Constructing Patient-Psychiatrist Relations in Psychiatric Hospitals: the role of space and personal action

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This essay investigates the role of space and personal action in the construction of patient-psychiatrist relations at psychiatric hospitals. In order to explore such a theme, the writings of R.D. Laing prove to be salutary. This is namely accredited to Laing's tenet that the staff and patients of a psychiatric hospital are institutionalised by both physical structures and personal action. A central approach taken in this essay is to explore Laing's theory through an intertextual reading of Michel Foucault's *Madness and Civilization* (1967) and Erving Goffman's *Asylums* (1961).

Keywords: R.D. Laing, Erving Goffman, Michel Foucault, psychiatric hospitals, patient-psychiatrist relations.

Introduction

This essay investigates the role of space and personal action in the construction of patient-psychiatrist relations at psychiatric hospitals. In order to explore such a theme, the writings of R.D. Laing prove to be salutary. This is namely accredited to Laing's (1985, 26) tenet that the staff of psychiatric hospitals are institutionalised along with

the patients. To attest to this theory, Laing believes that experience (or the negation of which) is made possible by two factors. Firstly, the physical environment offers either the potential of experience or its restriction. Secondly, personal action can either open up the possibilities for enriched occurrences or it can hinder such possibilities (Laing 1974, 28-29). In recognition of these points, the following becomes apparent: staff and patients are institutionalised by both physical structures and personal action. The dominant expression and formation of this institutionalisation is the It-district.[1] The 'It-district' can be defined as a difference constructed between staff and patients within psychiatric hospitals. This difference is neither neutral nor natural. Rather, it is a product of the physical environment of psychiatric hospitals that is structured to segregate, exclude and observe the patients. In addition it is the product of the personal action of staff that is based on control and excommunication. For Laing these manifestations are aligned to social power and not to health care. Yet these are nonetheless the dominant formation of the institutionalisation of psychiatric hospitals. The result of which is that certain modes of communication and power relations become apparent in the patient-psychiatrist coupling.

Yet, Laing's views cannot be read in isolation; rather his themes are corroborated and explored by both Michel Foucault's *Madness and Civilization* (1967) and Erving Goffman's *Asylums* (1961). Together, these books represent the broader zeitgeist of an interest in the history of mental health and the social institutions of psychiatry. As such, Laing's views are investigated within an intertextual reading of both Foucault and Goffman. In particular, this exploration is in terms of the physical environment and personal actions manifested in the psychiatric hospital. In terms of the former, Foucault deems psychiatric hospitals, more specifically, asylums as part of the disciplinary frameworks of modern institutions of

power. For the sociologist, Goffman, psychiatric hospitals are described as a total institution; as establishments that create a barrier to social intercourse from outside bodies or parties. In terms of personal actions, both Foucault and Goffman will be outlined in their examination regarding the patient-psychiatrist coupling and relationship. A cross-cutting theme between these two points is that both Foucault and Goffman consider psychiatric hospitals as spaces or relations of confinement and discipline.

Although Foucault and Goffman provide a corroboration and elucidation of Laing's themes, the following investigation of patient-psychiatrist relations in psychiatric hospitals is not merely a historical account. Rather, it aims to discuss the perpetuation of the dominant formation of institutionalisation in contemporary psychiatric hospitals. As such, the factors of institutionalisation (the physical environment and personal actions) are offered a historical and theoretical contextualisation by Foucault and Goffman. Subsequently, this framework is populated by contemporary examples for analysis. These examples will reflect exponents of the dominant formation of institutionalisation as well as alternatives. The alternatives are characterised by offering psychiatric practices that are hinged upon open communication as well as the sharing of responsibility and decisions within the patient-psychiatrist coupling. In doing so, these alternatives mend the rift between patients and staff: the It-district of psychiatric hospitals. It is exactly this act of mending that bears the hallmarks of Laing, who envisages a therapeutic relationship between the patient and psychiatrist that is based on human camaraderie.

Laing: background and context

Ronald David Laing was a psychiatrist, psychoanalyst and philosopher who achieved notable acclaim in the United Kingdom during the late 1960s and early 1970s (Jones 2005, 347). Prominent among Laing's achievements was applying existential philosophy and phenomenology as well as aspects of psychoanalysis to the understanding of mental illness – in particular to that of schizophrenia (Jones 2005, 348). From 1951 to 1956, first in an army psychiatric hospital then in a psychiatric hospital in Glasgow, Laing began to study patients with schizophrenia (Showalter 2004, 225). It is in these years working in the psychiatric hospitals as well as his experiences thereof that are considered a decisive influence on Laing's views (Abrahamson 2007, 203). Of particular note though was Laing's experience of long-stay patients at the Gartnavel Royal Mental Hospital in Glasgow. Laing was primarily assigned duties with the female patients' side of the hospital. Yet, in his writings he foregrounds only his experiences of the 65-bed female refractory ward and an associated rehabilitative unit commonly known as the 'Rumpus Room' (Abrahamson 2007, 203).

Laing (1985, 114) describes the refractory ward of the Gartnavel Royal Mental Hospital as overcrowded and the nurses constantly being under stress and overworked. In terms of the patients on this ward, there was nothing to do and the milieu was anything but 'therapeutic'. Furthermore, the patients were allowed no personal possessions and instead were issued with cotton uniform dresses. In regard to treatment, the patients were given electroconvulsive therapy (ECT) once a week and received sporadic and impersonal medical attention (Showalter 2004, 225). Laing was given permission to offer an alternative to such a milieu and to the management of

chronic patients. In particular, this was an experiment to determine the outcome of placing the same patients in less distressing surroundings (Laing 1985, 114). The experiment involved creating a special environment for 11 of the most despondent patients on the ward (Showalter 2004, 225-6).[2] Two nurses whose sole job was to be with these eleven patients were delegated. A large, brightly decorated room that was comfortably furnished was made available; in this room there were magazines and material for, amongst other activities, knitting, sewing and drawing (Laing 1985, 114-115). The patients spent from 9 to 12 a.m. and from 2 to 5 p.m. on weekdays in the room and returned to the ward each evening. The nurses were regularly on duty and the only direct instructions that they were given were to provide daily reports and to complete sociograms; the nurses would share these reports and exchange information with the respective staff members during weekly meetings (Abrahamson 2007, 206).

Laing (1985, 114-115) notes that the outcomes of placing the patients in this room were twofold: the patients' conduct had improved; and the nurses were no longer beleaguered. Further changes in the patients over the course of twelve months included the following: they were no longer secluded; their conduct became more social and they undertook valuable tasks; and their appearance and interest in themselves improved as they took a greater interest in interpersonal relations. As such, the patients lost many of the features of chronic psychoses: they were less violent to each other and the staff, they were less untidy and their language ceased to be vulgar. The nurses came to be well acquainted with the patients and spoke of them with both sincerity and amiability (Abrahamson 2007, 207). The results of the experiment made Laing aware of the importance of the human bond, a kinship between the 'sane' therapist and the 'mad' patient, which in institutionalised psychiatry is too often replaced by power relations (Showalter 2004, 225-6).

Psychiatric hospitals as 'It-districts'

One consequence of the abovementioned power relations between therapist and patient is that there is a lack of companionship between the two groups (Laing 1985, 116). Laing (1985, 29) continues with such insights by defining psychiatric hospitals as It-districts: there is a lot of camaraderie between the staff members as well as between the patients. Yet, there is most certainly an It-district between staff members and patients (Laing 1985, 29). This It-district is forged in psychiatric practices based on "… exclusion, segregation, seclusion, observation, control, repression, regimentation, excommunication, invalidation … [and] hospitalization ..." (Laing 1985, 29) that seem to belong to the sphere of social power and structure rather than to medical therapeutics (Laing 1985, 19). Laing (1985, 26) started to question the necessity of this sort of regime and cautioned that no one sort of psychiatric sensibility should acquire a hegemony of power over people (Laing 1985, 27). Thus, he began to envisage a whole new approach without the hallmarks of excommunication that are embedded in psychiatric practice (Laing 1985, 19). Central to this alternative approach is the establishment of psychiatric institutions whereby communication occurs "...within *solidarity*, community and communion, instead of the It-district, the no-man's-land between staff and patients" [emphasis in original] (Laing 1985, 28).

Practices of a therapeutic milieu

Laing's Rumpus Room experiment was not only considered a pivotal influence in his theories and publications (see *The Divided Self* [1960]) but also in his development of

therapeutic communities for people in crisis (Abrahamson 2007, 203-204). In the mid 1960s Laing was in part responsible for establishing the Philadelphia Association that aimed to launch the therapeutic communities that he had envisaged. Most notable of such communities was Kingsley Hall in East London. Kingsley Hall was predicated in part on the ideas derived from Laing's previous Rumpus Room experiment and aimed to offer a validating environment, the use of minimal restraint and opportunities for therapy (Heaton 2006:181; Jones 2005, 349).

However, there are a number of discrepancies between Laing's ambitions and the actual occurrences that took place in these therapeutic communities (Abrahamson 2007, 203; Clarke 1999, 318; Showalter 2004, 228). Thomas Szasz in particular dismisses Laing's aspirations for these communities. Szasz (2008, 82) cites that Laing had hoped that Kingsley Hall was to serve as a model for non-restraining, non-drug therapies for those people seriously affected by schizophrenia. Yet, in paradox to the abovementioned hopes, Szasz (2008, 91) outlines how Laing made use of LSD in 'therapeutic contexts' and recounted one particular episode in which Laing and his colleagues pursued an escaped patient of Kingsley Hall and subsequently assaulted, drugged and locked up the patient (Szasz 2008, 95-6). Additionally, there were other incidents of violence in Kingsley Hall which included a patient being placed inside a sack which was tied up and left at the bottom of the stairs (Sedgwick 1982, 116-117).

By taking these critiques into account, one can easily discredit Laing's ethical and intellectual contributions due to his lapses and departure from professional standards and responsibilities (Burston 2009, 6; Showalter 2004, 228). However, the inconsistencies in his accounts do not negate the substantive evidence from the Rumpus Room experiment that revealed the determination, emotional capacities and commitment to better qualities of life in long-term patients. Moreover, this

experiment is also accredited with establishing Laing's advocacy for open encounters with mental health patients. This aspect, rather than his model of therapeutic communities was the main aspect that many took from his earlier work (Abrahamson 2007, 212-13). To substantiate further, Laing's promotion of respect and mutual understanding in communicating with mental health patients is accredited with initiating a number of humanising reforms in the treatment, care and management of mental illness (Heaton 2006, 181; Jones 2005, 349; Showalter 2004, 228).

From the previous points, it becomes clear that Laing's Rumpus Room experiment was a formative influence on his views. Specifically, the experiment influenced his ideas about the patient-psychiatrist relationship as well as later led to the development of his therapeutic communities (Abrahamson 2007:204). Although, Laing's therapeutic communities are marred in botched aspirations and copious amounts of critical critiques, his ideas about the patient-psychiatrist as constituted by a rift (Laing 1985:28) and his attempts to mend this rift, through a relationship based on human camaraderie, remains a beneficial influence in psychiatric practices.

Theoretical approach

Laing's first books appeared at the same time as that of Michel Foucault's *Madness and Civilization* (1967) and Erving Goffman's *Asylums* (1961). These books were part of an international trend interested in the history of madness and the social institutions of psychiatry (Showalter 2004, 221-222). As such, Laing's work can be bracketed within the writings of Foucault and Goffman; works that are all critical of the practice of psychiatry and the effects of confinement in a psychiatric hospital (see Leff 2000, 292; Sedgwick 1982, 197; Scull 2011, 413; Smith 2006, 82). Additionally, in Laing's

theories there is a clear influence, reference and intertextuality of Foucault and Goffman. To explicate but one point, it has been noted that through the influence of Goffman, Laing began to fully understand institutionalisation as an effective force for social control (Showalter 2004, 225-6). As such, this paper seeks to explore Laing's theory within the intertextual reading of both Foucault and Goffman.

As previously mentioned, this reading is not just limited to an historical account. Rather, it aims to discuss the perpetuation of the dominant formation of institutionalisation in contemporary psychiatric hospitals. However, before such discussions ensue, one needs to acknowledge to what extent the principles described by Foucault, Goffman and Laing are still applicable. On first assessment, the aim of this paper appears at odds with the impact and influence of Foucault, Goffman and Laing. The critique of psychiatric hospitals offered by these authors and others from anti-psychiatry is recognised as motivating the turn towards deinstitutionalisation (Henckes 2011, 165; Scott 2010, 222; Scull 1984, 95-96; Smith 2006, 76). From the second half of the twentieth century, deinstitutionalisation – the transfer of patients from psychiatric hospitals to community-based structures and systems – was fuelled by research from the abovementioned authors which outlined the negative effects of institutionalisation and the segregative techniques as well as custodial functions of psychiatric hospitals (Scull 1984, 95-96; Scull 1993, 388).

Deinstitutionalisation has resulted in a decline of psychiatric hospitals; a wane that has been heralded to mark the "twilight of asylumdom" (Scull 1993, 393). Yet, globally 63% of psychiatric beds are still located in mental hospitals, and 67% of mental health spending is directed towards these institutions (Mental health atlas 2011, 10). Thus, it may be inappropriate to speak of a post-asylum period in which the asylum has completely disappeared (Moon, Kearns and Joseph 2006, 240). Even in

Western health economies where community based structures are the dominant offering for mental health care, psychiatric hospitals continue to survive either in the private sector for clientele willing to pay for institutional care (see Moon, Kearns and Joseph 2006), or within the public sector for the care of long-term chronic mentally ill patients as well as acute inpatient care (Osborn 2009, 229).

The continuing pervasive presence of the psychiatric hospital, albeit in decreased numbers, is equally met by the continued persistence of the dominant formation of institutionalisation.[3] Although, psychiatric patients have more rights today and are more aware of their existence, their basic needs are still actively ignored and denied despite official policies mandating otherwise (Gillett 2009, 69). Additionally, patients continue to be treated in an infantile manner and are subject to abuse (Helmreich 2009, xv). To elucidate further, in countries like Macedonia and Chile, patients still remain in inhumane and degrading custodial institutions (Leff 2000, 287). In South Africa, a recent report highlights the human rights abuses of patients at one particular psychiatric hospital that included the patients being sexually, physically and emotionally abused by the staff (Mkize 2007). Even in the US, physical restraint and seclusion are still in general use in psychiatric hospitals (Leff and Warner 2006, 64). Equally problematic is the lack of open communication and therapeutic democracy within psychiatric hospitals that cater for acute and chronic patients (Sedgwick 1982, 211). The above findings, that expose the dehumanising and degrading practices in present-day psychiatric hospitals, undermine most attempts to create a departure from the historical abuses and critique that mark the institutionalisation of the mentally ill. As a result, the characteristics that define Foucault, Goffman and Laing's work on psychiatric hospitals, namely depersonalisation, segregation and mortification, are still manifest in contemporary

expressions of the dominant formation of institutionalisation within psychiatric hospitals.

For the purposes of this essay, an alternative to this dominant formation of institutionalisation is explored through the ideas of Laing.[4] As outlined earlier, the investigation of Laing's ideas is limited to the findings of the Rumpus Room experiment that a psychiatrist-patient rift exists in institutionalisation; a rift evident in the fact that "[c]ompanionship between staff and patients had broken down" (Laing 1985, 116). For Laing, this psychiatrist-patient rift was accorded to be a product of a loss of human camaraderie (Laing 1985, 145). Consequently, Laing offers an approach to mend the rift between staff and patients through a professional therapeutic relationship based on human camaraderie (Laing 1985, 28). This approach includes re-engaging patients as persons through communication based on understanding and respect. To do so, staff and patients need to be "... on the same side and on the 'right side' of each other" (Laing 1985, 24); no longer a split between patients and psychiatrists, a divide between sane and insane, but a relationship of camaraderie based on "'Power-sharing' [and] sharing 'responsibility' for 'decisions'" (Laing 1985, 24).

The above insights guide the following discussions. First, the essay aims to discuss the perpetuation of the dominant formation of institutionalisation in contemporary psychiatric hospitals. As such, the factors of institutionalisation (the physical environment and personal actions) are offered a historical and theoretical contextualisation by Foucault and Goffman. Second, the article reflects on practices in contemporary psychiatric hospitals that offer an alternative to the dominant formation of institutionalisation; alternatives that refer to Laing's central insights pertaining to

the patient-psychiatrist coupling to share power, responsibility and decisions within open communication.

The physical environment of the psychiatric hospital

"Everything was organized so that the madman would recognize himself in a world of judgment that enveloped him on all sides; he must know that he is watched, judged, and condemned; from transgression to punishment, the connection must be evident, as a guilt recognized by all" (Foucault 2009, 253).

This section focuses on the physical environment of the psychiatric hospital. Goffman (1973, 15-16) defines psychiatric hospitals as 'total institutions'.[5] For Goffman (1973, 15-16) all institutions have encompassing tendencies but in 'total institutions' there is a larger degree of encompassment. In particular, the encompassing or total character is symbolised by a barrier that prevents social interaction with the outside. This barrier is often built right into the physical structure, such as locked doors, high walls and barbed wire (Goffman 1973, 15-16). In terms of Foucault; psychiatric hospitals are viewed as part of the disciplinary frameworks of modern institutions of power. Foucault's descriptions of the psychiatric hospital will be explored in the subsequent paragraphs.

Foucault identifies a number of structures essential to the nineteenth-century asylum – structures that are fundamental in order to understand psychiatric history and its current manifestations (Sedgwick 1982, 134). One such structure, namely observation and classification, is argued by Foucault to be an essential component in the science of mental disease that developed in the asylum (Foucault 2009, 238). In particular, observation was deployed in order to "... spy out any incongruity, any disorder, any awkwardness where madness might betray itself" (Foucault 2009, 236). In this regard, observation provided a means to persistently scrutinise the patient in

order to reveal the presence and various incidences of mental illness – a continual pursuance of the individual for the signs in which madness becomes distinct from reason (Foucault 2009, 236). A second structure named by Foucault is judgment. For Foucault, the structure of judgment acted as a positive operation that "... confined madness in a system of rewards and punishments, and included it in the movement of moral consciousness" (Foucault 2009, 237). This is an important operation as it encouraged patients to cooperate in becoming docile, to manage their own disagreeable behaviour in order to assure their lack of restrictions and guarantee their rewards. As such, this operation is at odds with modes of discipline that are enacted through brutal and repressive means. Thus, physical restraint in the asylum is censored in favour of self-restraint (Foucault 2009, 237). Foucault provides further description and specific details of the exact workings of these structures in his later publication *Discipline and Punish* (1977). It is to this publication that the essay turns to in order to further articulate Foucault's asylum structures as instruments in discipline.

Foucault states that disciplinary power is derived from three simple instruments, namely: hierarchical observation, normalising judgement and the examination (Foucault 1991, 170). Only the first two instruments will be delineated in the course of this section. Hierarchical observation can be conceptualised as a `disciplinary gaze' that operates through a series of supports that take the form of consistent surveillance. This gaze renders people visible and consequently makes it possible to recognise individuals and alter their behaviour (Mohr 1999, 1053). In terms of normalising judgement, the instrument consists of the correction of non-conformity. It accomplishes the task of correction by a system of gratification-punishment in which individuals are encouraged to make rewards more frequent than

penalties (Foucault 1991, 180). This process allows for the individuals to be differentiated as 'good' or 'bad' subjects in relation to one another (Foucault 1991, 181). As such, this distribution provides for both punishment and reward: it rewards simply by the issuing of awards and as a result it makes it possible to attain higher ranks and places; and it punishes by reversing this process (Foucault 1991, 181). The exact working of this operation, a constraint towards conformity, is a tacit act of normalisation (Foucault 1991, 183). These two instruments are deemed by Foucault to not only constitute the mechanisms of disciplinary power but also that they mark the birth of the human sciences, specifically that of psychiatry (Mohr 1999, 1053). Each of these two instruments will be outlined and applied to examples from contemporary psychiatric hospitals.

Hierarchical observation

Foucault believes that the power of surveillance is demonstrated by the well-known example of the panopticon (Walsh, Stevenson, Cutliffe and Zinck 2008, 254). The panopticon was originally conceived by Jeremy Bentham in the late eighteenth century as a type of building design which allows an individual to observe others without the observed being able to tell whether they are being watched or not. Hence, it is a spatial arrangement that from the point of view of the guardian or the observer, the multitudes can be numbered and supervised; and from the point of view of the inmates or the observed they become detained by steadfast scrutiny (Foucault 1991, 201). The panopticon is invoked by Foucault as a metaphor for modern societies in their pervasive inclination for surveillance (Foucault 1991, 217). In this regard, Foucault's interest is not in the panopticon (the actual type of building design) but in

panopticism – a movement to generalised surveillance and, of consequence, its contributions to aspects pertaining to discipline (Foucault 1991, 209). To further clarify, Foucault's use of the term panopticism refers to:

> ... a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics' or an 'anatomy' of power, a technology. And it may be taken over either by 'specialized' institutions (the penitentiaries or 'houses of correction' of the nineteenth century), or by institutions that use it as an essential instrument for a particular end (schools, hospitals), or by pre-existing authorities that find in it a means of reinforcing or reorganizing their internal mechanisms of power; ... or by apparatuses that have made discipline their principle of internal functioning, ... or finally by state apparatuses whose major, if not exclusive, function, is to assure that discipline reigns over society as a whole (the police) (Foucault 1991, 215-216).

From the above, it becomes discernable that Foucault's panopticism includes institutions, apparatuses and the nature of many other 'disciplinary techniques', through which human subjects are observed, surveyed and converted into dependable 'docile bodies' (Philo 1989, 264). Thus, asylums might not reflect the physical space of the panopticon but the programmes and arrangements at the asylum reflect panopticism (Walsh, Stevenson, Cutliffe & Zinck 2008:254). In this regard, patient observations, record keeping, individual and group therapy, ongoing risk assessments, regular ward reviews, and so forth, can all be understood as examples of panopticism. Therefore, through a Foucauldian analysis the above elements of 'care' are revealed to be interventions whose effect is to create and maintain within patients an awareness of being continually monitored; an act to ensure that there conduct is in accordance with the norms of the institution (Roberts 2005, 36).

More explicitly, surveillance in psychiatric hospitals is manifest in practices of special observation for patients deemed at risk or risky. For example, Stevenson and Cutcliffe (2006) explore the practices of special observation as a means of controlling

suicide risk. Through a Foucauldian reading, they identify that observation can be related to moral therapy, wherein the person relinquishes mental illness for responsibility through a disciplinary process (Stevenson and Cutcliffe 2006, 713). Such an approach is deemed to be the dominant recommendation. However, recent research (see Stevenson and Cutcliffe 2006) has challenged the benefits of observing patients who are defined as 'at risk' and have come to view surveillance as a custodial activity rather than a therapeutic activity (Hamilton and Manias 2008, 179).

Normalising judgement

Goffman (1973, 18) states that when patients are moved in blocks, they can be supervised by personnel whose chief activity is not guidance but rather surveillance. The staff see to it that everyone does what they have been told is required of them, under conditions where one person's indiscretion is likely to stand out against the all-embracing compliance of the others (Goffman 1973, 18). In this light, the act of surveillance moves beyond mere observation to the scrutinisation of patients' behaviours and activities in order to compare them against the expected models of behavior; this very process is defined as normalising judgement.

In order to further examine normalising judgement, Foucault's outline of the concept will be subsequently elucidated and applied. As already indicated, discipline operates in a double system of gratification-punishment. In this system, correction is encouraged through making rewards more frequent than penalties. Of consequence, all behavior and performance is assigned along a binary field of good and bad points (Foucault 1991, 180). Through the calculation of these points, a hierarchy is established between 'good' and 'bad' subjects. Such a hierarchy of subjects aims to

differentiate individuals not just according to their acts but also in terms of the individuals themselves – of their nature, potentialities, skills, aptitude and value (Foucault 1991, 181). Thus, discipline operates to differentiate individuals from one another, creating either an average that is to be attained or an optimum towards which one must move. In other words, discipline acts by offering a constraint of conformity that is achieved through a double system of gratification-punishment (Foucault 1991, 182-183). As a result, this system of discipline normalises and imposes homogeneity while simultaneously individualising by making it possible to measure gaps and determine levels of individual differences (Foucault 1991, 184).

Normalising judgement can be seen in the structures of many psychiatric hospitals that employ behavioural techniques (Bentley 1987, 360; Mohr 1999, 1057). These techniques use a formalised set of rewards and punishments, and its goal is to mould a patient's behaviour to a set of norms imposed by the staff (and society) (Mohr 1999, 1057). Bentley (1987, 360) defines a number of such techniques, in particular, time-out procedures and the step-level system. Time-out refers to the removal of a person from access to positive reinforcement. It might be regarded as a punishment procedure due to the withdrawal of something positive. Many institutions also have a step-level system in which patients begin with minimum responsibilities and privileges but through appropriate behaviour on the unit, patients are gradually 'moved up'. As they move up, their rights and responsibilities increase (Bentley 1987, 360). Both of these techniques and their manifestation in psychiatric hospitals will be discussed in the subsequent sections.

Time-Out

The time-out technique will be elucidated further with reference to one particular study. The study in question is by Malacrida (2005), who reports on interviews with 21 institutional survivors who lived until the mid-to-late-1980s in a psychiatric hospital operating in Canada. The focus of the study is the survivors' descriptions of Time-Out Rooms (Malacrida 2005, 523). In the hospital, Time-Out Rooms were an omnipresent means of exercising both hasty and defensive control by the staff. These rooms were not hidden away; rather the rooms were part of the wards, within the visibility of warders and other patients. Each Time-Out Room had a locked door and the inside of the room contained only one fixture which was a drain in the middle of the floor. Patients who were housed in the Time-Out Rooms were typically naked as the staff feared that the patients may harm or try to hang themselves. Furthermore, these rooms had a one-way mirror through which staff (and other patients) could observe the individual being given a 'Time-Out' (Malacrida 2005, 527). The patients were housed in Time-Out Rooms as a result of resistance to daily institutional practices. These acts of resistance included refusing to eat the food that they were given, refusing to go to bed or wake up at the times they were told to, aggressive behaviour towards staff or other patients, or refusing to perform work duties (Malacrida 2005, 527).

In the above accounts, there is a clear relation to Foucault's thoughts and the discourses of behaviourism (Malacrida 2005, 528). Time-Out Rooms are ostensibly used to 'extinguish' bad behaviour through seclusion and restraint. This goal is achieved in non-violent ways in which correction is achieved via the system of gratification-punishment: the removal of the patient from positive reinforcement for lacking conformity and docility to the institution's rules and conduct.

Step-system

Central to Goffman's premise is that patients in a psychiatric hospital experience a loss of moral career which is composed out of the progressive changes that occur in the belief that the patient has concerning self and others (Goffman 1973, 24). The patient's moral character is mortified from admission to the psychiatric hospital, as the patient is inflicted with a loss of personal possessions that can prevent the individual from presenting their usual image to others. This is enacted, for example by stripping the patient of personal belongings and replacing them with standard issue uniforms. After admission, this degradation continues through other ways. In particular, "[g]iven the expressive idiom of a particular civil society, certain movements, postures and stances will convey lowly images of the individual…" (Goffman 1973, 30) and as such they are deemed as demeaning and avoided. Thus, any instruction or task that forces the individual to adopt these movements or postures may act to mortify the patient's self (Goffman 1973, 30). In total institutions, such physical indignities abound. This is most readily evident in psychiatric hospitals that deploy the step-system. By starting the patient on minimal benefits and responsibilities (for example, patients may be forced to eat all their food using only a spoon; they may also have restrictions imposed on them like bathing and using the toilets without closed and locked doors) a number of mortifications occur. All expressions of the step-system, from admission to the daily encounters in the psychiatric hospital, can be constituted as shaming and suppressing the patient. As such, the step-system is part of a larger disciplining system that castigates and controls patients and their behaviour.

Critique of behavioural techniques

The use of behavioural techniques in psychiatric hospitals has been widely critiqued. Central to these critiques are questions related to 'who or what determines inappropriate behaviour'; many times inappropriateness is deemed by institutional arrangements (Bentley 1987, 363). This is best revealed in patients that are resistant to the psychiatric hospital's ideological standards. Patients that refuse to talk with the staff members or with their fellow patients as an act of rejecting and resisting the institution's standards may be misconstrued as the sort of symptomology the institution was established to deal with. Consequently, these patients are then usually punished and lodged on 'bad' wards in which very little personal possessions and utilities are given to them, for instance clothes may be taken from them, recreational material may be withheld and only limited furniture is provided. In doing so, further acts of hostility against the institution have to rely on restricted and intimidating modes of communication, such as banging a chair against a floor. Yet, such modes of communication are not understood as conveying dissatisfaction with the hospital and the treatment received but is misconstrued as a tacit manifestation of a psychotic symptom and as signs of an aggressive patient that necessitates placement in a 'bad ward' (Goffman 1973, 268-269). In summary, psychiatric hospitalisation out-manoeuvres the patient by depriving the patient of the common expressions through which people resist organisations: impoliteness, silence, lack of cooperation, malicious destruction and so forth; these signs of disaffiliation are rather cast as indicators of mental illness (Goffman 1973, 269).

Alternative to the physical environment of observation and restraint

Goffman (1973, 314) highlights that a refraction of conduct is recorded during patient observation by the staff. In other words, the patients are assessed according to their deviation from institutional standards, thus the staff only record their disobedience. In doing so, the walls of the institution act like a thick and faulted prism (Goffman 1973, 314) that only records conformity and penalises resistance; what is missing is any record on the subjectivity of the person it concerns or the narrative of events that transpired before the disobedience was recorded (Gillett 2009:63). Central to this paper is the provision of an alternative to such formations. To offer possibilities of experience that does not collapse back into the dominant formation of institutionalisation; to offer therapeutics and not social control. In this light, the recommendations by Mohr (1999) are explored to offer a different approach to observation and assessment. Mohr (1999, 1058) states that assessments should be performed to no longer focus exclusively on a single behaviour; rather they should record a range of competencies and behaviours (not just on handicaps or areas of weakness) that are evaluated within the context of space and time. Professionals that make use of assessments must be taught: that observations are only samples of behavior rather than reflective of an individual's inherent traits, capacities or personalities; that behaviours should be interpreted in light of an individual's cultural background, primary language and handicapping condition; that behaviour may be affected by momentary states of fatigue, anxiety or stress; and that behaviour should be interpreted in relationship to other behaviours, contingencies and case history information (Mohr 1999, 1058).

In psychiatry, the use of alternative methods to seclusion and restraint has been at best insufficient (Kontio, Välimäki, Putkonen, Kuosmanen, Scott and Joffe 2010, 66). Although there are a number of alternatives to seclusion and restraint,[6] for the purposes of this essay, only the alternatives that underscore communication and sharing of power and decisions with patients will be bought to the fore. A notable approach in this regard is by Kontio et al. (2010), who describes a number of steps to avert the use of seclusion and restraint. The first step pertains to nursing interventions: by the nurses being present, conversing with and giving responsibility to patients, the patients are provided with safety and comfort; thereby mitigating any patient aggression based on unease. Additionally, by the nurses becoming familiar with patients, the early onset of any unwarranted behaviour could be identified and addressed without requiring the use of restraints (Kontio et al. 2010, 71). A second step includes multi-professional agreements with aggressive patients. Underscored in such agreements is the statute that patients are seen as active participants, whose opinions and thoughts on their own treatment are valuable. Thus nurses and physicians are required to co-operate and negotiate with patients; most often this takes the form of negotiating written or oral agreements with patients about treatment plans and possible alternatives (Kontio et al. 2010, 71).

Even when seclusion may be unavoidable, it should never be at the expense of open communication and co-operation. In order to ensure the implementation and demonstration of communication and co-operation in the use of seclusion, Moosa and Jeenah (2009, 74) provide a number of guidelines. Firstly, patients undergoing seclusion need to be provided with counselling, reassurance and support. They need to be provided with an explanation regarding the purpose of seclusion and an explanation of the co-operation required to act as a prerequisite to discontinuation.

Secondly, the basic dignity of patients who have been secluded needs to be protected – the patients need to be provided with access to facilities to maintain their personal hygiene (bathroom and toilet) and physical health (exercise) while also ensuring that the provision of food is always available. In other words, secluded patients need to be provided with a comfortable environment that is safe and clean in order to support and maintain human dignity (Moosa and Jeenah 2009, 74-75). Thus, although the patients are in seclusion, this act should not expose the patient to experiences that hold the potential for possible mortifications or to withhold open communication and contact between staff and patient.

Personal action: patient-psychiatrist relations

Goffman (1973, 20) sees that the restrictions of social contact that define a psychiatric hospital (a total institution) help to maintain an antagonistic stereotype between staff and patients. In more explicit terms, each grouping (staff and patients) tends to conceive of the other in narrow hostile stereotypes. For instance, the staff members often perceive patients as bitter, guarded and deceitful, while patients often see staff as condescending and mean. The staff tend to feel superior and righteous, whereas the patients tend to feel inferior weak and frequently in the wrong. Social mobility between the two groupings is rigorously restricted and social distance is characteristically both vast and often formally prescribed (Goffman 1973, 18-19). The above groupings provide justification for the claim that one of the main roles of total institutions is the construction of difference between two categories of persons; "a difference in social quality and moral character, a difference in perceptions of self and other" (Goffman 1973, 104). Accordingly, all social arrangements in a psychiatric

hospital position the staff doctor and mental patient as profoundly different and on opposing sides (Goffman 1973, 104). Yet this difference, between doctor and patient, is not a new construct, but has its roots in the eighteenth century, a period that marks the entrance of the medical doctor to the asylum.

Historical context

> "What we call psychiatric practice is a certain moral tactic contemporary with the end of the eighteenth century, preserved in the rites of asylum life, and overlaid by the myths of positivism" (Foucault 2009, 262).

Both Foucault and Goffman account for the entrance of medical doctors as core components in psychiatric hospitals. Goffman (1973, 305), explains that in the latter part of the eighteenth century Britain, the medical mandate over the insane began in which "[i]nmates were called patients, nurses were trained, and medical case records were kept. Madhouses, which have been retired asylums for the insane, were retired again, this time as mental hospitals". Foucault (2009, 256) also locates the entry of the medical personage at the end of the eighteenth century. It is in the writings of Foucault that will be expanded upon in order to best illustrate the historical roots of the differences staged in the patient-doctor coupling.

From the eighteenth century onwards, the doctor becomes the essential figure of the asylum (Foucault 2009, 256). The doctors' presence in turn converts the asylum into a medical space. Yet the crucial point is that the doctor's involvement is not fostered by a medical skill or by science, but as a juridical and moral guarantee (Foucault 2009, 257). In other words, doctors could exercise their absolute authority in the world of the asylum only insofar as they were described as 'Father and Judge', 'Family and Law' (Foucault 2009, 258). Foucault calls on these archetypal figures as

part of his broader interest in the construction of 'madness'. For Foucault (2009), 'madness' in the era of modernity is constructed to create clear distinctions between itself and sanity or reason. Thus the above archetypes become mediums that forge distinctions or relations between 'madness' and sanity. A brief discussion of the interface of these archetypes will be discussed in order to elucidate how they served to manifest the conceptual divide and lived relations between sanity and 'madness'.

Foucault (2009, 239) describes that until the end of the eighteenth century, the mentally ill were kept confined by guards that were often recruited among the 'inmates' themselves. However, a new mediating element begins to emerge between guards and inmates. In particular, this element refers to the entry of people or keepers that represent "… both the prestige of the authority that confines and the rigor of the reason that judges" (Foucault 2009, 239) into the spaces reserved for insanity. Thus a new personage appears that will be essential to the nineteenth-century asylum: authority. The people or keepers of the mentally ill confront madness no longer with instruments of constraint but with the authority invested in not being 'mad' (Foucault 2009, 238-239). One such consequence of investing the keepers with authority and reason is that the mentally ill are regarded with a minority status. Such a status is best realised in the laws that consider the mentally ill as minors. This act, however, was originally not an infringement of the rights of the mentally ill but was assigned to protect them as a subject of law. Yet, the idea of the mentally ill as minors becomes reconceptualised as a concrete mode of relation between people: asylums organised the mentally ill and their keepers around the concept of the 'family'. In this conception, the keepers are enveloped as the figure of the adult; the mentally ill as child. This structure alienated the mentally ill by delivering them entirely, as a psychological subject, to the authority of the keepers (of reason), who assumed for

them the figure of an adult embedded in both domination and destination (Foucault 2009, 239-240). Thus the asylum imprisons the mentally ill in the obligatory fiction of the family: the 'madman' becomes a minor and the keeper takes on the aspect of the father (Foucault 2009, 241).

In this view, the entry of doctors to the asylum was attributed not by science but by the moral and social order that accredited them as 'men of reason'. Their medical practice in the asylum became a mere complement to the archetypes already forged in the construction of the mad versus sane (reason) divide; archetypes that were first manifest in the entry of non-medical keepers of the mentally ill (Foucault 2009, 258).

As such, these archetypes are present in the patient-doctor couple. This 'coupling' is structured to reflect the microcosm of the bourgeois society and its values (Foucault 2009, 260): "Family-Child relations, centered on the theme of paternal authority; Transgression-Punishment relations, centered on the theme of immediate justice; Madness-Disorder relations, centered on the theme of social and moral order" (Foucault 2009, 260). For Foucault (2009, 260) it is in these relations that the doctor derives the power to cure while simultaneously leading to the patient becoming alienated in the doctor. Yet, from the beginning of the nineteenth century, the ideological underpinning of the patient-doctor couple, escaped the doctor: psychiatrists no longer recollected the nature of the power that they had inherited (Foucault 2009, 261). One consequence of this neglect is that the patient-doctor coupling sinks deeper into an ideological arrangement:

> In the patient's eyes, the doctor becomes a thaumaturge; the authority he has borrowed from order, morality and the family now seems to derive from himself; it is because he is a doctor that he is believed to possess these powers... [I]ncreasingly, the patient would accept this self-surrender to a doctor..; increasingly he would alienate himself in the physician… (Foucault 2009, 261-262).

The differences staged between doctor and patient as noted by Goffman are not only historically contextualised by Foucault but are revealed to have explicit power relations (that in turn reflect society's structures and values). These staged differences reflect binary opposites: the doctor is active, paternalistic, authoritative, sane and moral; the patients are passive, lack the means to care for themselves, powerless, insane and immoral. These are neither natural nor neutral. Rather these differences reflect ideological structures that mediate social existence and ideas within the specific context of the psychiatric hospital. As such, the binaries forge tangible relations between the doctor and patient, which are underpinned by power and 'othering'.

Contemporary recognition of binaries present in the patient-psychiatrist coupling

The binaries discussed above do not just reflect the tangible relations between patients and doctors historically. Rather, the abovementioned binaries and its associated relations are revealed in numerous studies.[7] In particular, Hinshelwood (2000) cites a number of descriptions about relations between staff and patients in psychiatric hospitals. In these descriptions, the focus is on the effects of power relations on patient subjectivity. One way in which power relations operate in psychiatric hospitals is that the staff dictate and impose restrictions on the movements and activities of the patients. Consequently, not only are limits inflicted upon the actions and activities of patients but such restrictions also amount to the loss of individuality and initiative of each patient. The patients lose autonomy, self-determination and independence; their subjectivity is severely curtailed and at times even denied (Hinshelwood 2000, 123). What becomes apparent is that the staff impose constraints on the acts and activities

of the patients without considering the patients' beliefs, feelings and desire. Thus, the regimentation and control of acts and activities allows for surveillance and control but at the expense of the patients' subjectivity; a process that according to Laing (1985, 27) strips patients of "... all discretion and responsibility for every single observable detail..." in their respective lives. Another way in which subjectivity is constructed in psychiatric hospitals is in terms of the binary roles of health and illness: the staff are resolutely healthy, knowledgeable, powerful and active; whereas the patients are relegated only to the categories of illness, suffering, ignorance, passivity and obedience. These roles mediate the character, responsibilities and position of the individual parties in the staff-patient coupling (Hinshelwood 2000, 121-124). The above points reveal that power relations between staff and patients have a tacit impact on the subjectivity accorded to each of the two groups. Thus, one can argue that the personal identity of each individual in a psychiatric hospital is highly determined by which side of the patient and staff divide that they inhabit (Hinshelwood 2000, 124).

In summary, both historical and more recent accounts recognise that in psychiatric hospitals the patient-psychiatrist coupling is immersed in binaries. One consequence is that communication between the doctor and patient lacks communion; it is alienative. For Laing this consequence is central to the hypothesis he reached from the Rumpus Room experiment.

Alternatives to the patient-doctor coupling

Laing is critical of the alienation of the patient from the doctor. For Laing (1974, 98-99), "... if one ceases to identify with the clinical posture, and looks at the psychiatrist-patient couple without such presuppositions, then it is difficult to sustain

this naive view of the situation. Psychiatrists have paid very little attention to the experience of the patient". In this consideration, Laing provides descriptions of how patients, when they enter a psychiatric hospital, are assaulted by staff that have little or no idea of the patient's wishes, wants and fears (Heaton 2006, 183). This is linked with Goffman's theme of mortification of self within the psychiatric hospital. As previously discussed, patients experience mortification through physical indignities that are inflicted by the staff; yet, this mortification is enlarged when the indignity pertains to forced interpersonal contact and, in consequence, a forced social relationship (Goffman 1973, 35).

Rather than patients being just passive and receptive, there are findings[8] that reveal patients as active agents in both treatment and relations with staff. Contemporary studies (see Borge and Hummelvoll 2008, 371) reveal that patients are conscious of the staff they wish to have contact with. This confirms the patients' aspiration to have influence and co-determination in their therapy and relations with staff. This is not just an aspiration but has been revealed to result in better outcomes for treatment (Borge and Hummelvoll 2008, 371). Yet studies have also shown that clinical decisions still remain out of reach to the patients (Pinto 2009, 5).[9] For Goffman (1973, 19), the restriction of information, especially information about the diagnosis, planning and treatment of patients, is characteristic of psychiatric hospitals. Such acts of exclusion provide staff with a foundation of establishing both distance from and control over patients (Goffman 1973, 19-20). One reason for the restriction of information is that doctors lack communication skills, in terms of relationship building skills, and specific abilities to involve the patient in the shared decision-making process (Goss et al. 2008, 420; Lezzoni et al. 2006, 1112). In particular, Lezzoni et al. cites (2006, 1112) that there are few efforts to teach medical students

the communication skills specifically to care and treat patients with major mental illness. Indeed, most of the limited literature on this topic is severely outdated and predating any significant scientific advances in psychiatric therapeutics (Lezzoni et al. 2006, 1112).

In contrast to the traditional approach whereby patients have been passive recipients of health-related information conveyed by the professional staff, the benefits of collaborating with patients in solving the patient's problems is significantly extolled. Such collaboration entails a therapeutic alliance whereby patients offer their thoughts and solutions while psychiatrists suggest theoretical and research-based knowledge. By focusing on the patient as an active self-healer, psychiatrists are no longer required to be a supplier of objective and neutral knowledge of diseases (Borge and Hummelvoll 2008, 366). This acknowledgement will simultaneously lead to a higher quality relationship between psychiatrist and patient, which is a central factor in terms of both patient and clinical perspectives (Borge and Hummelvoll 2008, 365).

Conclusion

Sedgwick (1982, 197) proclaims that the politicisation of psychiatry is unique in the way that it affords the character of the hospital itself as an agency for both adding to, and aggravating mental distress and illness. Thus, the critique and campaign against psychiatric hospitals has been and continues to be a principal topic of debate and action in psychiatry. In particular, this critical onslaught of the psychiatric hospital is linked to the theories of Foucault, Goffman and Laing (Sedgwick 1982, 197). These intellectual figures questioned the management and treatment of mental illness at

psychiatric hospitals and revealed how the aims of such institutions are aligned more towards the themes of coercion, control and discipline than to medical therapeutics. Yet, of the three theorists, it is only in the writings of Laing that provision is made for an alternative to the disputed acts and practices of psychiatric hospitals. Specifically, this alternative is based on a patient-psychiatrist coupling in which communication as well as the sharing of responsibility and decisions is manifest.

Although the twenty-first century has seen a number of changes in terms of laws and policies that recognise the rights of the mentally ill, as well as the shift towards deinstitutionalisation with its ethos of patient autonomy; the abuses of psychiatric patients continue. Grant Gillett (2009, 69) attests the abuse of psychiatric patients to the dehumanising and degrading practices adopted by caregivers. The caregivers' resolute adoption of such practices stems from a denial of the mentally ill as persons:

> This alienation (the treatment of psychiatric patients as 'other', not like us, abnormal, threatening, disruptive as if they are a contagion in normal society, abject) is insidiously objectifying and/or abjectifying in ways that pose a deep moral and personal challenge to all dealing with injured and damaged human souls (Gillett 2009, 69).

In consideration of the above quote, the binary opposition of self (as the sane caregiver) and other (as the insane psychiatric patient) may be an inherent feature of mental healthcare which leads to segregation, antagonism and violence inflicted upon the psychiatric patient (Gillett 2009, 75). This proposition is also an essential tenet of Laing (1985, 30) who stipulates that the binary between patient and psychiatrist leads to both parties being "...ranged on opposite sides. We are enemies, we are against each other before we meet. We are so far apart as not to recognise the other even as a human being or, if we do, only as one to be abolished immediately". This rift between psychiatrist and patient (across the sane-insane line) is, according to Laing (1985,

145), a product of a loss of human camaraderie. As such, its restoration can be regarded as a possible solution to mend the rift (Laing 1985, 145). This mending entails a professional therapeutic relationship based on human camaraderie (Laing 1985, 28).

In sum, Laing's theories propose an alternative to the dominant formation of institutionalisation within psychiatric hospitals by offering: a physical environment that is non-threatening and therapeutic; and personal actions of the patient-psychiatrist coupling that underscores communication as well as the sharing of responsibility and decisions. Additionally, such an alternative based on understanding and respect, holds the potential to mitigate the persistent abuses of psychiatric patients that are a product of othering, objectifying and abjectifying the mentally ill. Thus, Laing's advocacy for treating mentally ill patients as persons and meaningfully engaging with them through interpersonal relations based on camaraderie, support and power-sharing has been argued in this essay to be applicable in terms of influencing the 1960s and 1970s reform of psychiatric practice as well as remaining an aspect that is applicable in addressing the problems posed in the present-day treatment, care and institutionalisation of the mentally ill.

Notes
1. For the purposes of this essay, the term institutionalisation is used to refer solely to the factors of the physical environment and personal action in psychiatric hospitals. Thus it excludes reference to additional factors usually associated with the term institutionalisation.
2. The only criterion for selection was the patient's social isolation on the ward. They were all patients with schizophrenia, aged from 22 to 63 years, who had been confined continuously for at least four years (Abrahamson 2007, 206).
3. There are a number of psychiatric hospitals that offer an alternative to the dominant formation of institutionalisation, for example the Fulbourn Hospital. In terms of psychiatric hospital reform, Fulbourn is noted for having established social therapy, patient freedom, unlocked ward doors, and 'therapeutic communities'. See: Adams (2009); Clark (1974); Clark (1996).

4. The article is limited to the alternatives of the dominant formation of institutionalisation provided by Laing – solely in terms of psychiatric hospitals. As such, the article does not explore the positive aspects and outcomes of deinstitutionalisation as an alternative to the dominant expression of institutionalisation. Although this remains a limitation of the article, there is no doubt value in examining deinstitutionalisation as a response to the problems posed in institutionalisation. In particular, the ethos of deinstitutionalisation emphasises: patient participation in treatment (Hamilton and Manias 2008, 178); the acknowledgement of the experiences, values and personal goals of individual patients (Bachrach 1997, 31-32); the gaining of patient autonomy within a homely living environment (Trieman 1997, 57); privacy (Leff and Warner 2006, 75); and the importance of caregiver's establishing a permanent relationship with a patient (Bachrach 1997, 33).

5. Goffman (1973, 16) outlines five types of 'total institutions'. Firstly, psychiatric hospitals and leprosaria are a category of places that are established to care for persons felt to be both incapable of looking after themselves and a threat to the community, albeit an unintended one. The second grouping refers to institutions established to care for persons felt to be both incapable and harmless; these are the homes for the blind, the aged and orphaned. Thirdly, institutions organised to protect the community against what are felt to be intentional dangers to it, with the welfare of the persons sequestered not the immediate issue: jails and penitentiaries. Fourthly, institutions established to better pursue some work-like task and justified in terms of instrumental grounds: army barracks, boarding schools and ships. Finally, institutions designed as retreats from the world while also serving as training stations for the religious: abbeys, monasteries and convents (Goffman 1973, 16).

6. See Janelli, Stamps and Delles (2006); Sturrock (2010); Taxis (2002).

7. See Gilburt, Rose and Slade (2008); Helmchen (1998).

8. See Borge and Hummelvoll (2008); Goss, Moretti, Mazzi, Piccolo, Rimondini & Zimmermann (2008); Lezzoni, Ramanan and Lee (2006).

9. In particular, the study by Kotzé, King and Joubert (2008) reveals that there is considerable scope for improving patients' knowledge and understanding of their diagnoses and medication. The lack thereof can be seen as a plausible explanation for the non-compliance and consequent relapse rates of patients (Kotzé et al 2008, 90).

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