This book is a study of schizophrenia in a modern psychiatric hospital. Its purpose is to develop a contextual understanding of schizophrenia by studying the clinical setting in which this disorder is experienced, diagnosed, and treated. It arises from an anthropological investigation of the day-to-day work of clinical staff: admitting patients, writing in their case records, and talking about them at case conferences.

The author, who is both a psychiatrist and an anthropologist, focuses on three core professions — psychiatry, psychiatric nursing, and social work — examining the relationships among them in terms of team work and professional autonomy. He offers a penetrating analysis of the language used by hospital staff as they write and talk about their patients and the way in which this practice both reflects and defines the attributes of schizophrenia.

The book traces the evolution of the concept of schizophrenia, showing how contemporary theoretical constructs are applied by clinical staff. It shows how the organizational features of a modern psychiatric hospital have fundamental consequences for the way in which schizophrenia is constituted as a diagnostic category and a moral state, with broader implications for how we understand the person.

In its analysis of the schizophrenia team and of those experiencing the disorder, this book reveals to mental health professionals many of the unspoken assumptions of their role. It also confirms to social scientists and clinicians the power of the ethnographic approach in psychiatric research.
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The Psychiatric Team and the Social Definition of Schizophrenia

An Anthropological Study of Person and Illness

ROBERT J. BARRETT
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Foreword by BYRON J. GOOD
To Mitra
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Foreword

Bearing a deceptively modest title, *The Psychiatric Team and the Social Definition of Schizophrenia*, this book provides a remarkable analysis of psychiatric knowledge and practice in a late twentieth century asylum.

‘Ridgehaven Hospital’ is a state institution in Australia undergoing transformations easily recognizable to any who have observed or worked in large psychiatric hospitals in North America or Europe. Once a total institution in Goffman’s sense, a place where chronically mentally ill men and women lived out their lives, at the time of Dr. Barrett’s research Ridgehaven was progressively reducing the number of its beds, discharging former patients into the community, and exploring new approaches to care. It had come to emphasize relatively brief hospital stays to stabilize the acutely ill, to provide them initial medical and pharmaceutical treatments, and to begin their rehabilitative services. In place of long term hospitalization, most patients were being sent back into the community where they face far less centralized surveillance and care than that provided under the old regime. This book thus provides a report on the status of the asylum and the practices it houses as the era of the ‘Great Confinement’ draws to a close after more than 300 years.

Barrett’s book joins Sue Estroff’s *Making It Crazy* and Lorna Rhodes’ *Emptying Beds: The Work of an Emergency Psychiatric Unit* in analyzing a central component of the mental health system that is emerging as ‘deinstitutionalization’ moves forward. In conversation with the work of Michel Foucault, all three writers demonstrate that institutional powers and surveillance,
though diffused, are pervasive in the lives of the mentally ill in the new regime as they were in the old. Barrett’s primary interest, however, is not in the asylum as an institution of repression or in “schizophrenia” as a category justifying disciplinary procedures—one line of critical theory stimulated by Foucault’s writing. Instead, this work starts from an assumption that institutionalized power is a “productive force which generates categories of knowledge and practice” and undertakes a detailed examination of everyday speaking practices through which ‘schizophrenia’, ‘the schizophrenic’, and ‘the person with schizophrenia’ are constituted as objects of medical practice and a domain of highly specialized knowledge in the contemporary hospital. It is in this context that psychiatric “teams”—psychiatrists, nurses, and social workers joined together to form an “Acute Team,” a “Rehabilitation Team,” and a “Schizophrenia Team”—are shown to be far more than incidental organizational groupings for providing care. They are formally assembled professionals who reconstitute individual patients as multidimensional “cases,” evaluated in broad ‘biopsychosocial’ terms and treated accordingly.

By taking on the role of ethnographer, Barrett—a psychiatrist as well as anthropologist—submits the “taken for granted ideas and practices,” the common-sense language of everyday psychiatric work, and the organization of time, space, and people at Ridgehaven to sustained “archaeological” analysis. He moves from the surface of professional groupings and their claims to authorized knowledge, to a less visible, procedural level of speaking and writing practices, to a set of deep historical formations that exert their influence on the everyday contours of psychiatric knowledge. Layer by layer, a set of key discursive forms that serve as the building blocks of this knowledge are uncovered, allowing a number of conclusions to be drawn that have relevance well beyond Ridgehaven.

First, whatever the fate of totalizing institutions in this post-modern era, and whatever the limits of the psychiatric armamentarium, Barrett shows that the metanarrative of “progress” remains as powerful in psychiatry as in the rest of medicine. It is apparent in the organization of space at Ridgehaven: “progressive” forms of care are provided in the newest buildings in the front of the complex, while remnants of the
old institution, the locked wards in which custodial care is provided for chronic patients, are hidden away in the buildings at the rear of the institution, an embarrassing reminder of psychiatry’s ancient history. Space and time are thus joined by a common historical narrative, and confinement is “transposed to the past and depicted as having been rendered unnecessary by humane care . . . and modern medicine.” This image of progressive care requires a category of patients susceptible to diagnosis and worthy of therapeutic investment. Not surprisingly, those patients most resistant to treatment and return to the community are excluded from this trajectory and end up in the care of nurses rather than the multidisciplinary Schizophrenia Team. Claims that psychiatric knowledge and therapeutics are advancing—along with neurobiology—are thus preserved, and patients, treatment forms, and bureaucratic practices are all submitted to moralizing judgements rendered in the language of progressive history.

Subtly embedded in assumptions about social and scientific progress is the counterimage of “degeneracy.” Barrett’s historical archaeology traces the distinction between chronic, degenerative mental illness, which is almost always incurable, and circular or periodic forms, which are curable, back through the writings of Emile Kraepelin to the institutional settings for psychiatric knowledge production in the nineteenth century asylum. These asylums provided a gathering of patients and a set of techniques that facilitated the development of a *Klinisches Bild*, a “clinical picture” of insanity, through a layering of case descriptions mapping out course and prognosis of illness. When linked to colonialist and evolutionary theorizing about non-progressive or degenerate races, and to concerns about moral degeneracy associated with the urban industrial poor, the image of insanity as degeneracy which is rooted in heredity provided a powerful model for observation and interpretation and a justification for eugenics as a social project. While we now know that long term confinement produced much of the chronicity that came to be seen as a hallmark of schizophrenia, it is remarkable how persistent in psychiatry is the distinction between chronic, degenerative disorders and circular or periodic disorders. Several decades of longitudinal studies have shown that schizophrenic
illnesses are often periodic, while “bipolar” illnesses are often chronic and degenerative; nonetheless, the historic image of *dementia praecox* as the classic degenerative disorder is subtly present in contemporary psychiatric practice as it was in the old asylum.

The image of the disintegrated self is also unearthed as a part of everyday clinical lore in Ridgehaven, as well as in popular talk about schizophrenia. Rooted in the romantic ideal of the coherent and unitary self, an ideal associated with nineteenth century nationalists’ efforts to resurrect a whole from a fragmented people, the counterimage of the dissociated, fragmented, or split person persists in the popular imagination and everyday psychiatric knowledge.

While these images are potent symbolic resources with enormous subterranean force, Barrett’s most powerful analyses are of everyday practices rather than symbols and semantics. In two central chapters of the book, Barrett provides an ethnographic account of the most mundane practice through which the work of psychiatry is accomplished: writing and speaking. Data about every patient who enters Ridgehaven are recorded in a chart. Writing in the chart, providing a record of intake interviews and evaluations, is part of the everyday routine of members of the psychiatric team. However, as Barrett’s careful comparisons of tape-recorded interview texts and written notes in patients’ charts make clear, writing is no simple copy of the patient’s verbal accounts. Writing is the central act in the construction of a ‘case’ of schizophrenia. It is a professional account that documents the presence of symptoms necessary for a diagnosis; more than that, it is an account that characterizes the illness as an active agent in control of an ultimately passive patient. The first act of incorporating a patient into the clinical world is thus an act of writing that defines him or her as a case.

Barrett shows, however, that this is only the first step in situating the patient within a therapeutic trajectory. Such a trajectory is a movement through time—from the origins of the illness to potential and hoped for outcomes. It is a passage through space—through the physical spaces of the hospital and back into the community, as well as through metaphorical spaces of being out of one’s mind before returning to reality.
Foreword

And it is a moral trajectory from a case of schizophrenia to a person who can be held responsible for his or her actions. Barrett argues that facilitating or enacting this trajectory, transforming the patient from case of schizophrenia to moral agent, is the central objective of treatment at Ridgehaven. And contrary to all expectations, Barrett discovered in his research that the most “unprofessional” forms of talk by members of the psychiatric team—off-hand comments about whether a patient was ‘acting’ in order to gain admission to the hospital, whether he was playing up to the staff or manipulating the physicians, for example—were crucial to the reestablishment of the patient as moral agent. Such talk was informal, judgmental, and explicitly subjective; staff at Ridgehaven, as elsewhere, were embarrassed to be heard using such language by any outsiders. However, rather than simply signifying disrespect for the patient or relieving tensions among the staff, Barrett argues, such talk is central to the therapeutic work of the team, to monitoring the patient’s ‘progress’ and effecting the transformation of a case into a moral actor.

These findings, as well as the analytic methods from which they are derived, have significance for some of the most difficult problems facing mental health workers and consumers in the current era. How can psychiatric patients be ‘empowered’ in the context of emerging institutional arrangements? How can agency be restored to those suffering from severe and sometimes debilitating mental illnesses? How can schizophrenia be reframed, represented in new and less constraining ways, given the over-determined nature of symbolic resources we inherit for talking about this disorder? How are we to understand and value those writing and speaking practices associated with clinical work, and how might the subversive resources of everyday speech be employed in ‘psychoeducational’ efforts employed with families and sufferers? If social response and cultural interpretations are important for explaining course and outcome of schizophrenic illness, as recent research suggests, reframing mental illness may be essential to the emergence of more positive therapeutic trajectories for those who are ill. And if the historical record is to be a guide, the progress of biological psychiatry is likely to be achieved in a cultural medium that reproduces many of
the most disempowering contradictions of Euroamerican psychologies.

Tucked away in the conclusion of this book is one of Barrett’s most provocative suggestions. “When we gather together a group of people with schizophrenia in order to study this illness,” he suggests,

it must be recognized that we are categorizing them on the basis of cultural principles which first began to form in eighteenth century Europe, which crystallized in the nineteenth century, and which have become consolidated and transformed in this century. It would be astonishing indeed were we to identify a singular biochemical process or gene to account for such a dynamic cultural category. For the purpose of conducting research, psychiatry may find it useful to temporarily suspend belief in schizophrenia, and to focus biological investigations on groups of people categorized in other ways which are less steeped in our cultural history, for example people who experience hallucinations or who manifest thought disorder.

This modest suggestion runs counter to the dominant stream of neo-Kraepelinian psychiatry, just as does much of the writing in this provocative book. But it indicates quite practical implications of an archaeological analysis of this ‘dynamic cultural category’. It suggests, for example, the importance of serious cross-cultural research, in which ‘belief in schizophrenia’ is at least held open for discussion. It argues for further research into the interplay of the idioms of science and moral agency in the shaping of the psychiatric subject and the trajectory of mental illness. And it suggests approaches to clinical and even biological investigations that are less constrained by the hidden contours of our linguistic and theoretical heritage. It thus sets forth a challenging agenda for psychiatry, the behavioral sciences, and anthropology.

Byron J. Good

Cambridge, Massachusetts
March, 1995
Preface

This study was carried out while I was employed as a psychiatrist at 'Ridgehaven Hospital'. I experienced a tension between my two roles—ethnographer and psychiatrist—similar in kind to that experienced by most anthropologists when they participate in the social group they are observing. Perhaps I felt it more keenly than most because the role of a psychiatrist was so conspicuous in Ridgehaven Hospital.

My education and professional training have oscillated between anthropology and psychiatry. After graduating in medicine and working as an intern in a general hospital, I completed undergraduate studies in anthropology. This period was followed by postgraduate training in psychiatry. After that I began working part-time at Ridgehaven as specialist psychiatrist and undertook this study as part of a doctoral programme in anthropology.

I thus brought to the study a fluency in the language of medicine and psychiatry. It was an undoubted asset but also an impediment; my familiarity with the world of the psychiatric hospital and its language often made it difficult for me to perceive the taken-for-granted assumptions on which that world was built. It was only with the assistance of my anthropologist colleagues, who continually insisted that I maintain a sense of curiosity about what I normally regarded as self-evident, that I was to make use of my cultural competence in an analytic way.

Being a member of the staff facilitated my entry into fieldwork. It gave me access to the clinical sphere of hospital life from which a nonclinician might have been excluded on
Preface

grounds of confidentiality. I was also drawn quickly into ad-
ministrative domains of the hospital. Once it became known
that I was interested in studying how people wrote in case
records I was press-ganged into chairmanship of the hospital’s
medical records committee, a position that thrust me into the
interface between the administrative and clinical divisions of
the hospital, an area of conflicting pressures. As the same
time, because I was already identified as a psychiatrist, I had
to work hard to establish myself as an anthropologist, which
involved bridging the social boundaries that separated the vari-
ous professional and occupational groups. I found it fairly
easy to undertake field-work with psychiatrists, psychiatric
nurses, and social workers; but it was only by persevering that
I gradually gained the trust of domestic cleaners and pantry
maids. The most pronounced division within the hospital lay
between staff and patients. I was never adequately able to cross
this social chasm and be accepted as an anthropological re-
searcher by the patients because at other times I might find
myself in a position of detaining these same patients to a
closed ward. I deliberately focused this study on the staff, al-
though I tried, as much as possible, to incorporate into my
analysis the contribution patients made to our understanding
of hospital life and of schizophrenia.

My dual role as anthropologist and psychiatrist has given
me a personal experience, though a limited and benign one,
of the inner divisions within the person that become a focus of
this analysis. As the eminent social anthropologist Evans-
Pritchard (1973:1) observed:

Perhaps it would be better to say that one lives in two different
worlds of thought at the same time, in categories and concepts
and values which often cannot easily be reconciled. One be-
comes a sort of double marginal man, alienated from both
worlds.

Toward a better understanding of inner division and margin-
ality, I offer this book.
Acknowledgements

The same duality is embedded in my ancestry. My father combined dental research with cultural anthropology in a series of studies he carried out among the Wailbiri people at Yuendumu in central Australia. He sparked an interest in anthropology within me when, as a young teenager, I accompanied him on field trips to Yuendumu.

Of those who directly helped me with this work, my chief debt is to Roy Fitzhenry, who stimulated and developed my interest in the ethnographic study of modern institutions. Roy generously shared his ideas and his wide reading with me and provided rigorous and detailed criticism of this study as it developed. John Gray assisted me greatly in developing the skills of an ethnographer; and it was he, more than anyone, who forced me to question as an anthropologist what I as a psychiatrist took for granted. Issy Pilowsky fostered and supported this study from its beginning to its completion. Arthur Kleinman, Byron Good, and members of the Departments of Anthropology and Social Medicine at Harvard University offered careful criticism of this work during the period I was writing it up. My close friend, Don Pollock, who was at the time working on related problems in a study of a general hospital, continually extended the analytic scope of this work. Many others have given me encouragement and support, especially Nancy Munn and Renée Fox. More recently I have worked on this manuscript in association with my colleague Rod Lucas. At first Rod offered his skilled editorial assistance, but gradually his contribution developed into a critical analysis of the ethnographic data. Rod has a special ability to express anthro-
Acknowledgements

...pological and sociological concepts in clear English without sacrificing their complexity. As a result of his influence, successive versions of the manuscript became more readable and, at the same time, much more incisive and penetrating in their analyses of the psychiatric hospital and of schizophrenia.

The study was supported, in part, by a Neil Hamilton Fairley Fellowship from the National Health and Medical Research Council. I received the full support of my colleagues at Ridgehaven Hospital, which included financial assistance from the hospital research fund. In particular, the Chief Executive Officer encouraged this project from its inception to its completion, when he proof read the manuscript with his customary enthusiasm. I wish to thank the staff of the Schizophrenia Team, particularly the psychiatrists and trainee psychiatrists who showed great patience in being studied and tape-recorded, and in answering the many questions which I put to them, especially those where the answers seemed, at first, to be self-evident. The Team Leader not only subjected himself to my scrutiny but provided thoughtful comments on the research findings. The nursing staff, more than any other group, were enthusiastic about the research and willingly helped me at every turn. I am particularly grateful to the patients of Ridgehaven for the insights they gave me into schizophrenia and which I have tried to convey in this work. Anne McGrane gave many hours of time helping with the transcription of audio tape-recordings. Carla Fujimoto removed all the split infinitives from the drafts of this book and Judy Liney checked the proofs with precision.

My wife, Mitra Guha, with her physician’s knowledge of hospital culture and her clarity of English expression, was the final judge.