1

Schizophrenia in context

Ridgehaven Hospital is a state psychiatric hospital in an Australian city. In 1980 one division, or 'Team', of the hospital was designated exclusively for the treatment of schizophrenia. This book is a study of the 'Schizophrenia Team', the clinical staff who worked on it, and the patients they treated. Its purpose is to develop a contextual understanding of schizophrenia by studying a clinical setting in which this disorder was experienced, diagnosed, and treated.

At the time of the study, Ridgehaven Hospital was widely regarded as a modern public psychiatric hospital that had very high standards of practice, the first such hospital to be accredited by the Australian Council of Hospital Standards. There was an esprit among the staff. This book is thus a study of hospital psychiatry at its best, not a critique of a custodial backwater. It is an opportunity to examine the place of modernity and progress in psychiatric treatment.

The book focuses first on the clinical staff of the hospital, who were members of different professions but worked together in teams when treating patients. It looks at three core professions—psychiatry, psychiatric nursing, and social work—comparing the different perspectives their members employed in their individual therapeutic work and when acting in concert as part of a treatment team. My purpose is to examine how the professions were organized in relation to each other within a psychiatric hospital, and how this organization influenced the way clinical staff approached patients and constructed them as cases of psychiatric illness.

Two of the basic tools of clinical work are writing and talking. The second part of this book looks at how the staff of Ridgehaven wrote and talked about their patients. It concen-
The social definition of schizophrenia

trates on assessment interviews and the ways in which these interviews were documented in case records, tracing the transformations that occurred from spoken dialogue to written record. I compare these written accounts of patients with the way staff members spoke to each other about their patients—that is, with what could be said but never written in the record. This section of the book poses a number of questions: What consequences do such basic clinical processes as diagnosis and treatment have for a person? What transformations are achieved in a person’s experience and identity when he or she engages with an expert team of talking, writing professionals?

Ridgehaven was not only a place where patients were treated, it was also a site for the production of knowledge about psychiatric illness. The third part of this book looks at some of the prominent psychiatric theories of schizophrenia that have been produced by institutions such as Ridgehaven Hospital. To accomplish this task it is necessary to go back to the origins of the concept of schizophrenia itself, beginning with ideas that were current during the nineteenth century and that emerged mainly from European psychiatric asylums and universities. I trace how these ideas have changed during the twentieth century as psychiatric hospitals and their related institutions have themselves undergone change. These theories are not merely abstract ideas about schizophrenia found in textbooks or scientific journals; they have practical significance for patients. Thus I take a number of contemporary theoretical constructs and show how they are applied by clinical staff when they teach patients about their schizophrenia.

A standard method of studying schizophrenia is to proceed from illness to context, that is, to take the psychiatric category of schizophrenia as a given and show that it can have different clinical manifestations depending on the cultural and institutional context in which it occurs. This book turns that method on its head. It proceeds from context to illness. It begins with an analysis of a modern psychiatric hospital and shows how its organizational features have fundamental consequences for the way in which schizophrenia is constituted as a diagnostic category and a moral state.
Schizophrenia in context

There are important differences between this approach and that of labelling theory, which asserts that the hospital merely imposes a false and stigmatizing identity upon the patient. By contrast, I argue that the psychiatric hospital is a site where common-sense ideas about mental illness are concentrated and refined. Many of these ideas have currency within the broader community and are shared by patients and their families. Worked up into scientific concepts of schizophrenia they take on a distinctive objectivity and distance. When patients, during the course of their treatment, learn that they are suffering from schizophrenia, their experience of illness and of themselves is transformed. This book traces these transformations.

In the course of this analysis, schizophrenia is encountered in a variety of guises. For patients it is a multitude of experiences: confusing, unusual, often devastating, but also entrancing and sometimes quite mundane. Some patients may not even define these experiences as an illness at all. Family members speak of schizophrenia as a tragedy and, in the more recent context of deinstitutionalization, as a burden that strains their ability to cope. For clinicians it is a severe illness that is difficult to treat and that usually has a poor prognosis. Within the field of biomedical research it is a poorly understood syndrome at the basis of which is a brain disorder with genetic, cognitive, and neurophysiological aspects. To the antipsychiatrist it is a myth—an invention of psychiatry and the mental hospital as joint agents of social control. At a common-sense level it is madness. Many of these views are incompatible, and some of them are put forward and defended with great vehemence. These competing definitions point to fundamental ambiguities in the way reason, autonomy, and the person are defined in our culture. Advocates of each approach often assert their particular view as an exclusive truth, but it impoverishes schizophrenia to reduce it to one version or another. On empirical grounds it is more accurate to assert that schizophrenia is all these things; and that in order to understand it we must grasp it as a multiple reality. An objective of this study is to map out these multiple manifestations in order to develop an anthropological analysis of the cultural logic that
generates them and that accounts for the various relationships between them.

In this book, no one view of schizophrenia is accorded priority. In particular, it is neither an apology for nor an attack on psychiatric definitions of schizophrenia. In much sociological literature the ‘medical model’ has been something to be dismissed out of court by marshalling contrary evidence. On the other hand, cross-cultural psychiatry has tended to treat the psychiatric definition of schizophrenia as an *a priori* entity and then proceed to show how it is variously experienced within different social groups or influenced by various cultural factors. Both in its dismissal by sociology and its unquestioning acceptance by cross-cultural psychiatry, there has been a failure to disarticulate and examine the psychiatric definition of schizophrenia itself in order to demonstrate how such a set of ideas and attendant practices can come to exist at all. This study seeks to burrow underneath medical, psychiatric, and sociological reasoning, to look at daily interactions between patients and clinicians, to examine the ideas that constitute schizophrenia, to locate these ideas within Western culture and institutions, and to understand the consequences for those who experience the disorder.

Ethnography and the interpretive approach to schizophrenia

To grasp schizophrenia in its various guises it is necessary to use an ethnographic research strategy. This provides the most sympathetic and exacting way of exploring relationships between ideas, the people who use them, and the settings in which they are used. Ethnography is a method of gathering data about people’s everyday lives that requires the researcher to immerse himself or herself in their world. It is also a mode of analysis that accords a central place to interpretation. At one time it was associated solely with social anthropology and was of interest to medicine only as a curiosity. However, in the last three decades ethnography has increasingly penetrated medical research to the point where it is now acknowledged as an important and innovative research strategy, though it has
not yet achieved the complacency that comes from being a conventional method.

Ethnography produces a different type of knowledge about schizophrenia than that produced by positivist clinical science. Within the positivist paradigm, a researcher gathers a group of patients, either an epidemiological sample or a case series. They are then ‘measured’ in terms of their clinical state, neurophysiology, psychological functioning, or sociodemographic profile. Techniques are standardized because the researcher’s own interpretations are regarded as a bias that contaminates the findings. Clinical interviews are therefore structured into questionnaire and rating scale format, giving them a mechanical or instrumental quality. The chief technical concern is to conduct investigations that can be repeated reliably by numbers of researchers in varying contexts.

Positivist science produces a form of knowledge known as ‘facts’, which are attributed objectivity because they are quantifiable, replicable, and lie beyond the interpretive discretion of the individual researcher. Data are translated into variables and rendered into numbers in order to discover statistical correlation and test hypotheses. Cases are studied in sufficient numbers to allow the variety and range of patients’ experiences to be eliminated by an averaging process. The purpose of such research is to study the illness by isolating it from its context. This is reflected in the style of research reports. The passive tense, abstract nouns, and technical language convey a sense of distance, moving the patient and clinician out of focus in order to bring a decontextualized disorder into focus. The method derives its mandate and validation from the spectacular success of twentieth century medicine in understanding the mechanisms of illness.

By contrast, ethnographic inquiry brings the context—the patient, family members, clinicians, and setting—into focus. As a field technique it depends on an intimate association with the group of people under study and is usually carried out by one or two individuals at most. Rather than seeking anonymity and distance, the ethnographer plays an active role in the group he or she studies. This strategy of engagement aims to elicit data that would be told only to an accepted member of the group, and it enables the researcher to observe at first
hand the social processes of that group. Fluency with language is mandatory—in this instance, the language of psychopa-thology and psychiatric hospital argot. Observations are re-corded in field notes, jotted at the time and written up in more detail within a day or so. I also found it useful to openly tape-record interviews in which clinicians assessed patients, as well as the case conferences in which the treatment of patients was discussed.

Ethnographic research pays special attention to ceremonial occasions such as, in this study, the weekly team meeting or the admission of a new patient into the hospital. Such cere-monies boldly display the values and social processes of the group. Texts are another valuable source of data, particularly the case records and the voluminous documentation pro-duced within the hospital about the hospital itself, its organi-zation, its public image, and its history. Open-ended question-ing of patients and staff provides a source of data in which informants reflect on themselves and their practices. The fo-cus of all observations is the culture and social organization of the hospital.

As an analytic technique, ethnography begins with the sys-tematic description and analysis of recurring social interac-tions (for example, in this study the admission interview, the morning coffee break, or the team meeting), of organizational categories (for example, the trainee psychiatrist or the chronic patient), and of major social processes (such as the process of writing in case records). These data are employed to identify more general processes, cultural meanings, and problems that pervade the organization and give it its coherence and dis-tinctiveness. These first-order generalizations are analysed in the light of higher-order theories, so the conclusions of the study are grounded in a dialectic of formal social theory and field observation (Glaser and Strauss 1967).

Ethnographic research recognises the importance of inter-pretation at every stage, from the collection of field data to the conclusions of the study. When a researcher writes down so called ‘naked’ observations, interpretive judgements are already at play in choosing what is relevant, omitting what is taken for granted, and couching the data in a prose style that ensures it is read as a witnessed fact. The analysis seeks to lay bare these
Schizophrenia in context

interpretive processes, both those of the researcher and the group being studied. In the case of the researcher, it involves a reflexive process that takes the unstated assumptions that she or he brings to the field and seeks to make them explicit rather than mask them. Applied to the group, ethnography’s chief concern is with the way people interpret and make sense of their world. In this study I was concerned with how people make sense of schizophrenia in the setting of a psychiatric hospital.

Ethnographic studies of the psychiatric hospital

Isolated ethnographic studies of mental hospitals were started during the 1930s, but the major, classical studies were carried out in the United States during the two decades following World War II. This was a time of reform and therapeutic vigour, of the kind that had periodically swept through asylums since their inception. Health policy determined that these inward-looking institutions, which had come to epitomize state oppression, should be opened to public scrutiny, democratized, and eventually dismantled. Ethnographers worked in collaboration with hospital administrators to articulate such state policy, and the perspectives they used to analyse hospital organization reflected this political context.

Thus Caudill (1958) expressed the reformer’s view that the psychiatric hospital was in trouble because it was a small, static society, an enclosed system with interrelated subsystems, walled off from the larger world. Stanton and Schwartz (1954) had proposed a similar functionalist view of the mental hospital as an integrated social system that could achieve effective treatment of the mentally ill so long as its subsystems meshed in harmonious consensus. According to their analysis, which differed little from the thinking of hospital administrators of that era, failure was located in the covert disagreements and pseudo-consensus that were symptomatic of a malfunctioning system. Rushing (1964) also drew on the functionalist theories of Parsons and Radcliffe-Brown to study how members of different professions adapted to conflict in a university psychiatric hospital. Belknap (1956), when he documented the failure of a southern state mental hospital to achieve its own goal of humanitarian treatment of the mentally ill, pitted the abject...
conditions of the hospital against an ideal of scientific psychiatry as a salvation. By embracing the contemporary enthusiasm for psychiatry, Belknap committed himself to the rational-efficient model of hospital organization commonly espoused by clinician–administrators. As a consequence, he was unable to perceive that hospitals might have structured, though unintended, consequences that differed from their publicly stated goals.¹ The most influential works were those of Goffman (1968), whose essays on the ‘total institution’ and the underlife of the asylum were, respectively, an indictment of state control and a celebration of the freedom-seeking self.

One study, *Psychiatric Ideologies and Institutions* (Strauss et al. 1964), deserves a more extended critical analysis because its perspectives were not wedded to state health policy but derived instead from the theoretical school of symbolic interactionism. This school, which developed in Chicago over the first half of the twentieth century to become a dominant paradigm of American sociology, is germane to the arguments developed in this book. Symbolic interactionism stressed the symbolic environment of shared ideology, meanings, and values that characterizes the human social world (Blumer 1971; Rose 1971). Its principal theorist, George Herbert Mead (1934), viewed social interaction as a mutually interpretive process, based on the capacity of the individual to take the role of the other person—to imagine how he or she might be interpreted by the other. At a macrosocial level, symbolic interactionism posited a fluid model of society in which change and conflict are integral to social structure, an explicit critique of previous models of society as static and harmoniously functioning systems. At a microsocial level, it posited a ‘self’ that was not only grounded in social roles but also a locus of reflexivity and creativity.

From this basis, Strauss (1978:31–8; Strauss et al. 1964:172–5) argued that Goffman’s view of the asylum was overly pessimistic. For Goffman the total institution was primarily coercive,

¹ See Etzioni (1969) for a critique of Candill, Stanton and Schwartz. Belknap and a number of others who have approached the study of mental hospital organization from a ‘human-relations’ perspective. They place too much emphasis, argues Etzioni, on communication and participation in decision making, and they tend to see the mental hospital as an autonomous totality, at the expense of analyzing its structural location within the broader society.
and the patient’s ‘moral career’ was fately determined by the hospital. He could define freedom only in terms of the distance individuals accomplished from institutional roles (Goffman 1972). Strauss accorded a more central place to the way members of an institution actively affected their own fate. For him, the institutional order was not an external force that controlled passive individuals. Individuals, including patients, participated in determining this order.

Psychiatric Ideologies and Institutions compared three settings: the ‘chronic’ section of a state mental hospital in Chicago, the ‘treatment’ section of the same hospital, and a private psychiatric hospital. In the chronic service, custodial care was provided for large numbers of patients by poorly trained staff. In contrast, the treatment service comprised wards that had been established in a spirit of reform. Each was well staffed by professionally trained clinicians who brought with them a zealous commitment to treatment. Three distinct psychiatric ideologies were evident in this hospital. One was a ‘somatotherapeutic’ ideology, which took a biological view of psychiatric illness and was associated with the use of physical modes of treatment such as electroconvulsive therapy. The second was ‘psychotherapeutic’. It argued that psychopathology is caused by emotional trauma during the formative childhood years, and it advocated psychotherapy as a mode of treatment. Third, there was a ‘sociotherapeutic’ ideology whose proponents stressed the importance of environmental factors in mental illness. For them, the whole ward was a therapeutic milieu.

The state hospital was characterised by conflict and change. The treatment service was in conflict with the chronic service. Within the treatment service itself, each ward was in fierce competition with the others for successful cure rates and financial resources. Within each ward there were shifting alliances as different professional groups struggled to assert therapeutic dominance. The psychiatric hospital was an arena into which changing ideologies were introduced from universities and training institutions. Different ideologies generated conflict. As a consequence of this conflict, the ideologies themselves were sharpened and amplified. Thus the hospital was both a recipient of and a crucible for the production of the ideologies that influenced how patients were treated.
The social definition of schizophrenia

The private hospital was similar. Explicit and tacit negotiation between staff members was a pervasive aspect of hospital life. Rules emerged and then faded into the background. The institutional order was not simply a formal jurisdiction governed by fixed administrative rules; it had an informal area of negotiation as well. The whole order was negotiable, the rules being just one resource that people used in their negotiations. Patients too bargained with staff for discharge or privileges. Although there were recurring patterns in this web of negotiations, the negotiated order itself was in continual flux. According to Strauss et al. (1964:375):

Such findings suggest that organizational theory, elaborated largely from studies of both bureaucracy and rather formalized industrial or governmental organizations, needs considerable modifications to be meaningful for hospitals. When professionals are brought together and enjoined to carry out their work in the same locale, concepts of structure (formal or informal) as relatively set systems of norms and expectations, are inadequate to explain resulting activity. The activity of interacting professionals is, we submit, largely governed by continual reconstitution of bases of work through negotiation.

Anselm Strauss’s symbolic interactionist perspective is a point of departure for this study of Ridgehaven. Like Strauss, I view the psychiatric hospital as an arena of competing professional perspectives in which individuals actively negotiate institutional rules and meanings. However, my study has a number of objectives that cannot be addressed adequately within Strauss’s framework because symbolic interactionism fails to deal with two important issues: one concerning taken-for-granted ideas of mental illness, and the other concerning the broader social and historical location of psychiatric knowledge. The social phenomenology of Alfred Schutz and Michel Foucault’s analyses of power and knowledge, in turn, provide the theoretical means to address these two issues.

Taken-for-granted ideas and practices

Strauss pays insufficient attention to those ideas about psychiatry that are taken for granted by the people who work in the