mental health services. Only if the organisation supports the staff, can they in turn support the patients. Only then, they say, can the system work toward healing and recovery (Wadsworth & Epstein, 1996b).

The *Understanding Anytime* (McGuiness & Wadsworth, 1992) project found a need for staff to get beyond their current practices and think about why they objected to patients' comments. It queried what stopped them from engaging with patients, which required ongoing discussion and an opportunity for self-reflection. The opportunity for self-reflection was considered vital for change as: 'All new practice involves a pause and conceptual shifting and distancing from old practice' (Epstein & Shaw, 1997: 15). The Understanding and Involvement Project found that for this 'reflecting on practices and making changes' to occur, there needed to be the presence of some form of research or evaluation to provide the opportunity, as otherwise staff maintained a distance from patients. This meant that they were not aware of the patient perspective, so that inappropriate and insensitive approaches were also used when surveys were done. The current role of consumer consultants fulfils

The reliance on the subjective view of the medical professional as the tool of diagnosis is based on a rationale that assumes crediblity. The legitimacy of this endowment is established through the legal authority of the *Mental Health Act 1986* (Victoria, 1998). Even so, the implications of this legally sanctioned mental health practice are extreme. What this rationality means for mental health service providers in practice according to Kahr (1994: 76), is that the 'bizarre behaviour' of the 'mentally ill', elicits 'powerful effects of revulsion'. That is to say that psychiatrists respond to a patients 'bizarre behaviour' with the authority invested in them through the *Mental Health Act 1986* (Victoria, 1998) in the words of a Melbourne consumer/survivor activist Jon Kroshel (1997) 'to order the patient to be jumped, stripped, injected and secluded'.

The threat and/or use of violence is not limited to involuntary patients, but accompanies even voluntary public mental health patients experiences of 'treatment'. One of the entrenched problems of mental health services in public hospitals is that this impoverished style of practice is the site of training for psychiatric registrars. This effectively means that the least trained staff are responsible for the most distressed patients. The training is 'on the job', so the failure to develop skills for understanding is missing from the trainee's clinical experience which is primarily in the acute care settings of public hosptials.

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this function of having someone who has been there and knows what it is like and has come through it and survived. This offers a positive role model and hope for the patient that there

The impact of these legally protected coercive 'psychiatric' services is that people subjected to them feel traumatised and dehumanised: 'You're not a person any more, no matter what you were before' (Epstein & Wadsworth, 1994: 62). Patients do not experience being treated with respect, though this is what is desired:

> I would have liked to be treated as a person. You are treated as if you are an idiot, as if you can't understand English. I am at least as intelligent as the staff. I was not treated as a person with a problem; I was treated as if I was the problem... I was degraded when they stripped me. Someone came in and said 'take everything off' (McGuiness & Wadsworth, 1992: 14).

So even though a mental state examination, like a physical examination, is meant to be independent of the case history and prior to making a diagnosis, 'in practice an immediate intuitive diagnosis; often made in the first few minutes (a good clinical nose) plays an inordinate role' (Scharfetter, 1980: 25).

Finlay-Jones (1990: 5) says an adequate examination would take 100 hours, but as indicated, diagnosis is usually made within the first one to two minutes of an interview (Cooper, 1986; Finlay-Jones, 1990; Tasman et al., 1997). What concerns the psychiatrist for the rest of the 10-20 minutes is finding evidence to confirm the diagnosis. Expected symptoms are more diligently sort in the interviewing technique so as to confirm diagnosis. It seems that cognitively, the psychiatrist:

> first of all makes a decision that the person is good or bad in general; he then makes more specific trait ratings so as to fit in with the overall goodness or badness to a much greater extent

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are prospects for the future.

> than is justified by the detailed evidence available about the specific traits (Cooper, 1986: 240).

The diagnosis is later written up in the case report. Dakis and Singh (1994) in 'Making Sense of the Psychiatric Patient' discuss the case report as a 'comprehensive account of the patient's illness' which is:

> a valuable reference point for the clinician and acts as a vital communication tool in clinical settings and between the numerous professional groups (Dakis & Singh, 1994: 79).

In *A Psychiatric Catechism,* McGuffin and Greer (1987) discuss how psychiatrists customarily write up each 'case'. The case history includes the history of the presenting symptoms, their effects and treatment and any other past, family or personal history along with the mental state examination, written up in a formulation.

The formulation involves guessing at the aetiology by considering the role of the predisposing, precipitating and perpetuating factors. A formulation is 'a conceptualisation of the 'case' which involves, 'postulating connections' between 'aetiological determinants' and will often be 'hypothetical' (Dakis & Singh, 1994: 93). The formulation also includes a list of the evidence upon which the diagnostic inference is based. Cohen (1995) argues that the diagnostic formulation is an attempt to incorporate all factors in 'a unique profile'. The major 'findings reported in the psychiatric case history are on mental state' (Dakis & Singh, 1994: 79).

Dakis and Singh (1994) argue the case report appreciates the life-story of the person as a major part of a psychiatric history. However, the psychiatric admission, interview and case report does not involve listening to a patient's problems. Rather, it involves finding evidence to fulfil the criteria required to

establish a diagnosis so that treatment can commence. Psychiatry's reliance on diagnosis is because diagnosis is central to treatment and it is what psychiatrists are trained to do: 'In company with all medically trained physicians, psychiatrists abhor the absence of a diagnosis' (Snaith, 1991: 129).

The Mental Health System depends on diagnosis to determine treatment and prognosis.

> Psychiatrists are encouraged to believe that once the diagnosis is made, the correct treatment will follow. Unfortunately treatment is prescribed by diagnostic category rather than by the needs of the patient (Snaith, 1991: 140).

Diagnoses are dependent on clinical descriptions. What symptoms are looked for is dependent on diagnostic categories. A mental illness, which is considered to have an established course and treatment, is derived from a body of general empirical knowledge, which is not unique to the individual.

Patients' on the other hand, resent their feelings being responded to as symptoms: 'Emotions are seen as mental illnesses' (The Melbourne Consumer Consultant's Group, 1997: 2). Ex-patients report the experience of feelings being pathologised as invalidating and humiliating.

> It's all right if you're not mentally ill and you're angry and express anger. But if you've had a psych disability or whatever, if you become angry and express it, then that's seen in a totally different context (The Melbourne Consumer Consultant's Group, 1997: 2).

Once diagnosed, patients report: 'The diagnosis becomes the master status which (then) determines everything else' (Epstein & Wadsworth, 1994: 56). Despite the arbitrariness of the categories, they are used as if they are

substantiated. The diagnosis is primarily the meaning the psychiatrist makes of the patient's behaviour.

Cooper (1986), argues the diagnostic approach necessitates a confirmation bias. Cooper's analysis of diagnostic decision-making found that psychiatrists were unaware of what factors were important in this decision making process. Even though a search for disconfirming evidence would be more scientific, this evidence is not noticed. The reverse occurs. Diagnostic categories shape what symptoms are looked for to confirm diagnosis. Cooper argues that clinical experience interferes with the ability to make nonprejudicial ratings. The length of the clinician's experience in this process is important. The clinician's judgement about the patient is subject to the same errors any judgements are. Consequently, the reality perceived is the product of a process whereby what is observed is selected according to a limited frame of reference. This involves:

> a process of omitting some features, supplying others, highlighting one or a few and subordinating the rest in the interests of making sense of the environment (Newcomb, 1950, in Cooper, 1986: 203).

This demonstrates that those things not considered relevant are not perceived.

Another 'logical error' is that those considered 'mentally ill' are rated similarly on traits without the necessary evidence to support the view held in the mind of the observer. Cooper points out that:

> The perceptual processors and personalities of those making the judgements can have a considerable influence upon

> supposedly rational ratings of normal individuals (Cooper, 1986: 204).

Kleinman (1988: 78-91) also found in observations of clinicians at work, that data collected was constrained by both the patients' and clinicians' personal experiences. Though there will always be bias in judgement, being aware of it can minimise it. Cooper argues that:

> some knowledge of one's own decision processes and prejudices should form part of clinical training and continued education, for without it there is presumably an inevitable tendency to develop idiosyncratic and inexplicable clinical habits (Cooper, 1986: 205).

Even though 'the expectations of the observer influence the conclusions he arrives at from a given set of information' (Cooper, 1986: 239), these factors that influence the judgement are not recognised or discussed in psychiatric training.

Diagnostic reliability is also a problematic feature of a psychiatrist's decision making. Though diagnostic accuracy is meant to depend on the consistency of what the patient says and how the patient behaves, diagnostic reliability based on an unstructured interview is low. Cohen (1995) makes the case that diagnostic accuracy relies on the way the questions are put to the person, the interpretation of the answers by the interviewer, the symptoms that the patient reports and how important the interviewer considers the answers given. The consistent differences in psychiatrists' diagnostic ratings are well established (Round, Bray, Polak & Graham, 1995; Sheldon, 1994). Cooper discusses this as a result of psychiatrists' tendency to judge according to stereotypical categorical thinking, which disregards

disconfirming evidence. Even so, diagnostic inter-rater reliability does not establish the reliability of the categories themselves.

> The virtues of the operational criteria for comparative research must not be allowed to elevate them beyond their arbitrary and completely practical nature (Cooper, 1986: 208).

The admission interview is the only occasion when the doctor spends one-on-one time with the patient. Once diagnosed, patients are supposedly reviewed regularly and evaluated by the resident on the ward. What happens in practice though is that the reassessment is made by the resident passing though the ward on his rounds in consultation with the nursing staff who report 'disturbed behaviour'. The resident is required by the demands of the system to respond with adjustments to treatments, including increased prescription of drugs, the options being psychotropic, neuroleptic, antidepressant, anti manic medication. Other options include seclusion, electroconvulsive therapy and/or restraint.

From the point of view of the patient, this is not considered adequate: 'They reckon they review us, yeah! But they don't involve us or listen to us' (The Melbourne Consumer Consultant's Group, 1997: 10); 'They make arbitrary decisions around here, they never consult us, we're just the bastards that come here for help' (Consumer Consultation Report, 1993: 16). Patients feel that their distress is not taken seriously:

> I was having a terrible time and needed to talk to someone, the doctor was busy and my case manager could not see me, and when I finally got to see somebody it was only for 5 minutes, My God I needed to see somebody for a F------ hour (The Melbourne Consumer Consultant's Group, 1997: 7).

Ex-patients consider these practices as excluding, inappropriate and inadequate. Patients say they do not feel respected, validated, listened to:

> [Psychiatrists] want to lock you up to shut you up, but see, locking you up only makes it worse because you've got more to—you want to communicate past that room at the people—someone there that should be listening to you (Epstein & Wadsworth, 1994: 57).

Consumer/survivors consider this type of 'treatment' to be in the interests of 'the system' or institution: 'They always listen to their reality, never my reality' (The Melbourne Consumer Consultant's Group, 1997: 11).

Professionals defend diagnostic practices, on the grounds that it is necessary for the purposes of drug treatment. However, recipients of drug treatments claim that drugs do not address the underlying problem:

> The medications only mask it and when I come off them I am still left with exactly the same problems. While I'm on the medication they aren't a problem to me, so I don't bother addressing them. All of these core things that I've carried for a long time—they need to be worked through (The Melbourne Consumer Consultant's Group, 1997: 126).

The reliance on drug treatment has also been contested by consumer/survivor advocate organisations.

Sane Australia has highlighted that The National Survey of *People Living with Psychotic Illness: An Australian Study 1997-98* (Jablensky et al., 1999b) identified difficulties with daily living experienced by people with mental illness were the side effects of prescribed drugs. Reports of distorted thinking, perceptions and cognition are attributed to the disorder by professionals without recognition of the impairments induced by the drugs themselves. Eighty-six percent of those surveyed were taking prescribed

medication and eighty-four percent said that the side effects impaired their daily activities. These people also had high rates of smoking, alcohol and drug abuse, physical abuse and violence, suicide, self-harm, criminality and homelessness. Highlighting a consumer/survivor's claim:

> People like us are human too and we need to be understood. We don't need to be brushed under the carpet like the sexual assault never happened. We are human too [Graham, 1994: 56).

Clinicians also rely on their subjective clinical judgement to monitor and evaluate the outcome of their treatments. However, this judgement is subject to cognitive bias called 'The Clinician's Illusion' (Cohen & Cohen, 1984). This is where constant exposure to people experiencing chronic and difficult problems means that the psychiatrist has an impression that the outcome for this type of patient is always poor, while if the entire cohort is followed, a good prognosis is evident. In other words, exposure only to those whose problems are unrelenting in acute psychiatric services, means the impression is held that such problems are persistent. This means that treatment is affected by a distorted representation of outcomes.

These tendencies have coincided with a number of other reports and findings (Andrews et al., 1994) that have resulted in an initiative generated by the National Mental Health Strategy to measure 'consumer outcomes'. Consumer outcome measures are an attempt to overcome these limitations of clinicians bias, and to measure the effectiveness of treatments (Andrews et al., 1994). But as Tanenbaum (1994) has explained, this is a different type of assessment and therefore does not address the limitations in the practitioner's knowledge base or style of reasoning and assessment.

2. Diagnosis as Surveillance: from Subject to Mental Patient

The medical profession discards patients' complaints, as outlined in the last chapter and in the first section of this chapter, as symptoms of 'mental illness'. In contrast, Foucault offers another explanation for the way psychotic behaviour is examined by mental health professionals. Foucault (1991a: 185) asks questions, not as medicine does, of the history of the presentation of mental illness, but of the process of the examination. Foucault's analysis will be utilised to reframe symptoms, conceptualised in diagnostic practices as evidence of pathology.

The process of examination is important, according to Foucault (1991a) as outlined in the 'The Means of Correct Training' in *Discipline and Punish,* as such practices constitute subjectivity. He defines disciplinary measures as the specific techniques that create individuals' as objects. The tools of discipline he identifies as observation, judgement and examination. Observation is considered a subtle coercive mechanism of subjection and exploitation. The structural organisation of psychiatric units recently mainstreamed into general hospitals, are characterised by the ability to maintain visibility of patients, which facilitates control, training and recording. Thus, present day patients are disciplined and altered through the mechanisms Foucault described.

This organisation of surveillance Foucault (Foucault, 1991a: 170-194) suggests, derives effects for supervisors and the supervised alike. The effects are automatic, discreet, permanent, everywhere, silent and unseen

(Foucault, 1991a: 187). Constant visibility, he suggests, produces fixed and docile individuals. Domination is achieved through observation, surveillance and judgement, which links individual patients together in a disciplinary space. The structure of the hospital can be seen as unimportant if these objectifying effects are not appreciated. It is the constant surveillance of behaviour that is the key to disciplinary technology. Disciplinary technology Foucault (1991a: 170-192) argues, produces individuals as objectified, analysed, fixed.

Foucault (1991a: 189-192) also identifies the individual as a case, made concrete in writing or records. The documentary apparatus is an important component of the growth of the power of health services. The accumulation of documentation establishes characteristics and distributions of a population. The chief disciplinary technique is the examination. The examination is the technique by which, individuals are subject to power:

> its rituals, its methods, its characters and their roles, its play of questions and answers, its systems of marking and classification. For in this slender technique are to be found a whole domain of knowledge, a whole type of power (Foucault, 1991a: 185).

In this space of domination, surveillance and judgement patients are reduced to objects through a 'ceremony of objectification' (Foucault, 1991a: 187). This ritual involves the use of power and knowledge to subject 'those who are perceived as objects and the objectification of those who are subjected' (Foucault, 1991a: 185). The claim to truth, though constructed, is rationalised and ritualised through examination and diagnosis, with real effects (Foucault, 1991a: 192).

Foucault (1991a: 192) identified the clinical examination and the imposing of the diagnosis as the moment of crossing over of knowledge and power between the professional and the patient. Dreyfus (1982a) writing on Foucault states:

> The individual is the effect and object of a certain crossing of power and knowledge. Here is the product of complex strategic developments in the field of power (Dreyfus & Rabinow, 1982a: 160).

The experience of the clinical examination for the patient is one of crossing over of power, because this is the moment when a person is stripped of their right to define their own identity, through the imposing of a diagnosis: the *diagnostic-identity*. This process of diagnosis was also identified in chapter one by users of mental health services, as the point where people experienced their sense of wellbeing was being undermined.

The initiation into the acute psychiatric public hospital ward via the clinical mental state examination and diagnosis raises existential questions for the patient: 'Am I what you say I am?' (Kroschel, 2000). The diagnosis of a person by an authoritative medical professional with control over the patient's social, legal and health status, denies the patient the power to answer for themselves the question: 'Who am I?' (Ferreiro, 2000). This denies the patient the power to define their identity for themselves. Patients report that they feel that they have become a product of a coercive clinical, disciplinary and objectifying practice and conclude: 'I am a schizophrenic' (Kroschel, 2000). These diagnostic objectifying practices are at the expense of understanding the person's lived experience which leaves him/her feeling distressed, isolated, not understood and less than human (Watkins, 1998).

Foucault (1982; 1990) points out how modern science has created a science out of confession. An authoritative scientific interpretation of what the subject says results also in subjectification. The confession, in a clinical setting, interpreted through the methodology of the examination, results in both the production of a subject and object for itself. These objectifying and subjectifying modes of interpretation have allowed medical sciences the privilege of interpreting hidden meanings to which the persons themselves are not considered to have access.

Constructing problems in this way has meant an expert, the psychiatrist for example, is considered needed to decipher the language, behaviour and experience of the person who is deemed 'mentally ill', where: 'Individuality, discourse, truth and coercion were thereby given a common localisation' (Dreyfus & Rabinow, 1982b: 180). The continuing reliance on an expert as the source of truth, through privileged access to interpretation, maintains relational power structures. The continued reliance on diagnosis in acute psychiatric services preserves the diagnostic method unproblematically as a suitable way of addressing human distress. But this approach denies the reality of the person on the other side of 'the diagnostic encounter'.

The structuring of this 'science' around a profession has resulted in the denial of the power of the patient to interpret his/her own discourse and establishes the need for an expert to interpret 'truth'. The authority of the medical profession of psychiatry demands that the client speak, while claiming that only professionals can interpret 'the truth' of what is said. The continuing reliance on a truth other than the patients' own maintains the

dynamics of power that reduces the patient to an object. The professional's claim to the authority to interpret 'the truth' of a person's speech establishes the authority to prescribe enforcement treatment. This is reported by the consumer/survivor movement, as has been demonstrated already in this thesis, as an experience of the denial of a patient's legitimacy.

The refusal to allow the patient to arbitrate his/her own truth is, according to the consumer/survivor movement, an experience of violence. The violence of this approach is particularly evident in public mental health services where reports of abuse and trauma are considered symptoms of pathology (Graham, 1994). The consequential interventions on these objectified bodies are therefore-punitive. This is despite growing evidence that abuse explains even the most unresponsive psychosis (Hawthorne, McKenzie & Dawson, 1996; Herman, 1992; Read, 1997; Read, 1998). What alternative interventions or responses might be attempted will be discussed in chapters seven and eight.

The medical examination according to Foucault (Foucault, 1990) 'functions as a mechanism with a double impetus: pleasure and power' (Dreyfus & Rabinow, 1982a: 173). Dreyfus and Rabinow (1982a: 173) articulate the seductive power of the encounter explicitly: 'the medical power of penetration and the patient's pleasures of evasion seduce both parties'. The evasion of medical power is evident in the consumer/ survivor movement's failure to reveal relevant details of their experience in order to maintain some power and control over their lives.

This process was articulated explicitly as 'secret nutcase business' at the launch of The Melbourne Consumer Consultants' Group self written text, *Do You Mind?... The Ultimate Exit Survey: Survivors of Psychiatric Services Speak Out* (Group, 1997). The Melbourne Consumer Consultants' Group bemoaned the fact that this necessity was learnt the hard way: through suffering the consequences of being pathologised: that is, treated 'badly', for revealing personal information.

In clinical services however, the meaning of symptoms for patients is considered outside the domain of concern, which also ignores the implications of the experience of services for recipients. Meanwhile, reliance on diagnosis alone in acute public psychiatric services as a means of responding to a person's distress is a failure to respond to consumer/survivors' reports of their experiences and therefore the expectation of an appropriate and ethical response to their needs.

Dreyfus and Rabinow identify the continuing claim that knowledge is independent of power as the problem. They maintain that 'biopower rests on this assumption of externality and difference' (Dreyfus & Rabinow, 1982b: 182).

> While insisting that the truth they uncover lies outside the sphere of power, these sciences seem fated to contribute to the strategies of power. They claim a privileged externality, but they actually are part of the deployment of power (Dreyfus & Rabinow, 1982b: 180-181).

This maintains the objectifying practices that consequently dehumanise people's suffering and pain.

These difficulties plague public mental health services and result in a range of anomalies. One such anomaly that Dreyfus and Rabinow identify, is that for practices already found to be ineffective, rather than reduce funding, funding is increased in an attempt to verify results.

> The promise that these anomalies will eventually yield to their procedures justified the grant proposals, enlarged research facilities, and government agencies… the failure to fulfil their promises does not discredit them, in fact, the failure itself provides the argument that they use for further expansion (Dreyfus & Rabinow, 1982b: 182).

Dreyfus and Rabinow concluded that both objectification and subjectification are problematic. The resolution they suggest is in an alternative approach as advocated by Foucault: relocating power back with patients as the authority on their needs.

3. Acute Psychiatric Services: A Total Institution

The common site where objectification and subjectification come together is in the psychiatric institution. This coalescence of the two (objectification and subjectification) can be considered as a total institution. Drawing further from Goffman's (1961) work *Asylums* provides an analysis of acute public psychiatric services as a total institution and supplements Foucault's analysis. Goffman conducted ethnographic fieldwork in a mental hospital in an attempt to understand the patient's point of view in acute psychiatric services.

However, critics of Goffman's (1961) *Asylums* claim it is 'more a delineation of the mental hospital from the researcher's point of view than from the patient's (Weinstein, 1994: 358). Even though its approach is different to

what is attempted by the British mental health user movement, whose focus is on the experience of consumer/survivors more generally (Rogers & Pilgrim, 1991a: 130), similar themes and issues reoccur as will be seen. Goffman's observations have been re-affirmed by contemporary consumer/survivor claims as outlined in chapter one and elsewhere (Rogers & Pilgrim, 1991b; Rogers et al., 1993) and in recent literature (Wright, Gronfein & Owens, 2000). Consumer/survivor claims have in turn been supported by Goffman's research and analysis.

Despite the changes in acute psychiatric services since Goffman wrote his text—such as length of stay, mainstreaming, and funding structures—the dynamics that define psychiatric services as total institutions, which he named, remain (Quirk & Lelliot, 2001; Weinstein, 1994). Weinstein however, discounts Goffman's reliance on the notion of a totalitarianism to define the mental institution. He argues that 'the total institution model is not representative at all of the system of hospitalised care' (Weinstein, 1994: 351). Nonetheless he still considers Goffman's analysis as applicable, as the public hospital not only continues to be the major source of care in the mental health system, the demand on the hospital system has increased since deinstitutionalisation. [2]

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[2] Though Goffman's analysis is forty years old, it is still quoted as the classic study regarding treatment in acute psychiatric services, as little other ethnographic research has been conducted on the wards since the 1970s (Quirk & Lelliot, 2001). 'The second chapter of the book, 'The Moral Career of the Patient' originally published in 1959, has been reprinted 33 times, more that any other article in the journal history' (Weinstein, 1994: 349).

Goffman immersed himself in the life of the patients on the ward in an attempt to understand them. In 1955-56 Goffman spent a year's fieldwork at St. Elizabeth Hospital Washington D.C., an institution of over 7000 'inmates'. In the guise of assistant to the athletic director, he set out to study 'the social world of the hospital inmate, as this world is subjectively experienced by him' (Goffman, 1961: 7). He found patients:

> develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies they are subject to (Goffman, 1961: 7).

On the basis of his experiences, Goffman (1961) went on to write *Asylums* and to make a number of important observations.

Goffman (1961) identified the power of the psychiatrist over the life and circumstances of the patient as surpassing that of any other profession in society. This power, professionals claim, is necessary to 'treat the whole person'. But Goffman (1961: 358) notes this has negative consequences for patients, reluctant to reveal their problems for fear they will be considered and treated as if to be 'imagining things', which has also been reported by consumer/survivors. Meanwhile, Goffman notes, the meaning the person him/herself gives to their experience is considered irrelevant: the psychiatrist is only concerned with information of relevance to the diagnosis of mental disorder.

Weinstein's (1994) recent review of *Asylums* notes that it is quoted 90-160 times a year and as such, its influence as a remarkable text endures.

The medical language of the staff in these institutions, Goffman maintains, presents the nature of treatment as medical. When a person is admitted as a patient he/she is said to be mentally ill. However, the reasons that people enter psychiatric wards are multiple. The *People Living with Psychotic Illness: An Australian Study 1997-98* (Jablensky et al., 1999a), concluded that needs were multiple and it was the absence of provision of basic needs for housing and support services that resulted in admission to a service which is provided on a 'crisis-response basis'.

The professional identity of psychiatrists as doctors also gains society's confidence in the delivery of mental health services as medical treatment. The medical treatment model rests on the assumption that those who receive psychiatric care are receiving 'treatment' not 'punishment' from a doctor. However, inpatient admission is an occasion that induces trauma, recognised in the professional community by attempts to prevent admission and the trauma associated with it, with the use of preventative drugs (McGorry, 1994). But this reliance on drugs by-passes the need to respond to social factors that may have a role in the precipitation of the problems, and raises other serious ethical concerns, such as the serious side effects from the administration of these psychotropic drugs.

Goffman argues mental health professionals develop a belief system that works to reinforce the medical account of the situation. Professional subjectivity limits their perspective to that in line with their professional

identity. To validate the professional perspective, a professional narrative develops to support their belief system. [3] Tanenbaum (1994: 31) identified clinical medicine to be essentially interpretive in that a narrative is developed in an attempt to make sense out of an object of study. However, this medical narrative, as demonstrated in sections one and two in this chapter, are at the expense of delegitimising the narrative from the patients' perspective.

The concept of the subject that Goffman distinguished in psychiatry is one of a sick, fractured or split self, in contrast with the ideal of an unimpaired self. This split legitimises and constructs the psychiatrist as the guardian of the split object. Goffman goes on to say, that what psychiatry requires of a patient is 'a change of self'. Succumbing to treatment voluntarily requires that the patient must admit to being 'ill'. Goffman acknowledged the hospitalisation of patients considered to be suffering a mental disorder as a difficult situation for both the patient and the doctor. The doctor is called upon as a medical officer to utilise a medical approach while the patient cannot afford to accept medical terms 'if any sense is to be made of the hardships he is undergoing' (Goffman, 1961: 369). And as has been discussed in chapter one, the resistance to medical terminology is centrally important for patients to retain some sense of their humanity.

[3] Tanenbaum's (1994: 32) research showed that 'physicians organise and communicate their interpretative work through the telling of stories'.

The importance of resistance for patients was made clear by Merinda Epstein (1997: 38) who said 'The only thing clear to me was that I would not survive if I succumbed to naming myself as a psychiatric patient'. She later said:

> I realise now that I made a very important decision when I decided that I couldn't really afford to define myself as pathetic—or as victim or as any other things that were so tempting at the time. As an anthropologist I was able to keep what vestiges of professional identity and personal power I still had (Epstein & Shaw, 1997: 39).

Warning patients of the limits of knowledge from this powerful position Goffman considered useless, as:

> The medical role is defined otherwise in our society, and because the power the psychiatrist has over the patient is not readily understood as something that would be given to anyone who knew little (Goffman, 1961: 372).

Nonetheless, failure to accept the treatment model results in involuntary treatment. Significantly, Goffman (1961: 330) states 'to be made a patient is to be remade into a serviceable object', 'the kind of object upon which psychiatry can be performed'. This, Goffman casts as an irony, as so little service is provided.

Goffman observed that the hospital utilised a disciplinary system with a small number of staff organising a large number of 'inmates' using coercive methods to regulate behaviour. Any deviation in behaviour, resulted in punishment. A consumer consultant, Jon Kroshel, identified in an interview the problems with this system and the problems with the process whereby one learns what constitutes breaking a rule.

> No one tells you the rules. You find out once you break one what the rules are by being punished with an increase in drugs. Any expression of emotion in an acute ward is treated with an increase in drugs. If a family member comes to visit me while I

> am in hospital and I feel sad about the trouble I am for them, and am upset when they leave, my drugs are increased. If I am in for bipolar and I am happy when a friend comes to visit, my drugs are increased and I become a zombie. It is not seen as okay to have emotion in acute wards. Such treatment is inhumane (Kroshel, 2000).

Goffman describes the coercive nature of psychiatric services as counterproductive for the development of personal relationships within them. The patient experiences the use of coercive methods as a rejection. This means contact with professionals is experienced as threatening. Coercive treatment results in an experience of alienation for the patient which Goffman suggests, expresses itself in the patient's unwillingness to leave hospital. This often has more significance for the patient and his/her family than the original problem. The threat of incarceration is also used as an ongoing threat against a patient by family members: 'be good or else I'll send you back' (Goffman, 1961: 362). Similarly, psychiatry is often used by perpetrators' to threaten victims with being 'locked up' and called 'mad' if they tell (Bass & Davis, 1988).

Goffman points out, it is patients' complaints about these difficulties and their treatment, that are considered inconsequential by professionals who consider the principal issue as the 'illness'.

> Interpersonal happenings are transferable to the patient, establishing him as a relatively closed system that can be thought of as pathological and correctable (Goffman, 1961: 375).

This means that patient's difficult engagements with staff are ascribed to problems located within the patient and which need to be 'treated'. Staff are trained to interpret any problems the patient might be having with the delivery of the 'service' as the patient's problem, and to 'treat' the problem in

the person with medicine. This approach fails to consider the limitations of the service itself.

Taking complaints about coercive treatment seriously, Goffman explains, is not what psychiatrists are trained for. The professional's role requires that these 'outpourings' be discounted and treated as evidence of illness. But:

> To treat the statements of the patient as signs, not valid symptom reporting, is of course to deny that the patient is a participant as well as an object in a service relation (Goffman, 1961: 368).

This is important, as the denial of the validity of the patient's account is the site of the denial of respect for him/her as a valid human being, and as a participant in his or her own care. Goffman (1961: 363) highlights, in contrast to Jaspers, how in psychosis the 'interpersonal environment is inseparable from the trouble he/she is experiencing' and that to understand the symptoms requires observation of the patient's 'whole situation'. [4]

Nonetheless, to describe the patient's behaviour as forming part of a psychiatric syndrome labels it as 'involuntary, non-responsible and non-culpable' (Goffman, 1961: 317). Goffman appreciates that it is the technical schema, which disqualifies patients from participation, while creating

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[4]The removal of the original environment makes observation of the person irrelevant. Though a change of scene may in itself be therapeutic, this usually is followed by a return of the patient to the same environment 'of which his psychotic response is a natural part' (Goffman, 1961: 363). Discharge, claimed to be due to effective treatment of a correctly identified problem, has left the specific needs of patients' unattended.

patients as objects: this is the very opposite of what the consumer/survivors movement literature suggest as desirable (Wadsworth & Epstein, 1996a).

Goffman appreciates the gap between the different perspectives of the patient and the psychiatrist as an ongoing struggle where one cannot find in the other what they want: 'The psychiatrist and the patient tend to be doomed by the institutional context to a false and difficult relationship' (Goffman, 1961: 368). The attempt by the psychiatrist to sustain polite appearances is experienced as a hypocritical insult according to contemporary consumer/survivor literature (The Melbourne Consumer Consultant's Group, 1997). What would be desirable is direct engagement with patients' perspectives while acknowledging the limitations of resources.

The psychiatrist is in a predicament where what is required of him or her is to act in a professional stance, which the patient cannot accept.

> Each party to the relationship is destined to seek out the other to offer what the other cannot accept and each is destined to reject what the other offers (Goffman, 1961: 368).

Nonetheless, Goffman appreciates the plight of psychiatrists who attempt to be polite while administering coercive treatment as difficult. Negotiating this terrain results in a complex encounter: 'All day long the psychiatric staff seems to be engaged in withdrawing from its [psychiatry's] own implicit overtures' (Goffman, 1961: 368).

Even so, the use of lobotomy and electric shock, Goffman insists, is used in psychiatry to ensure adherence to acceptable modes of behaviour:

> In all of these cases the medical action is presented to the patient and his relatives as an individual service but what is

> being serviced here is the institution, the specification of the action fitting in to what will reduce the administrator's management problems (Goffman, 1961: 383).

The way lobotomy and electric shock is used is still an issue in current practice. For instance, The Mind Mental Health Charity (Pedler, 2001) recently conducted a survey of 418 people: *Shock Treatment: A Survey of People's Experiences of Electro-Convulsive Therapy (ECT).* One of those surveyed said:

> I went in as a voluntary patient and was told: 'Do as you are told or you won't see your children for years' (Woman—Leicestershire, ECT 6 or more years ago) (Pedler, 2001: 11).

Another person said:

> I was given no information and had to sign for it after all my medication at night so I was very drugged when I signed the form for my consent (Woman—Yorkshire, ECT 3–5 years ago) (Pedler, 2001: 11).

The serious and long lasting side effects from ECT lead the researchers in this study to conclude:

> It seems impossible to predict who will be adversely affected, and given the seriousness and permanent nature of the potential side-effects recorded above, we believe that it should no longer be able to be imposed without consent (Pedler, 2001).

Goffman says that whereas in the general hospital, physical ailment is the indication for treatment, in the mental ward, the failure:

> to be polite to staff–tends to be taken as evidence that one is not ready for liberty and that one has a need to submit to further treatment. The point is not that hospital is a hateful place for patients but that for the patient express hatred of it is to give evidence that his place in it is justified and that he is not yet ready to leave it (Goffman, 1961: 385).

Goffman's analysis has revealed a 'systemic confusion' in the way that treatment is conceptualised and delivered. This confusion, discussed in

chapter two as a methodological confusion, is still evident in today's acute public mental health services.

Goffman explained this confusion to be a result of the role of mental health services: the protection of the self-concept of professionals. As has been pointed out in sections one and two and will be discussed further in chapters five and seven, one's professional identity blinds one to the limitations of a perspective and the burden that it might impose for those subjected to it. Goffman succinctly states: 'Mental patients can find themselves crushed by the weight of a service ideal that eases life for the rest of us' (Goffman, 1961: 386)

Goffman concludes, considering an acute mental health patient to be different from ourselves allows one to then 'speak of him as being crazy, mentally ill, insane, psychotic, immature' (Goffman, 1961: 365). Psychiatry claims to maintain a stance of ethical neutrality while dealing with offences in society through sanctioning 'the offender, negatively and correctively' (Goffman, 1961: 318). These conflicting requirements of sanctioning offenders of the social order and ethical neutrality create ambivalence for the psychiatrists. Likewise, Szasz (1974) questions the conception of mental health in terms of 'successful' living and mental illness in terms of 'bad' living. He considers that whether the patient is considered 'ill' or 'wrong' is dependent on the perspective of the observer. Szasz also regards the medicalisation of problems a denial of dignity and human rights.

This chapter has identified the failure to recognise and validate patients as persons as contributing to a mental health patient's experience of damage. A consumer/survivor comments:

> I don't think you can base a mental health system on the physical health system, which seems to be what's happened. And taking people in, filling then full of drugs and sending then out again is not solving anything for a lot of people (Epstein & Wadsworth, 1994).

Consequently, while the articulation of the patients' concerns are considered symptomatic rather than authentic, patients will continue to embody their distress and be stigmatised (Johnstone, 1996). Goffman acknowledged the difficulty of the institutional setting which, aided by the legal and institutional power of the psychiatrist, is changing towards the 'custodial' aspects of institutionalisation, where contact with the patient is abandoned in favour of administrative roles and practices. The implications of this direction are discussed further in the next two chapters