CHAPTER ONE

INTRODUCTION

Psychiatrists in Postmodernity

*The complaints of our patients include every part of human need: their disclosures to us embrace every aspect of human life. Our profession embraces several orthodoxies, each of them the centre of a cluster of strongly held heresies, all of them claiming some clinical respectability* (Ratcliff, 2002: 97).

This research is a study of psychiatrists and their perceptions of their role in mental health. It provides an interpretation of what they say about themselves from a postmodern philosophical perspective. The term postmodern or postmodernity, as used in this research, refers to the contemporary society in which we currently live. This means an ‘historically and structurally specific set of cultural conditions’ (Dunn, 1998: 2). Postmodernism is broadly used to refer to a loosely related number of philosophical, theoretical, political and methodological perspectives. As such, postmodernism is a different way to study the conditions of knowledge in society and to reach an understanding of complexity. An important characteristic of postmodernism is using it in the sense that Lyotard meant: As ‘incredulity towards metanarratives’ (Lyotard 1984: xxiv; cited in Cilliers, 1998: 114). Lyotard’s incredulity
attacks totalising and universalising theories and methods. Lyotard rejects claims that one method or set of concepts has privileged status. This is in contrast to the traditional (or modern) viewpoint that legitimates itself explicitly through reference to a metadiscourse or some metanarrative (Cilliers, 1998: 113). The development of postmodernism together with the characteristics and criticisms of it, are discussed in more detail in the next chapter, Chapter Two.

To apply a postmodern perspective to this research means having an understanding of the development of postmodern philosophy together with the history of psychiatry as a profession and the associated development of psychiatric theory and practices – the discourse of psychiatry. It also requires an understanding of the different types of psychiatric practice, psychiatry’s place within the medical profession and its place within contemporary society – the postmodern. The interpretation of conversations and interviews with psychiatrists from this research about practicing psychiatry in Australia today, contributes to our knowledge of how psychiatrists talk of what they do. It provides a narrative about psychiatrists in the context of the social, scientific, economic and political environment in which they currently exist and within which this research is being conducted.

Motivation

One psychiatrist in interview described the reason she became a psychiatrist as an accident: ‘my career is always accident’ (Rene, #1: 4). This research was motivated by its purpose but also because of some fortuitous accidents. The initial purpose was, broadly, an inquiry into healthcare from a postmodern perspective. The choice of psychiatry and psychiatrists came later and was more accidental. Psychiatrists as subjects were chosen because of my employment position within the pharmaceutical
industry taken at the time of starting the research. The predominant therapeutic agent I was working with at this time meant meeting and conducting clinical trials with psychiatrists. I had very little prior knowledge of psychiatry and mental illness but I soon observed that psychiatrists themselves were as much the subjects of stereotyping and mythology as their patients and madness. I was curious to know more about this and why.

To find out more I would need to talk to psychiatrists about this; ask them questions. In this respect, it would be similar to how they talk to their patients when trying to find the “truth” behind patients’ mental illnesses. Psychiatrists’ conversations with patients are referred to as “the clinical interview”. The clinical interview makes use of the historical method (the taking of a personal history) to provide answers about why a person is in front of them, as psychiatrists, at a particular time, which then enables elucidation of probable associations and creation of a problem list (Kalucy, 1980: 284; cited in Judd, 2000: 208). In some respects then, my conversations with psychiatrists could be considered a reversal of the clinical interview.

In a broader context I also became interested in knowing how mental health service provision was organised. What was the place of the psychiatrist in mental health? This meant considering psychiatric practice from a government policy and funding perspective. These motivating influences, to gain further knowledge and understanding of the myths and social context concerning psychiatrists in mental health provision, are further described below.

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3 Clinical trials can be very varied in design and objectives but basically they test, in controlled ways, new medications or treatment interventions for particular diseases or medical problems.
Psychiatrists: Scientists, Artists or as Mad as their Patients

There have been many definitions and perspectives on what constitutes, and what to do, about "madness" – mental illness or disorder – to achieve that defined as the opposite, mental health. Western medicine predominantly uses the natural sciences to define and explain illness and in doing so 'explains an event by considering it as 'the effect of a "cause"' (Strasser, 1985; cited in May 1996: 35). However, the causes, symptoms and treatment of mental disorders, for example, social phobias and post traumatic stress disorder (PTSD), involve a different type of consideration of the human condition from physical illnesses. Psychiatry requires an understanding of the human condition and relations.

To study human relations ... must involve "understanding what makes someone tick" or how they feel or act as a human being (Taylor, 1981; cited in May, 1996: 35).

The knowledge of psychiatrists as qualified medical practitioners is regarded as medical, scientific, professional, expert and is often portrayed a unified one with respect to mental illness. Yet, their science and medicine combines the natural and human, and their perspectives are many. Dr McFarlane, an Australian psychiatrist, writes of psychiatry as:

A slow-moving juggernaut, which is driven as much by politics and convention as it is by the application of knowledge and the conversion of knowledge into effective interventions (McFarlane, 2000: 896).

Psychiatrists use both art and science because the causes of mental illness are largely unknown and therefore cannot be attributed to any one biological, genetic,
social or psychological phenomenon. The inability of psychiatry to use the natural sciences to attribute a scientific cause or origin to most mental disorders means that the diagnosis and methods of treatment used within psychiatry do not fit well within the medical model\(^4\). This is unlike the physical illnesses treated in other medical specialties. Researchers in psychiatry are seen as measuring the measurable in the quest of evidence-based data. However, as clinicians, they meet daily with the immeasurable and are questioning what psychiatry is and what it is not (Ratcliff, 2002: 97). ‘Part of our problem is that many of our “categories” are in fact dimensions and their boundaries are uncertain’ (Ellard, 2002: 104). The non-discrete categories, definitions, unknown causes, non-specificity of treatment, and chronicity and intractability of some disorders to treatment, has been problematic for psychiatrists who have struggled, since becoming a professional speciality and discipline within medicine, to gain acceptance and equivalence with other medical specialties.

Maybe it is because of the multiple perspectives on definition and diagnosis that throughout psychiatry’s history, psychiatrists have often been the objects of criticism from within their own profession. Strong criticism has also come from other medical and mental health care professions and from society generally. Psychiatrists and what psychiatrists do has been the subject of myth making just as much as their patients' suffering mental illnesses.

The public at large has always maintained an ambivalent view of psychiatrists. Our perceived omniscience is envied and feared, so psychiatrists must be continually ridiculed and put down to neutralise these negative feelings (Gabbard, 2001: 365).

\(^4\) The medical model is medicine based on pathology, the ascribing of a causal agent or biological cause to a medical condition (Jones and Porter, 1994: 19).


*Interviewing Psychiatrists*

The social research academic literature, as well as more journalistic style articles on psychiatry that use interview material, predominantly report the opinions given by patients or users of mental health care services. These reports focus on the users of services and their opinion on mental health care provision. The view of the psychiatrist as expert is documented by psychiatry, but opinions given on their personal experiences are few. One explanation for the lack of reported interviews in social research suggests that social research concentrates on less powerful groups; 'as such we know little about "elite" groups who possess the power to prevent research being conducted upon themselves' (May, 1996: 37).

Certainly psychiatrists have written about what they do themselves. There are reported interviews with colleagues on professional practice and numerous patient case studies. There exists some autobiographical material, revealing insights from a more personal perspective (Rogow, 1970; Walkenstein, 1972; Tewfik, 1981; Ellard, 1994/1998b; Cawte, 1974/1998). However, the majority of material is largely clinical or 'about general changes in practice and law rather than personal experiences' (Nairn, 1999: 586). Literature searches failed to report a study that documented qualitative interviews with a number of psychiatrists by a non-psychiatrist from a postmodern perspective. This research redresses this and documents interviews with psychiatrists by a non-psychiatrist researcher.

Through first meeting psychiatrists in the role of a Clinical Research Associate (CRA), the opportunity arose to understand more of what they do through interviewing them as a social researcher. Combined, these roles provided a unique opportunity to access and record a perspective on psychiatrists that is different and new.
The work of a CRA required the review of patients’ medical records for verification with transcribed data collected on patients’ Case Report Forms (CRFs), to meet specific clinical trial objectives. In this situation, the patients’ records required were psychiatrists’ diagnoses and ongoing assessment of individual patient’s depression and recorded response to the use of a particular antidepressant medication. The conduct of this type of clinical trial gives psychiatrists a quantitative measure and a qualitative “feel” for how effective, safe and useful a new pharmacological agent, or other type of treatment intervention, would be in treating the symptoms of the particular mental disorder under investigation.

In the CRA role, conversations with psychiatrists ranged from the scientifically professional to more relaxed and variable with respect to topics discussed. These conversations were subsequently seen as easy compared to the thought of interviewing a group of “professional interviewers”. Psychiatrists were trained in the clinical interview to elicit information from patients. Wilson (2000: 267) interviewed a prominent Australian doctor about the balance of power between the person asking the questions and the person giving the answers in clinical interviews and received the following response:

"During the interview you are also eyeing the patient and getting non-verbal messages about, for example, whether they are depressed or how anxious they are ... From the pace of the voice, the way they express themselves and so on, you actually get a lot of both direct and indirect information out of the interview (Wilson, 2000: 265)."

I was not looking forward to being eyed.
An Interest in Mental Health

Psychiatrists are sometimes the designers and implementers of mental health policy initiatives. However, mostly they are the recipients of implementation plans that need to be enacted to meet policy objectives. This research provided an opportunity to hear psychiatrists’ voices and their perspective on mental health policy that could contribute to a more meaningful dialogue about mental health.

The Research Challenges

Some psychiatrists may agree that their biggest challenge is being a part of the widest of medical disciplines, as they apply on a day-to-day basis the entire bio-psycho-socio-cultural spectrum (Rosen, 2001: 133). In undertaking this research I frequently found myself ranging across the multidisciplinary spectrum of thought that informs a postmodern philosophical perspective. A constant challenge for me was to choose and use research methods that would be considered consistent with a postmodern perspective. The research process, which includes the choice and documentation of the methods and outcomes, was often questioned and challenged. The question asked was: Is what I am doing in conflict with, or inconsistent with, a postmodern perspective?"5

5 Many conversations were had with my supervisor Dr Margaret Vickers on this issue. I quote below excerpts from an email that she sent to me on 26 August 2002 on this point. They were written after her review of the initial draft of the research methods and outcomes in Chapters Five and Six. ‘You need to get very clear in your mind the four separate areas of your research process (At the moment these are combined, not very comfortably): (a). What you wanted to find out; (b). How you planned to find out (a) above; (c). What you actually did; (d). What you found out. I have come to the conclusion that only (d) above should be written from a postmodern perspective. (A), (b) and (c) should all still be presented in some kind of Modernist form, not a “postmodern” collection of material. Your research design (a and b above) should certainly indicate your ability to do your interpretations and analysis from a postmodern perspective. However, I think that you still should be detailing what you intend to do in a very modernist way’ (Vickers, Feedback on Chapter 7, 2002: 1-2).

This advice, as we had also often discussed, entailed a degree of compromise. As a scientist, I had experience in writing suitably “objective” modernist study protocols, reports and papers divided, as appropriate, into sections called objectives, study design, analysis, statistics, ethical considerations, results, discussion and conclusion. Consequently, this modernist
At some point in the research process you eventually arrive at a stage where you are faced with pages of data or results. In this research, these are the pages of transcribed interviews, additional notes and contextual commentaries, describing the conversations and interview experiences. These are the research generated materials or texts, and you have to do something with them. This something, in modernist qualitative and quantitative methodological frameworks, is referred to as the analysis and discussion of results. The results section is usually followed by the drawing of some conclusions about the results together with a call for the need for further research to investigate or explain the phenomenon, or any emergent new phenomenon, even further. Postmodernism does not require a denial of the validity of this approach to the categorisation of research generated material and processes. However, it does require the researcher to recognise and question the limitations the use of such words as, objectives, analysis, results and conclusions, would impose. What these words imply is the need to dissect, compare and contrast, categorise, assign meaning, explain results, and to demonstrate that this is possible. This modernist approach places not only the generation of this text into a self-fulfilling structure, but also the research experiences and the research process. Another limitation of using such modernist research terms is that they impose a degree of order and linear chronology to the whole research experience that may not be appropriate. There is the expectation that the results will satisfy the objectives and, through the conclusions, closure to the whole process is possible.

The complexity of the research process is diminished through use of modernist research terms, and what they have come to mean, because they serve to segment discretely the research phases. Again, postmodernism would not require a

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approach was not unfamiliar. Whilst initially uncomfortable with the degree of compromise suggested in the Feedback given, if it meant a clearer understanding of the text produced for the reader, then it was a necessary compromise.
researcher to deny the time and spatial dimensions of the research process, but, rather, to have considered and questioned the reasons for this underlying perception or need for a continuum of progress and closure. The most obvious reason underlying the desire for closure seems to be that one has to make sense of the research material. The researcher needs to draw boundaries around what needs to be done, then what has been done and the results of these actions, and then to present this in ways that are meaningful for the researcher and the reader of the final text.

The first boundary drawn in this research was the identification of the research challenges, which were informed by a postmodern philosophical perspective. The research challenges identified were:

1. To listen, question, document, interpret and present the experiences shared and issues raised in conversation and interview with practising psychiatrists.
2. To consider the relationship between motivation, rationale, medicine in psychiatry and the identity of psychiatrists. This is through presenting an interpretation of their stories and experiences about the meaning and consequence of what psychiatrists do. This relationship is for the individual researcher⁶ and of psychiatrists, as the perceived healers of the mentally ill.
3. To place the research interpretations within the context of the current mental health policy in Australia. To ask the question: Is there, or can there be a postmodern psychiatry?

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⁶ I say ‘for the researcher’, as the consideration and interpretation of the relationship is a continual process to be reflected upon. It is of the psychiatrist as they are the subjects of this research and they may or may not choose to have this same interpretation or understanding of the relationship.
To put these challenges into perspective, the circumstances and influences present at the start of the research are identified below.

Circumstances and Influences

The colloquial use of the phrase "no strings attached" means that something comes, or is being offered, at no extra cost, or with no hidden agenda, additional constraints or expectations. Many strings were attached to this research and these are acknowledged as influential at the theoretical, methodological and practical level in talking to psychiatrists about their work.

- The initial motivation that led to me enrolling as a student and embarking on this research, was to further pursue the question of earlier research, which was: What constituted “normality” in the work place and who were the arbiters of this normality?

- The second was the circumstantial choice of psychiatrists as the subject of the research. In the context of psychiatry, the concern with power relations meant considering the literature on mental illness and psychiatry, and the existing perceptions in society generally surrounding psychiatry, psychiatrists and mental disorder.

- Third, as a CRA employed by a pharmaceutical company, I was conducting clinical trials with psychiatrists and did not want to jeopardise this research or my employment. Keeping the CRA and social researcher roles as separate as possible, was also important for ethical and confidentiality reasons.
At the time of commencement of this research I had already been working with psychiatrists for several months, observing and talking to them about the practice of psychiatry. The influence of these encounters, combined with the above motivation and circumstances, led to the initiation of this research.

The CRA perspective of the psychiatric enterprise was often contradictory to the social researcher perspective. There was a tension between gaining "knowledge" and the desire for a unifying interpretation demanded by a modernist scientific "understanding", and the postmodern acceptance of the unknowable. As I prepared to interview and question psychiatrists, I questioned the presumptions of my clinical science to reveal the "truth" about things and people. The presence of these "truths" in psychiatry could be explored though the psychiatrists' use of science and medicine, and questioning how these knowledge(s) have helped them in their work.

The content of Australian psychiatry's published journals\(^{7}\) influenced the research process and outcomes by providing more voices and documentation of contemporary opinions additional to those given in conversation and interview. Similarly, the agenda, presentations and discussions held at psychiatry conferences, seminars and social functions attended by myself as a representative of a pharmaceutical company, were also influential when presenting the outcomes of this research.\(^{8}\) Additionally, the Australian Federal government’s Mental Health Strategy was an important reference document for me to enable meaningful discussion about mental health and psychiatry in Australia today.

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\(^{7}\) The Australian and New Zealand Journal of Psychiatry and Australasian Psychiatry.

A postmodern perspective underpinned the medical and psychiatric influences mentioned above. The postmodern perspective applied in this research was drawn from the diverse set of initiatives in French social and philosophical thought from the 1960s onwards. A number of these philosophical strands of thought, sometimes referred to as poststructuralist, have contributed significantly to the constitution of postmodernism (Smart, 1993: 20-23). One desire of the poststructuralists was to consider the possibilities beyond our usual frame of reference, as a way of interpreting phenomena. A challenge of this research was to draw another boundary to present a "unified" interpretation of the research experience. Unified in this context did not mean a single, ultimate "truth" about psychiatrists and their role in mental health, but an understandable interpretation of the whole research experience that presented the various dimensions, or perspectives, of psychiatrists and researcher.

**Time, Subject, Discourse and Voice**

This research extended over five interwoven periods of time. The first period involved meeting psychiatrists as a CRA. At this time, I was also considering the methodological options available to me, while researching the postmodern sociological and philosophical literature, together with the medical mental health and psychiatric literature. The second period involved planning, conducting and evaluating the structure and content of a pilot interview.

This was followed by the third period, which was to implement a two-part interview method and conduct the Part One interviews with transcription and content review. The fourth period involved the Part Two interviews, transcription and review. The fifth and most extensive period was a time of reflexivity, interpretation and writing.
This fifth period cannot be considered discrete or separate, but, rather, interwoven with the other four periods of this research as the reflexivity, interpretation and writing occurred throughout the entire time of the research.

The research involved five participant groups, the psychiatrists; me as CRA; me as social researcher; the research supervisors; and those in the community who are mentally ill. The mentally ill are included, not because they were direct participants in the research, but because they are integral to the identity of the psychiatrist – as respondents explained in interview.

The research included the consideration of four discourses. Discourses are the different ways of structuring knowledge and social practices that constitute subjects (Johnson, 1998: 13-15). The first discourse was that of psychiatry – how psychiatrists have come to constitute themselves through their words and practices. Second, was the discourse that defines the mentally ill, which is intertwined with that of the psychiatrist. The third discourse concerned the use of science in medicine, in particular, psychiatry. The fourth discourse was that of academic social science and philosophy, in particular, the postmodern perspective and how its concern for systems of knowledge and belief has directed this research.

This research contains the voices of both individual and collective subjects but also the author to tell their story in this text. This text was to be the 'object and site of struggle ... not fixed but the site of constant contestation of meaning' (Mills, 1997: 16). In writing the respondents' stories I asked myself: Had I provided psychiatrists the opportunity to interrogate and disrupt the discourse that is psychiatry, opening up spaces in which suppressed heterogeneity, discontinuity, and differences will
reappear (Flax, 1990: 41)? Had the interpretation identified and done justice to both possible commonalities and differences within peoples’ experiences (Flax, 1990: 6)? The story and interpretation that follows provides one possible response to these questions. It is recognised that one cannot be detached or neutral in any social context, and, as such, is ‘always engaged, self-aware or not, in taking a moral and political position – if only by default’ (Luske, 1990: 116). Consequently, the story and interpretation may be read and interpreted differently by its readers.

The following chapter, Chapter Two, presents the postmodern theoretical perspective. It traces the development of postmodern philosophical and sociological perspectives. Chapter Two then discusses the defining characteristics and the most common criticisms of a postmodern perspective. It then identifies four areas of concern when considering psychiatry from a postmodern perspective. These areas of concern are: the use of science in medicine, the role of government, the nature of contemporary society, and the nature of identity. Finally, Chapter Two considers the implications and challenges of adopting a postmodern theoretical perspective on methodological choices.
CHAPTER TWO

THEORY

A Postmodern Perspective

Postmodernity means many different things to many people. But it is also – perhaps more than anything else – a state of mind. More precisely – a state of those minds who have the habit (or is it a compulsion?) to reflect upon themselves, to search their own contents and report what they found (Bauman, 1992: vii).

The Passage to the Postmodern

The term postmodern was used as early as the 1870s to describe nihilism and collapse of values in contemporary European culture (Welsch, 1987: 12; cited in Bertens, 1995: 20; and cited in Best and Kellner, 1991: 6). Postmodern was not a term used frequently again until the 1960s. In the 1960s, works of literary criticism created the endurable link between postmodernism and anti-Enlightenment positions that persist today (Bertens, 1995: 20). Working in the 1950s and 1960s, Ihab Hassan’s use of the terms postmodern and postmodernism, in his literary and
cultural criticisms, gave it wider circulation. Hassan’s contribution to the postmodern debate was later acknowledged by Lyotard\(^9\) (Bertens, 1995: 37, 112).

Over time, the terms postmodern, postmodernity and postmodernism have been invoked to describe a wide range of objects, phenomena and perspectives across many disciplines, not just literary criticism. These disciplines have included art, architecture, politics, journalism, film, music, sociology, philosophy and linguistics (Best and Kellner, 1991: 256; Rosenau, 1992: 7; Smart, 1993: 13; Hollinger, 1994: xi; Bertens, 1995: 3, Matthews, 1996: 179). However, controversy and debate over what constitutes postmodern, and over the meaning of the terms postmodernism and postmodernity, remains.

In the 1960s most of the debate about postmodernism was confined to consideration of literature, architecture, design of social spaces and the arts, in a movement sometimes referred to as anti-modernist (Bertens, 1995: 20, 111). It was not in the field of social research that postmodernism had most impact initially. However, the beginnings of the development of a postmodern social theory have been variously placed from 1947, to the 1950s or 1960s. The first use of the term “post-Modern age”, to signify a new historical era characterised by wars and social turmoil, has been credited to the historian Toynbee in 1947/1954. The term was used to refer to the period from 1875 onward (Best and Kellner, 1991: 6; Smart, 1993: 24; May, 1996: 10).

There now exists a contemporary social theoretical perspective within sociology called the postmodern. What is confusing is the existence of literature on a

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postmodern philosophy of social science, a sociology of the postmodern and a sociological theory of modernity. The perspectives they offer are impossible to neatly separate (Bauman, 1992; Rosenau, 1992; Hollinger, 1994; Siedman, 1994; Fairlamb, 1994; Fay, 1996; Beilhardt, 2001). As Giddens has commented, ‘social theory has become more “philosophical” in recent years ... at the same time philosophy has become more “sociological”’ (Giddens, 1987: 53). The differences in perspective emerge from the order in which the following three questions are asked. Is it possible to understand others in contemporary society? How can we understand others in contemporary society? What does this understanding involve? A postmodern philosophy asks the question of possibility first. A sociology of the postmodern and a sociological theory of modernity first ask how we can understand others in contemporary society. All are, however, concerned with presenting a tenable cross-disciplinary perspective that builds on historical contributions with respect to studying and understanding society. It is this concern that makes the application of the postmodern perspective confusing.

Post-modernism is a concept which straddles the gap between empirical sociological description and philosophical interpretation, and that ... may be the source of most of the problems in the concept (Matthews, 1996: 180).

The impossibility of separation of the philosophical and sociological in postmodernism is evident in its significant philosophical influences and schools of thought starting from the beginning of the Enlightenment\(^\text{10}\) project with the work of philosophers Descartes (1596-1650) and Kant (1724-1804). It is generally agreed

\(^{10}\) The Enlightenment is defined as a period where there was a ‘conviction that reason could achieve all knowledge, supplant organised religion and ensure progress towards happiness and perfection’ (Frye, Baker and Perkins, 1988; cited in Saul, 1993: 40).
that the culture of the Enlightenment is at the heart of modern West (and also perhaps the move to a postmodern West) and, as such, informs the development and evaluation of social theory (Hollinger, 1994: 9; Seidman, 1994: 1; May, 1996: 30).

The following discussion traces the emergence of the characteristics that are the basis of a contemporary social theoretical perspective – called the postmodern.\(^\text{11}\)

*The Philosophical Influences on the Postmodern*

Postmodernism bears the legacy of a number of very influential philosophical schools of thought that rejected modernist Enlightenment ideas. The key exponents from the Enlightenment that contributed to the development of *modern* social theory can be very loosely categorised as starting with those that conceptualised society as something to be studied. Comte (1798-1857) saw modernity as good and embraced the positivist rationalist ideas of social progress. In contrast, Hegel (1770-1831) was interested in the development of the mind in society. Following them, and furthering Hegel’s ideas rather than the positivist views of Comte, were thinkers such as: Marx (1818-1883), Tonnies (1855-1936), Simmel (1858-1918) and Weber (1864-1920) (Hollinger, 1994: 30-35). They developed somewhat similar perspectives but with different political or economic emphases on the fate of the individual in modern life. Of influence for Weber, and regarded by many as the founder of postmodern thought, was Nietzsche (1844-1900). Nietzsche’s nihilism, criticism of the

\(^{11}\) A comprehensive description of each of the most influential philosophical schools of thought, contributing to postmodernism and postmodern social theory, would need several chapters in itself. What follows is a brief description of the significant contributions made by the most influential philosophical schools of thought, from The Enlightenment to the 1960s. Key exponents and dates of exponent’s lives are identified. The adoption and development of the philosophical contributions described, has resulted in the formation of a postmodern social perspective. Some philosophical movements of lesser relevance are excluded. The order of
importance of truth, knowledge and rationality, and emphasis on will to power are rejections of enlightenment ideas and are considered key influences in the development of postmodern sociology and philosophy. Like some postmodern thinkers to follow, Nietzsche was considered ambivalent about modernity and life in general (Hollinger, 1994: 8, 33). The interrogative character of modern reason was questioned. Rorty, in his work *Contingency, Irony, and Solidarity*, describes the turn to a postmodern imagination, away from reason and scientific inquiry, that was begun by Nietzsche.

Human solidarity ... is to be achieved not by inquiry but by imagination, the imaginative ability to see strange people as fellow sufferers (Rorty, 1989: xvi).

Durkheim (1858-1917), drawing on Comte’s work, was more optimistic. His contribution to postmodern thought was the development of a normative social theory by emphasising the idea of morality. Durkheim saw modernity as potentially providing a new model organic community or *Gemeinschaft*. This word, *Gemeinschaft*, was used by Tonnies to describe a community characterised by natural will (Hollinger, 1994: 31, 35). Durkeim and Tonnies’ optimism led them to rethink modern society, rather than think of the postmodern society, later visualised by postmodernists like Lyotard in his book *The Postmodern Condition*.

Characteristics from two interpretivist schools of thought were adopted by postmodern theory. The first was a type of hermeneutics that emphasised explaining, interpreting and finding validity in life. This is seen in the works of Dilthey (1833-1911). Dilthey saw individuals’ inner lived experience in terms of their history, where schools of thought mentioned is not strictly chronological with respect to their development, as some referred to existed contemporaneously.
understanding was necessary for the validity of interpretation (Bauman, 1978; cited in Beilharz, 2001: 136). The second school of thought, phenomenology, also questions interpretation by asking us to question our way of looking at the world. For Husserl (1859-1938) to find true meaning, people need to be freed from their cultural and tradition bound context. Heidegger’s (1889-1976) phenomenology however challenged Dilthey and Husserl’s focus on “true” knowledge. The implication for social theory was that hermeneutics was not a method for study but a part of the conditions of human existence. A part of a subjects’ life world was the interpreting of people’s everyday interpretations.

For Schutz (1899-1959), phenomenology was the understanding of how it is that people produce social life in a meaningful way. Later, Merleau-Ponty (1908-1961), building on the thoughts of Husserl, considered phenomenology as the replacing of ourselves in the world as we experience it. This meant forgetting the theorisations of science and concentrating on perception. The rejection of science and emphasis on interpretation and perception are later found in postmodern social theorisations. For example, Foucault described natural history as nothing more that the nomination of the visible (Foucault, 1973: 132).

Co-existing with these schools of thought, pragmatism considered actions rather than consciousness as the foundations of thought. Pierce (1839-1914) is considered the founder of pragmatism and also of semiotics. The consequences of pragmatism for social theory are seen in the works of Mead (1863-1931) and the Chicago school of symbolic interactionists. Their desire was to overcome the subject – object dualism in social thought. A legacy from pragmatism for postmodernism is the concept of truth as not a reflection of an objective reality. According to this view, the truth is what we say it is and, in this respect, the subjective and objective are one
(Pratt, 2001: 13-14). Rorty (1931- ) following earlier American pragmatists like Dewey (1859-1952) explains the consequences of pragmatism in a collection of essays by that name. Rorty presents a view of humankind as language using animals, trying to redefine their world to make it work better for them (Simpson, 1995: 119-126; Ramberg, 2001: 1, 8).

Semiotics is the theory and analysis of signs and significations and the way that signs signify. The sign is the basis for understanding the structure of social and cultural life (Lechte, 1994: 121, 125). For exponents like Eco (1932- ) and Kristeva (1941- ) their works focus on how language, both written and spoken, signifies and how there can be many readings or interpretations of language. Semiotics is heavily influenced by the linguistic theories of Saussure (1857-1913); that language is a system of signs and ‘individuals are as much formed by language as it is they who form language’ (Lechte, 1994: 151). The connection between language and its importance in the formation of the subject was the subject of much of Kristeva’s work (Lechte, 1994: 142). Interest in language, signs and the subject has been incorporated into postmodern perspectives of understanding the human sciences. In *The Order of Things: An Archaeology of the Human Sciences*, Foucault wrote:

> The language of a people gives us its vocabulary, and its vocabulary is a sufficiently faithful and authoritative record of all the knowledge of that people (Foucault, 1973: 87).

Also significantly influential for postmodernism was the interdisciplinary approach of the Critical Theorists, some of whom were members of the Frankfurt School in the 1930s and 1940s. For Critical Theorists, the connection between knowledge and human interest was essential (Hollinger, 1994: 84). In the works of Horkheimer
(1895-1973), Adorno (1903-1969) and Marcuse (1898-1979) we see an emphasis on power and control as restrictive forms of thought and action, imposed on humans by existing social conditions of capitalist production (Lechte, 1994: 178). The proponents of structuralism took elements from, and built upon, the ideas in critical theory.

For the structuralists, knowledge cannot be grounded in individuals or their historical context. Emphasis was placed on systems of language and a holistic view of dynamic interdependencies in society. Society was seen to be the system and people were its constituent parts. Some exponents and contributors to this school of thought were the anthropologist Levi-Strauss (1908- ), the psychiatrist and psychoanalyst Lacan (1901-1983), and the Marxist theorist Althusser (1918-1990).

Freud (1856-1939) and psychoanalytic theory was also influential within critical theory, structuralism and then poststructuralism, when considering the subject and formation of the self and sexuality. Major themes of postmodernism are derived from Freud. Freud believed that happiness, utopianism and pessimism were illusions (Hollinger, 1994: 83). The importance of Freud’s work is evidenced in the works of Lacan. Lacan built upon Freud’s concept of the ego, which was as important in human behaviour as human intention, understanding and consciousness became in the social sciences and humanism of the early and mid 1900s (Hollinger, 1994: 90-92). Lacan also incorporated elements of Sassure’s linguistics of the sign into his work on psychoanalysis. The language used in the psychoanalytic session is crucial for interpretation and understanding the subject (Lechte, 1994: 68).

The death of man and the decentering of the subject that is a main characteristic of [sic] French structuralism, poststructuralism, and
postmodernism, has a political, even an ideological root, but its theoretical agenda is taken from Saussure, the great Swiss linguist (Hollinger, 1994: 86).

Also of influence for postmodern social theory and coexisting with the above schools of thought to the middle of the twentieth century, were feminist theorists. While not the only theorists to do so, the first and second generation of feminist thinkers questioned social inequalities and drew attention to a society that excludes and marginalises. The emphasis that the feminists furthered in postmodern thought was in the consideration of the other, with particular emphasis on women. Exemplars of this are Woolf (1882-1941), de Beauvoir (1908-1986), then later Irigaray (1939–), and Pateman (1940–). (Lechte, 1994; Morrow and Brown, 1994; Hollinger, 1995; Matthews, 1996: 135-156; May, 1996:1-67)\(^{12}\)\(^{13}\).

In summary, the above brief overview of influential philosophical schools of thought from the Enlightenment to the middle of the twentieth century identifies several emergent themes that are brought to postmodern social theory. These are: a concern for individual lived experience and perceptions, the contextuality of language and signs, the relationship between power, knowledge and truth, and the place of the self and other in society. These themes were further developed throughout the 1970s and 1980s in the continuing development of postmodern social theory.

\(^{12}\) It is acknowledged that feminist theorists have provided valuable contributions to postmodern perspectives on society. However, feminist theories are not the basis for the postmodern perspective underpinning this research project, and therefore, will not be pursued further.

\(^{13}\) Existing alongside the schools of thought described above, was the rationalist positivist theory of Parsons (1902-1979) – systems theory. It discusses the maintenance of a social system being achieved through four functional prerequisites (May, 1996: 52). Parsons offers a system where the needs and dispositions of individuals are linked to a larger social system in a very patterned, ordered and goal-oriented way. He offers a very optimistic perspective on society at odds with the emerging postmodern sensibilities.
Several contemporary theories of society and social life emerged, not exclusively, from four of the previously referred to influential philosophical schools of thought – phenomenology, hermeneutics, critical theory and structuralism. From phenomenology and hermeneutics developed ethnomethodology. This is most associated with the works of Garfinkel. From structuralism, came Gidden’s structuration theory and the reflexive social science of Bourdieu. From critical theory and Marx, came Habermas’s theory of communicative action\textsuperscript{14}. Also developing from structuralism was poststructural thought. Poststructuralism is most associated with the works of Levinas, Deleuze and Guattari (Hollinger, 1994: 83). Also placed within poststructuralism, or sometimes the postmodern, are Derrida (1930 - ) and Foucault (1926-1984). Foucault’s contributions to postmodern thought will be considered in more detail later in this Chapter because of their relevance to this research with psychiatrists.

The legacy of poststructuralist thought in postmodern theory is predominant and complex.

Postmodern theory appropriates the poststructural critique of modern theory, radicalises it, and extends it to new theoretical fields (Best and Kellner, 1991: 26).

What is visibly transferred to postmodern theory is the poststructuralist examination of the notion of difference in all its facets. This manifests itself as the questioning of otherness and the subject-object relation. This questioning is combined with a focus

\textsuperscript{14} Habermas has been regarded as one of the most prominent critics of postmodernism. He shares the critique of Western rationality with postmodernists, but criticises postmodern theory for deserting reason, and modernity. Modernity, to Habermas, is an unfinished project. Postmodernists, among other things, criticise Habermas’s promotion of consensus (Best and Kellner, 1991: 238-245).
on language and writing as the source of subjectivity and culture. The result is a concern for the limits and limitations of modernism, and a growing scepticism about theorising in general (Smart, 1993: 20-22; Lechte, 1994: 95; Matthews, 1996: 149).

The progression towards a postmodern social theory continued through the second half of the twentieth century with pivotal social events like the French student strikes of 1968\textsuperscript{15} that involved and influenced many, including Foucault, Lyotard and Castoriadis (Best and Kellner, 1991: 23,148; Rotzer, 1995:32; Matthews, 1996: 180). Such events have contributed to the direction of thought and arguments for considering this a new period of history – the postmodern – which brings with it new theoretical and practical insights.

Further development from this historical passage to the postmodern, but also contemporary with the development of poststructural thought, has been the debate over the type of social theory postmodernism would produce. In forming a postmodern theory for the social sciences the contributions from seminal works by Lyotard (1924-1998), (1979), Baudrillard (1929 - ), (1972/1981) and Derrida (1976/1978) have been considered as highly relevant (Best and Kellner, 1991; Smart, 1993; Hollinger, 1994: xii; Seidman, 1994: 27- 45; May, 1996).

\textsuperscript{15} The French student strikes in May 1968 actually extended to organisational groups beyond the students and academics of the French universities. The groups involved were driven by the same goals. On the negative side, they were rejecting the empty futility of the Gaullist regime of the day. People wanted greater freedom for everyone. People were seeking truth, justice, freedom and community, but were unable to find the institutional forms that could support these views in a sustainable way (Castoriadis, 1997: 48; Best and Kellner, 1991: 23). The central question of all the political activity present during May 1968 was the question of the institution (Castoriadis, 1997: 52). The student revolts politicised the nature of university education and ‘criticised the production of knowledge as a means of power and domination’ (Best and Kellner, 1991: 23). Castoriadis (1997: 53) suggests that May 1968 had a contradictory effect; ‘structuralism melted away; no one dared invoke its name any longer’. However, structuralism’s previous adherents (Castoriadis includes Foucault here) were propelled to a different level of success and notoriety through adept media manipulation and the ultimate failure of the May 1968 movement (Castoriadis, 1997: 53).
In his work, *Just Gaming*, Lyotard analysed situations in terms of language games. He rejected the idea of a master-discourse (later called a metanarrative) that forms the basis of judgement of situations. This rejection meant the abandonment of universal judgements in favour of plurality (Best and Kellner, 1991: 146-153; Woodward, 2002: 7-9). In his influential report, *The Postmodern Condition*, Lyotard was concerned with the ways science, research, and the production of knowledge are being transformed in society. Lyotard raised questions about who decides what knowledge is, and how this is decided (Smart, 1993: 127-128). He attacks the increasing dominance of scientific knowledge over narrative knowledge. Scientific knowledge is regarded as no more legitimate and no more able to explain reality than other forms of knowledge. Baudrillard (1981) and others have called attention to the problems of sensory overload and displaced meaning from the proliferation of objects and images in our increasingly fragmented and commodity-driven culture (Dunn, 1998: 143). One of Derrida's main contributions to postmodern thought was to introduce the notion of a deconstructive stance towards culture and politics. Deconstructive critiques led to ‘challenging dominant meanings as oppressive, arbitrary, and fictional and therefore inherently unstable and susceptible to transformation’ (Dunn, 1998: 173).

As noted earlier, Foucault's thoughts on power, knowledge and the self, together with the many critiques of his work conducted, are chosen for closer examination because of their particular relevance for this research in psychiatry.
Foucault

The formation of the subject is at the heart of much of Foucault's writings on madness, power, knowledge and truth, and is central to postmodern thought. Foucault's works show the influences of Nietzsche's anti-idealist and anti-humanist philosophy. Nietzsche, as mentioned previously, is most often associated with nihilism, or the belief that all values are baseless. For Nietzsche, there is 'not objective order or structure in the world except what we give it' (Pratt, 2001: 1). From his writings on the existence and place of language, knowledge and truth in society Nietzsche is considered a sceptic. It is this sceptical perspective that is thought to have influenced the works of Foucault.

Foucault offered a new perspective on society and social relations (May, 1996: 180), as well as new perspectives on the sources and use of power and knowledge in the practice of medicine. Of particular relevance are Foucault's commentaries and methods for researching the perception, diagnosis and treatment of mental illness throughout history. In speaking of madness as an object of possible knowledge by medical science, Foucault describes the self-reinforcing power relations in psychiatry in a volume of his unpublished works, edited by Rabinow (1994) and quoted below.

Our science enables us to call your madness a disease, and consequently we doctors are qualified to intervene and diagnose a madness in you that prevents you from being a patient like others: so you will be a mental patient (Rabinow, 1994: 49).

Foucault's archaeological and genealogical methods focus on research with two questions in mind. First, 'at any historical moment, what kinds of conditions come into play in determining that a particular subject is the legitimate executor of a certain kind of knowledge?' Second, 'at any historical moment, what conditions come into play in determining that a particular object is the appropriate object of a particular kind of knowledge?' (Faubion, 1994: xii).
Human behaviour in modern society has come to be controlled by experts acting in the name of science (Matthews, 1996: 151-152). Foucault's methods of archaeology and genealogy focused on discourses, and to show the effects of the centralising of powers linked to the institution and functioning of an organised scientific discourse in society – like psychiatry.

It is thought that Tuke and Pinel\textsuperscript{17} opened the asylum to medical knowledge. They did not introduce science, but a personality, whose powers borrowed from science only their disguise, or at most their justification (Foucault, 1995: 271).

Some consider the centralising powers of institutions extend to other helping professions in society where the most significant effect of their involvement in the formal structure of social control is considered to be ‘the legitimisation of the dominant power structure’ (Jamozik and Nocella, 1998: 197).

In Foucault's writings on psychiatric knowledge and power he sought to show that, through the effects of discursive formations, we generate a system of possibilities for knowledge; a discourse, whose foundations are located in power (Rabinow, 1994: 49).

Without instruments of constraint, with observation and language only; he advances upon madness (Foucault, 1995: 251).

\textsuperscript{17} Tuke and Pinel were two psychiatrists working in the 1800s, who are credited with "freeing" psychiatric patients from the punitive conditions in the asylums at the time – something Foucault was sceptical about. "The legends of Pinel and Tuke transmit mythical values, which nineteenth-century psychiatry would accept as obvious ... But beneath the myths themselves, there was an operation ... which silently organised the world of the asylum, the methods of cure and the experience of madness" (Foucault, 1995: 243).
Discursive formations act like rules or guidelines, and also generate the possibility of an author and a knower of this discourse. In these discourses 'appearances and thoughts are the sum total of knowledge' (Kendall, 1999: 11). Or expressed another way, knowledge is words and things – the sayable and the visible. The sayable and the visible are the two poles of knowledge that are connected by power relations. Power is the capacity to influence others and by exposing this power relationship, Foucault wants to liberate us to new possibilities.

Foucault explains the relationship between power and knowledge and the subject by starting with the notion of the subject. In modern Western society, the subject is regarded as the product of the operation of power, and man is both the subject and object of knowledge. Deacon (2002: 105) describes the modern subject as: 'a product of a despotic reason, combining enlightenment and discipline'. Foucault views man as both subject and object, because we have placed ourselves as 'that which must be conceived of and that which must be known' (Foucault, 1992; cited in May 1996: 180). Power is a productive strategy, practiced not possessed, and it maintains the relation between the sayable and the visible. Foucault was interested in the when, where and who of the sayable – the place, space and subject. This allows us to think of the individual, not as the origin of all things, but, rather, of power relations differentially positioning subjects in space and time that could produce different, contradictory and fragmented individuals (Merquior, 1985; Gane, 1986; Hoy, 1986; Bernauer and Rasmussen, 1988; Gutting, 1984/1989; O'Farrell, 1989; McNay, 1992; Barker, 1993; McHoul and Grace, 1993; Lotinger, 1996).
Postmodern Social Theory


Of these sociologists, Bauman’s presentation of postmodernism and sociology was most influential in this research. Bauman explains that the dominant North American form of sociology, which developed out of the ‘false promise that it could help managers of public, economic and political life’, is disappearing (Beilharz, 2001: 27). Sociology in the postmodern is about undermining certainties, keeping possibilities alive. Everything is open to discussion and should be negotiated (Beilhart, 2001: 28). A sociology of the ‘postmodern would view phenomenon as what needs to be explained, not as the explanation’ (Beilharz, 2001: 12).

The cross-disciplinary evolution of postmodern thought and its rejection of rigid disciplinary boundaries has left postmodernism, it has been said, with no single theory or coherent set of positions, rules or values. Postmodernism is several things at once, a collection of views that are often conflictual (Best and Kellner, 1991: 2; Rosenau, 1992: 6; Bertens, 1995: 1; Jamrozik and Nocella, 1998:34). However, this type of criticism of postmodernism, alleging a non-specificity or incoherence, has also been made by critics of structuralism and poststructuralism (Giddens and Turner, 1987: 195). The Enlightenment too has been described as not representing
a set of ideas clearly demarcated, 'but represents a general shift in thought' (May, 1996: 8). This suggests that postmodern thought is no different to any other in its attempts to explain the social relations of its time. Saul (1993) sees this as one of humanity's two obsessions:

One is an uncontrollable desire to give ourselves the impression that we have made yet another fresh start. We are constantly declaring new ages (Saul, 1993: 40)\textsuperscript{18}.

The conflict over what postmodernism is, or is not, has produced at least two coexisting views. They are distinguishable but are not inseparable. One view is seen as derived from the cultural, primarily from art and architecture. The other is from a socio-economic orientation of thought, from sociology, philosophy and politics. Rosenau describes two forms of postmodernists, the sceptical and affirmative. The sceptical critique modernity and deconstruct everything. The sceptical have a pessimistic, negative and gloomy view of the present. The affirmatives are more optimistic and visionary, in a non-ideological way (Rosenau, 1992: 14-15). Yet other adherents of the postmodern, following Toynbee's use of the word referred to earlier in this chapter, see the postmodern clearly as an era after modernism, an historical characterisation more than a kind of theoretical position (Seidman, 1994: 153). Each of these views, or forms of postmodernism, attracts positive and negative critiques. These critiques try to explain the origins and potential consequences of describing the postmodern world as they each do (Best and Kellner, 1991: 14-15).

\textsuperscript{18} The other, Saul declares, is our difficulty in considering philosophy in the context of real events (Saul, 1993: 40).
Despite these divisions it seems that most agree that ‘the most conspicuous features of the postmodern condition [are] institutionalised pluralism, variety, contingency and ambivalence’ (Bauman, 1991a; cited in Beilharz, 2001: 173-174) where ambivalence is ‘the possibility of assigning an object or an event to more than one category’ (Bauman, 1991b; cited in Beilharz, 2001: 281). Ambivalence could also be described as a disguise, a coping mechanism leading to perception of control or non-confrontational acceptance.

In summary, to be postmodern, social theory is advised to cease its nostalgic quest for the whole, the one and claims to theoretical foundations. It should tell alternative stories, narratives that celebrate heterogeneity because social theory is also produced as a part of the conditions in society it describes (Seidman, 1994: 119; May, 1996: 216).

**Characteristics of a Postmodern Perspective**

Postmodernism is incredulous of all metanarratives and it opposes the oppressive aspects of modernism and modernity. Postmodernity is about restoring a re-enchantment of the world that modernity tried hard to dis-enchant (Cilliers, 1998: viii; Bauman, 1991a; cited in Beilhartz, 2001: 191).

Postmodernism sees reality as unordered and ultimately unknowable. There is an equivalence of knowledge-producing discourses (Best and Kellner, 1992: 9). In postmodernity there exists a relativism and plurality of perception and values, where no values are more important than another (Jamrozik and Nocella, 1998: 33). There is no classification of right or wrong, no hierarchy of sequence or superiority. The self is seen as multiple, and cannot be explained by any one disciplinary discourse.
There is a tolerance and recognition of the relevance and validity of the other's differences. In postmodernity, there is a decentering of the subject; no clear distinction between subject and object (Lechte, 1994: 231; Seidman, 1994: 5-15).

In postmodernity, the interrelationship of knowledge and power means power has no essential quality. Power is both constraining and enabling of human possibilities. In postmodernity new technologies, new forms of knowledge and changes in the socio-economic system are producing a postmodern social formation of imagined communities that provide the support previously sought in modernity's pronouncements of universal reason. Spicer (1997: 92-93) describes a modernist view of government as a purposive association, where the existence of some grand narrative towards the betterment of the human condition is presumed. In contrast, the postmodern condition denies the possibility of a shared grand political narrative. Spicer, following the work of Oakeshott (1995/1991/1993) believes the state, or community, should be thought of as:

A narrative, or a story we are used to telling each other about the terms of engagement with each other and our government (Spicer, 1997: 92).

Postmodernity rejects social cohesion in favour of notions of causality as contingency, multiplicity, fragmentation, ambivalence and indeterminancy. The political economy of postmodernity is concerned mostly with the production and distribution of public attention – the symbols of imagined communities are in their signs, speed and spectacles (Bauman, 1992: i-xvii; Best and Kellner, 1992: 1-31; Rosenau, 1992: 138-164; Hollinger, 1994; Nicholson and Seidman, 1995: 8-14; Beilharz, 2001: 23).
Postmodern perspectives have produced different ways to interpret and understand the world. These include antenarrative, story telling(s) that are 'polyphonic juxtaposed readings and writings of a chorus of narratives' (Boje, 2001: 16). Deconstruction is also a term associated with postmodernism. Deconstruction, a term associated with Jaques Derrida, is a complex concept and we are warned that it should not be regarded as a method, critique or a form conversation but a way of thinking about things (Caputo, 1997: 31-43). It is also not a destructive activity but a constructive positive one (Caputo, 1997: 36-37). Critchley interprets the Derridian goal of deconstruction to be:

To locate a point of otherness within philosophical or logocentric conceptuality and then to deconstruct this conceptuality from that position of alterity (Critchley, 1992: 26).

Farmer (1997: 13) explains deconstruction more simply as 'essentially a good reading of a text'. The concept of deconstructive readings of texts as a postmodern attitude, and its potential use in this research, is discussed further in Chapter Five. Similar to deconstruction, postmodern reflexivity demands a continual concern for whom and how we are in the world. Antenarrative, deconstruction and reflexivity are approaches aimed at discovering the truth of the truth, where the meaning of the text lies with the reader, and signs and language being the result of differential relations.

In summary, the Postmodern is many things to many people. Bauman summarises the post-modern condition, which has fostered these attitudes, as on the one hand:

Modernity emancipated from false consciousness; on the other, as a new type of social condition marked by the overt institutionalisation of
the characteristics which modernity – in its designs and managerial 
practices – set about to eliminate and, failing that, tried to conceal 

Farmer (1997: 15) summarises postmodernism as having a philosophical scepticism 
about the capability of human reason and having a socio-political core consistent 
with an ethic of difference, giving privilege to voices that are presently marginalised.

*Criticisms of the Postmodern*

Postmodernism has been criticised as being relativist, irrational, nihilistic and more:

> It is strong and fashionable. Over and above this, it is not altogether clear what the devil it is. In fact, clarity is not conspicuous amongst its marked attributes (Gellner, 1992; cited in Gray, 1999: 1550).

‘Postmodernism is characterised by relativism, namely, that there are no such things as objective facts’ (Gray, 1999: 1550). But this has been interpreted by saying it is a way of thinking where there is no value, interest or knowledge that can be universally shared. ‘Rorty’s enduring attitude to relativism and subjectivism is that both are products of the representationist paradigm’ (Ramberg, 2001: 3). In his work, *Truth and Progress*, Rorty says:

> In short, my strategy for escaping the self-referential difficulties into which “the Relativist” keeps getting himself is to move everything over from epistemology and metaphysics into cultural politics, from claims
to knowledge and appeals to self-evidence to suggestions about what we should try (Rorty, 1998: 57).

Postmodernism devalues theory building, the social collapses into the textual. Demolition is the only job the postmodern mind seems to be good at and deconstruction is the only construction it recognises. Postmodernism can only show what is wrong and cannot provide positive direction. Postmodern theory has sociological, political and ethical deficits because notions of community, intersubjectivity and understanding are lacking (Best and Kellner, 1991: 178; Bertens, 1995: 194).

Choosing to act on and promote one’s moral convictions suggests the superiority of them. Yet, postmodernism discredits the superiority of one opinion over another. Postmodernism is therefore contradictory in that it privileges its own ideas and theory, allowing no critique of postmodernism from outsiders. The ethical paradox of the postmodern is in the choice between the two opposed versions of the tolerance it advocates – indifference and solidarity.

Due to fears of representation and power, and of a totalising social reality, postmodernism is dominated by a capitalism born out of fierce opposition to the politics of the modern (Bertens, 1995: 199). This creates another paradox for modernity because it acknowledges that it has not replaced or superseded modernity; they coexist. It is argued therefore, that postmodernity is not valid. It is just another stage in modernity or late modernity because postmodernism and consumer culture exist in tandem. For some postmodernists this is not regarded as a criticism. In some respects postmodernists like Bauman agree. Bauman regards
postmodernity as a chance for modernity. In interview, Bauman explained postmodernity as:

Modernity which goes beyond its false consciousness and comes to understand what it actually was doing all along, i.e., producing ambivalence and pluralism (Beliharz, 2001: 19-23).

Rorty (1994: 58) suggests that Dewey's and Foucault's criticisms of the modernist notions of rationality, objectivity and truth led them to the same conclusion as Bauman, expressed above. Postmodernism gives mankind the opportunity to grow up and rationality is what history and society make it.

For this research with psychiatrists, elements of modernity continue to coexist alongside those of the postmodern in contemporary society. The appeal to science in psychiatry for truths about cause and effect appear to remain driven by modernist desires for a metanarrative of mental illness. However, in society, the nature and perceptions of mental illness, the role of government in health policy and the identity and role of the psychiatrist, are more complex phenomena to interpret and understand. A postmodern perspective on science, government, society and identity is now considered.

Postmodernism, Science, Government, Society and Identity

The use of science in medicine, the role of government, the nature of contemporary society, and the nature of identity and difference are identified as four areas of concern that emerge when considering psychiatry and mental health from a postmodern perspective.
Science

The modernist concept that science produces truths through its objectivity and rationality is under question by postmodernists in contemporary society. Postmodernism’s attack on science focuses on the positivist, empiricist, totalising rationality of its metanarrative. While it is acknowledged that science is useful for specific purposes, it can no longer have totalising claims to truth and promises of a better world. The knowledge generated in pursuit of scientific truths will not provide all the answers to reach a “higher” quality of life. The scientific narratives still being generated in the name and service of reason and progress are part of the modernist self-serving game. Postmodernism sees them as being no longer legitimate in contemporary society. This is the progress myth (Rosenau, 1992: 9-10, 85; Smart, 1993: 88-90, 101; Fairlamb, 1994: 1, 74; Seidman, 1994: 27; Nicholson and Seidman, 1995: 8; Jamozik and Nocella, 1998: 100-101; Fox, 1999: 174-175; Kendall and Wickham, 1999: 63-64; Boje, 2001: 41).

Science should not be considered superior to more narrative forms of thinking or language that use other criteria for assessment of validity (Rosenau, 1992: 84-85; Matthews, 1996: 184-186). Lyotard sees scientific research operating to augment its power in the service of “performativity”¹⁹ not truth. (Hollinger, 1994: 130; Bertens, 1995: 126; May, 1996: 209).

Despite the popular appeal of metanarratives, not only those of science but also more generally, practically all have been unmasked as fictions (Bertens, 1995: 125). Postmodernity does not, however, seek to substitute one truth for another (Bauman, 1992: ix).

¹⁹ Performativity was a word used by Lyotard to describe the optimisation of inputs and outputs as a judgement of performance or outcome. Performativity values capacity, efficiency and control. Postmodernists argue that performativity discourages diversity and autonomy, flexibility and openness (Rosenau, 1992: xiii).
The focus of psychiatry, as a medical profession, is to believe that further scientific research will deliver knowledge on the biological causes of mental illness and that this knowledge, when applied to designing treatment options, will eventually enable psychiatry to cure mental illness. The consequence will be that society will then be able to achieve a state of “mental health”. A postmodern perspective would suggest that the emphasis and privileging of science to deliver this knowledge is illusory as it is a part of the modernist progress myth.

**Government**

The second area of concern for postmodernism is government (or the conduct of conduct) in contemporary society. Dean suggests that putting all senses of the word conduct together means “government” entails:

> Any attempt to shape with some degree of deliberation aspects of our behaviour according to particular sets of norms for a variety of ends

(Dean, 1999: 10).

Dean (1999: 33) also observes that ‘government is fundamentally a utopian activity because it presupposes a better world, society, or way of doing things’ (Dean, 1999: 33). Foucault (1994) considered utopias as ‘spaces that are fundamentally and essentially unreal’ (Foucault, 1984a; cited in Faubion, 1994: 178), the existence within a society perfected. In the postmodern, government cannot use reason and objective knowledge of the world to create a utopian human society (where everyone is healthy and happy) because of the relativism of perceptions and values (Jamrozik and Nocella, 1998: 33; Dean, 1999: 33-34).
Farmer and Farmer (1997: 507-508) provide an example from Public Administration. Bureaucracy has historically relied on a positivist technological or efficiency ethic, combined with administrative effectiveness and reliability. This reliance has not solved its core problems. Farmer and Farmer advise that what is needed is an expansion beyond the superficial symptoms of bureaucracy's problems to include the "in-between" spaces. These are the spaces that allow new meanings, signs and limits for the self and other (Farmer and Farmer, 1997: 509). Politics and government and bureaucracy have to be rethought in a postmodern world to include the in-between.

Practices of government need to accommodate specialisation and cross functionality, a heightened individual distinctiveness, and contend with unpredictability and chaos, rather than creating the illusion of homogeneity and control (May 1996: 202-204). The utopian activities of government and policy making directed towards achieving homogeneity and control are questioned and challenged in the postmodern. The emphasis of the postmodern is on heterogeneity, plurality and locality. Under these conditions any order is emergent and transitory.

The moderns were 'prisoners of an absolute dichotomy between things, signs, facts and values' (Kendall and Wickham, 1999: 90). Postmodernism is not a solution but a symptom of the breakdown of this dichotomy (Kendall and Wickham, 1999: 100). Postmodernism's localism is also considered a symptom of its reaction against modernism's failure to totalise. Government in the postmodern, where the interrelationship between knowledge and power is so important, and the boundaries between public and private space are blurred, requires micropolitics. Faith is lost in party politics and western democracy that is traditional in macropolitics. This gives

Bauman considers the politics of the postmodern as inseparable from its ethics and is a result of two features of the postmodern condition: the pluralism of authority and the centrality of choice for agents. He describes postmodern politics as tribal politics of desire, fear and certainty. The politics of desire are desires for heteronomy of choice and autonomy of the choosing agent. The politics of fear is a consequence of uncertainty because the moral and social certainties promised in modernity, in exchange for part of the agent's freedom, no longer exist (Bauman, 1991a; cited in Beilharz, 2001: 181-185). In postmodernity, restrictions on freedom, or repression, are proclaimed illegal. Social certainty no longer remains (Bauman, 1992: xxiv). The result is a search for confirmation or certainty of the choices made by individual consumers. As a consequence, trustworthiness, credibility and perceived sincerity become major criteria by which merchants of certainty – experts [like psychiatrists] and politicians – are judged, approved or rejected.

Society
There is broad agreement that if postmodernism is describing contemporary society, it is a society that has moved from one of production to one of consumption (Best and Kellner, 1991: 111; Bertens, 1995: 162; May, 1996: 203). The rise of a
consumer culture in society has seduction replacing repression as the “vehicle” of social integration. This is in response to the lack of social certainty and the rise in individual freedom (Bertens, 1996: 233). Repression still exists where the “non-consumer” exists and it is a place where the business of life is directed toward mere survival (Bauman, 1992: 98).

In the contemporary society of the postmodern, control through seduction perpetuates the dominance of the existing market serving the pursuit of both autonomy and solidarity for the consumer. This shifts dissatisfaction and conflict from focusing on the political area to the area of commodities and entertainment (Bauman, 1992: 112). Mostly, though, society is about the reallocation of attention – public attention, something that is sought by each tribe or imagined community for their survival (Bauman, 1992: 198-200).

The issues of commodification, consumerism and globalisation, including of knowledge, are acknowledged as the dominant features of contemporary culture that postmodernism cannot overthrow. In particular, Jameson, Featherstone and Lash are sociologists with a view of the postmodern as a consumer culture of de-differentiation. The removal, blur or collapse of all the boundaries of certainty that modernism provided between reality and representation, thereby destabilising the real, characterise a de-differentiated culture. The social world becomes fragmented into a proliferation of communities (Hollinger, 1994: 122-123; Seidman, 1994: 14, 17; Bertens, 1995: 211-212, 215-216). In communities where individual freedom is linked to consumer freedom and choice availability, access to consumption and control over this access is important when considering social problems. It is also important when considering self-constitution or identity (Jamozik and Nocella, 1998: 38; Bauman, 1991a; cited in Beilharz, 2001: 180).
When considering psychiatry and mental health in postmodern society, the identity of normal versus abnormal, is questioned by consumers. So, too, is the judgment of the expert psychiatrist\(^\text{20}\) to make the distinction. Consumers are now more able to question what constitutes normal, and for whom. Diagnosis and treatment are challenged as the voices of consumer advocacy and lobby groups join in the mental health debate. Legislation now gives individuals increased freedom to access their health records that were previously restricted to the eyes of the medical profession only. This has implications for psychiatric practice, how psychiatrists relate to and offer treatments to their patients, and in what circumstances the psychiatrist is considered the expert. Psychiatrists are practising in a society where certainty and stability have been replaced by a culture where 'everything is up for grabs, available to be recycled' (Bertens, 1995: 214).

\(\text{Identity}\)

The concept of identity is central to much contemporary sociological analysis and is in crisis today in a postmodern world (Bendle, 2002: 1). This crisis plays itself out in the contradiction between the ‘valuing of identity as something so fundamental that it is crucial to personal well-being’ and a postmodern theorisation that sees ‘it as something constructed, fluid, multiple, impermanent and fragmentary’ (Bendle, 2002: 1-2).

Postmodernism considers the identity of the agent as neither given, nor authoritatively confirmed. The self is seen as multiple, not fixed, and always under construction in space and time, with no overall blueprint. Identity has to be constructed (Bauman, 1991a; cited in Beilharz, 2001: 179). Fay regards personal

\(^{20}\) Experts are 'holders of skills inaccessible to the lay and untrained public' (Bauman, 1992: 106).
identity as ‘determined by the cultural and social units into which its members have been enculturated and socialised’ (Fay, 1996: 4). Therefore, an interpretation of what psychiatrists say about themselves entails a critical examination of psychiatry ‘to see what baggage the term carries from [their] history and the political effects of that baggage’ (Nicholson and Seidman, 1995: 10). It also requires a questioning of the notion of a unitary, essentially fixed identity because we should be wary of constructions that essentialise and totalise group identities (Nicholson and Seidman, 1995: 15).

Identity surfaces in many guises and Bendle (2002: 5) has identified identity as emerging in stories in terms of:

- social performance of the self;
- narratives of the self, as stories one tells oneself about who one is;
- social context that varies with one’s social situation, and all the multifaceted experiences this provides;
- cultural categories reflecting contemporary conceptions of identity;
- social, racial, ethnic or gender differences or similarities;
- one’s subjective sense of self, possibly based on notions of an inner spiritual life;
- psychoanalytic terms, where identity and the self are regarded as constrained by unconscious structures of the mind.

The transformations of cultural and social conditions in postmodernity have been considered to have both destabilised identity but also played a ‘key role in the structuring of contemporary identity’ (Kellner, 1992: 148; cited in Dunn, 1998: 237).
This destabilization is linked to the processes of cultural fragmentation and pluralisation (Dunn, 1998: 222).

The idea of a psychiatrist identity 'continues to be invented and given personal force through myths and political organisations' (Nicholson and Siedman, 1995: 15). Such socially constructed identities should be defended but with an awareness of their social and political gains. Identity constructs need to be considered in their socio-historical context, and in relation to institutional and political forces (Nicholson and Seidman, 1995: 16).

The decentering and de-essentialising tendencies of postmodernism provokes conflict within a modernist psychiatry that relies on a strong classificatory system and psychiatrists drawing boundaries around themselves and others (Rattansi, 1995: 252-253). If psychiatrists are responsive to these tendencies it will inevitably have consequences on how psychiatrists rethink mental illness, and re-place themselves, in the postmodern. This would be timely, because we must all take responsibility for inventing and producing ourselves (Foucault, 1984b: 39-42; cited in Kendall and Wickham, 1999: 30).

**Methodological Implications of a Postmodern Perspective**

As mentioned earlier in this chapter, for some, the use of the term postmodern presupposes a sense of ending and transition into something different or new. In this context, the postmodern suggests new theories and methods that may be more appropriate to explore and conceptualise the world we experience. Fairlamb, (1994) in criticism of postmodernism and its anti-foundationalism, suggests that because of postmodernism's vaguely generalised antipathy to centres, systems, reality and truth
it 'can never be very sure what it is, where it goes or what it can appeal to for its authority' (Fairlamb, 1994: 256). Nevertheless, advocates for considering and researching society in the postmodern, and those prepared to acknowledge that there is no one postmodern paradigm of social knowledge, are advised to use 'a plurality of approaches and conceptual strategies to understand and interpret the social' (Seidman, 1994: 21). Furthermore, 'methodology should become more eclectic, flexible and less central to the subject of the social sciences' (Hollinger, 1994: 187).

Three characteristics of a postmodern research methodology are identified by Fox. The first recognises the pursuit of knowledge is local and contingent and that this engenders a commitment to difference. Second, that different qualities in people and things are accepted, and have equal value, so that there is no privileging or hierarchical positioning of people or things. Finally, theory building (as opposed to aiming for metanarratives) is not an end in itself but, rather, an adjunct to practical research activity (Fox, 1999: 179).

For Bauman, the characteristics of the social researcher pursuing Fox's postmodern methodologies are: as mediator between different social worlds, as interpreter of rules, as advocate for particular moral visions and a place where systematic study becomes a process of self-reflexive reinterpretation. The aim should be to provide interpretative not legislative inquiry, with and for knowledge that legitimates difference, expands tolerance, promotes diversity and the values of freedom and fosters understanding and communication between different groups (Smart, 1993:37; Hollinger, 1994: 178-179; Seidman, 1994: 14-15; Bauman, 1991a; cited in Beilharz, 2001: 188).
Research from a postmodern perspective has its ‘focus is on the interpretation and negotiation of the meaning of the social world’ (Kvale, 1996: 41). Then, as interpreters, we are no longer concerned with ascertaining the ‘truth of the experience they interpret’ (Bauman, 1992: 106). The logocentrisms21 of modernist methodologies are rejected as postmodernism sees knowledge as always being mediated by observation (Fox, 1999: 176).

In this research from a postmodern perspective, where the relationship between motivation, rationale, meaning and identities of psychiatrists were being considered, it was considered important to tie the experiential and cultural constructions of the identities of psychiatrists with the changes in the institutional means of identity formation (Dunn, 1998: 224-225). Consequently, the methods chosen needed to access these identities.

Also important was to place psychiatry in the broader context of historical change. The impact of commodification and technology on identity-forming processes in the postmodern needed to be addressed through the chosen methods of analysis and interpretation. The methods used are discussed in Chapter Five. In the following Chapters, Three and Four, a discussion of psychiatry and the current mental health policy in Australia is included to provide a meaningful context to situate this research.

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21 Logocentrism in Derrida’s (1976) view has informed many discourses to claim to be able to achieve an unmediated knowledge of the world, or, authority grounded in access to knowledge of reality. Scientific logocentrism privileges research data gathered by specific methods but downgrades the experience in practical settings. The postmodern response to this would be that knowledge is an effect of power and is constituted in language, not in access to reality (Fox, 1993: 8-11; Fox, 1999: 175).
CHAPTER THREE
PSYCHIATRY IN CONTEXT

History, Myth and Reality: Social and Medical Perspectives on Mental Health and Psychiatry

The history of psychiatry, unlike the history of medicine, exhibits a distinctive pattern of cycles of patient abuse and institutional reform (Szasz, 1994: 195).

The Institution and Identity of Psychiatry

Modern psychiatry in the West evolved during what has been described as the Age of Reason, 'which then converted into the Enlightenment' (Saul, 1993: 40; Stone, 1997: 1856-1859). The eighteenth century is considered the Age of Enlightenment and from this period the Frenchman Philippe Pinel was, for many, regarded as the 'founder of modern psychiatry' (Stone, 1997: 1859-1860). Pinel's diagnostic schema described four types of insanity: mania, melancholy, dementia and idiotism' (Pichot, 1983: 13; Stone, 1997: 1860). This was a simple classification but an improvement on the past, as was his more humane physical treatment of patients. While the chains may have come off the mentally ill during the eighteenth century, Foucault's history reminds us that these were replaced by other physical and psychological treatments that were also
punitive. Importantly, they also transformed the asylum into a sort of perpetual court of law with a whole network of moral chains (Foucault, 1987: 71). One development in psychiatry that emerged from the nineteenth century’s concern with moral regulation was the relatively stable and persistent category of “personality disorders” that has persisted into the twenty-first century (Rimke and Hunt, 2002: 83).

While ‘it is not easy to specify exactly when psychiatry as a distinct branch of medicine emerged’ (Rimke and Hunt, 2002: 63), it appears, that from the nineteenth century, psychiatry became a sub-profession taught within medicine. However, the acceptance of psychiatry and psychiatrists within medicine has not been straightforward. Psychiatric practice appears to have existed both within and alongside medicine and its other medical specialties. This is possibly because medicine has seen a gradual blurring of the line separating the pathological and the normal. In psychiatry, on the other hand, the notion of personality makes any distinction between normal and pathological singularly difficult (Foucault, 1987: 11).

It is also because psychiatry belongs to the ‘critical forms of thought and philosophies of life [that] find themselves in a position of reciprocal borrowing and contestation’ (Foucault, 1973: 162). Despite recurring efforts to base its claims on science, medicine, by its own admission, ‘cannot afford to shun the humanistic and the mysterious’ (Stone, 1997: 1858). This is more so for psychiatry than the other medical specialties because the clinical picture of illness the psychiatrist sees is culture-dependent. Time and place have dictated as much as the disorders symptomatic manifestations as to how a physician describes the illness they see (Stone, 1997: 1858).

By the early years of the twentieth century, research was being conducted to understand and measure many aspects of behaviour and personality including
intelligence, sexual orientation and genetic predisposition (Stone, 1997: 1867-1869). By this time, psychiatry had been fundamentally transformed. It had shifted from a discipline primarily concerned with insanity to one equally concerned with normality (Lundbeck, 1994: 3). This transformation perpetuated but refined a disciplinary thinking that classified individuals and their behaviours in relation to one another (Lundbeck, 1994: 5). Psychiatry became a discipline that dealt with everyday problems and psychiatry appears to have been a willing adherent to the wider project of twentieth century medicine, ‘to survey and discipline society at large’ (Jones and Porter, 1994: 11).

During the twentieth century, the ‘conventions governing commitment and confinement’ were redefined (Lundbeck, 1994: 5). Progressively since the 1950s (largely due to the discovery and use of psychopharmacological interventions) psychiatry offered society deinstitutionalisation of patients and psychiatrists, as treating doctors moved from the asylums into the community. Psychiatrists emerged from a cocooned existence working in the asylums and entered general hospitals, clinics and private practice. A consequence of this deinstitutionalisation has been the ongoing need for care of patients in the community (Stone, 1997: 1869). During the twentieth century, psychiatry also became more of a science, a science of biology concerned with the reorganisation of everyday experience where the psychiatrists were the ‘arbiters of social norms’ (Lundbeck, 1994: 37).

A new dimension to the authority of the psychiatrist was described by Foucault as ‘the mental normalisation of individuals’ (Foucault, 1980: 116; cited in Lundbeck, 1994: 47). Yet, as observed by Abraham Myerson as early as 1927, this ‘step into everyday life’ (Myerson, 1927: 100-101; cited in Lundbeck, 1994: 49), a concern with everyday problems in living (Rogow, 1970: 28) and, more recently, the de-
institutionalisation and ongoing treatment of patients back in the community, meant that psychiatrists had left themselves more open to criticism and disbelief. This concern for normalisation, everyday life, deinstitutionalisation and community care, meant that psychiatrists were no longer treating mental disorder only within the more secretive confines of the asylum. They were more observable within the community and their sources of medical power could be more readily scrutinised.

For Foucault, a source of medical power was found in the physician’s gaze to produce the truth (Foucault, 1994: 39; Turner, 1992: 20; Fox, 1993: 12; Jones and Porter 1994: 11). These conventions and the “truths” revealed were now more open to the gaze of the community within which the psychiatrists were now operating. The psychiatrists could now be criticised and their medical power threatened. With this scrutiny from the community, it was now more obvious that they were not enacting a performance as scientific as their medical colleagues practising in the other sub-professions within medicine. They had not “shunned the humanistic and the mysterious”. Psychiatry, Foucault argues, is mistaken in a general way in trying to be a science of human nature (Foucault, 1987: xvi).

One example of an earlier search for scientific “truth” and legitimisation of psychiatry occurred with the discovery of the causal organism and effective treatment for syphilis during the period from 1905 to 1913. The progression of the disease to general paralysis and dementia, with all the observed “mental” symptoms, was now seen as a medical problem. It was because of this that the American psychiatrist Southard (1917) commented that ‘syphilis, is in a sense, the making of psychiatry’ (Southard, 1973: 8; cited in Lundbeck, 1994: 50). The recognition of a diseased state of the brain for this disorder, it was hoped, would be the model for all the other mental disorders. The mysteries of mental disorders would now be able to be
attributed to physical disease states. To diagnose and treat those affected with syphilis now required in-depth questioning of an individual’s sexual practices. There emerged an attitude towards interview techniques to elicit truthful responses that stressed scientific objectivity and not moral judgment. At the patient level, emerged a concern over confidentiality of personal information. Syphilis became advertised as a disease of sexual promiscuity, a disease of moral and social concern. It was considered a disease resulting from a personal weakness (Szasz, 1994: 108-109) and a diagnosis of such carried stigma. Stigma and the associated need for confidentiality surrounding a diagnosis of a mental illness is still prevalent in society today (Turner, 1992: 216; Porter, 1998: 1049; Hudson Jones, 1998: 1060). However, this has been recognised and global programmes have been initiated since the Declaration of Madrid in 1996\textsuperscript{22} through the World Psychiatric Association in a number of countries, including Australia. The aim is to reduce stigma and discrimination in mental illness, with the focus being on schizophrenia (Sartorius, 1998: 1058; Rosen, 2000: 19).

The quest to be more scientific continued for psychiatry because it meant being able to ‘generalise, universalise, seek the invariant and attain it by reduction’ (Weber, 1987: 136). To develop as a science, psychiatry sought to present its subjects as objects (Foucault, 1995a: 188; Korner, 1998: 546). An example of psychiatry’s attempt to obtain a more scientific and “objective” assessment of a patient’s illness is in the use of rating scales. One rating scale used to determine the level of a person’s depression requires the psychiatrist to assign a number from zero to four, in up to twenty-one areas, indicating severity of symptoms. These areas include feelings of guilt; anxiety; insomnia; slowness of thought; insight; loss of weight and suicidal ideation. The final numerical score is a measure of the severity of the

\textsuperscript{22} The Declaration of Madrid states that mental health is a human right and calls for broader social action within the psychiatric field (Rosen, 2000: 19)
illness, which informs the management of the symptoms and provides a measure of
c omparative wellness, statistically analysable, between patients and different
treatments over time. This type of scoring, when assessing patients, has its critics.
Foucault regards the medical examination, surrounded by all its documentary
techniques, as making each individual a “case” (Foucault, 1995a: 191). For
Australian psychiatrist John Ellard (1998), ‘tests are more concerned with attaching
labels to patients’ (Ellard, 1998a: 808). Similarly, Blue and Gaines (1992) review of
The Ethnopsychiatric Repertoire: A Review and Overview of Ethnopsychiatric
Studies, suggest that disorders themselves are culturally constructed, and that
beliefs and assessment methods of most disorders are highly ethnocentric (Blue and
Gaines, 1992: 397-484).

The objectification of patients, through the appropriation and design of a quantitative
scientific methodology for assessment and classification, has contributed to the
popularity and expansion of biological psychiatry. The common assumption in
biological psychiatry is that the discovery of biological correlates for psychopathology
would diminish the importance of the experiential dimension and cultural factors and,
as such, would undermine the concept of attribution of a significant degree of
meaningfulness, intentionality or rationality to the patient's experience (Sass, 1994:
374).

Since the 1950s, ever more science has been talked about in psychiatry. The
language and practices of science have increasingly dominated the discourse of

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Psychiatry can be considered as loosely divided into three schools of thought concerning
the causes of mental illness. Biological psychiatrists believe that the underlying cause of
mental illness is biochemical. Opposing the biological psychiatrists are those who believe that
environmental and social factors contribute significantly to mental illness. More recently, a
third school of thought promoting a biopsychosocial approach has been popular. As the name
implies, it speaks of mental illness as resulting from combinations of biological, psychological
and social factors.
psychiatry. It has been an intentional collection of the language and rationality of science to explain the illusory, and perhaps illusionary, nature of mental illness.

Scientific rationality may have contributed to some explanations and treatments but it has also served to deflect challenges to psychiatric power because the rise in use of rationality serves to legitimate power (Jones and Porter, 1994: 1). Science has provided quantitative measures of illness and comparative wellness, to which the psychiatrist could match their own skills and performance and legitimate their activities and the interventions they choose. ‘In medical practice, the growth of scientific understanding has seen modern practitioners identify themselves as scientists’ (Komer, 1998: 546). The consequence has been an imbalance of pressure on psychiatrists towards seeking and providing scientific explanations and treatments. This pressure is from within psychiatry, from the adherents to biological psychiatry. However, it is also driven by the expectations of a broader community who want answers and cures for mental illness. Because of this, ‘diagnosis is considered to be a worthy ritual for the bulk of the profession where biological causes are favoured along with biological treatments’ (Pilgrim and Rogers, 1993: 4).

Not all psychiatrists agree. Berrios (1999: 146) advises that using the empirical research of science alone to develop a crucial test for mental illness is utopian.

Blue and Gaines’ (1992) review suggests that all psychiatric knowledge and practices could be considered cultural. Therefore they are ethnopsychiatric. If no single theory is given priority over another then biological psychiatry is just another form of “folk” theory. The biological psychiatrist’s ‘interpretations appear to be an expression of a professional “thought model”; a folk theory of “biological essentialism” as well as organicist training’ (Blue and Gaines, 1992: 400). Scientific explanations are a part of a social institution – health care – and are the preferred
current “folk theory” for the community today. Society has come to expect and desire scientific explanations and cures because social institutions, like medicine, ‘hold sway over individuals because they fabricate and mould them’ (Castoriadis, 1997: 134).

To uphold the psychiatric project of the preservation of functional normality (Fox, 1993: 147-148), psychiatry embarked, and continues, on a search to maintain psychiatrists status as doctors of medicine through grounding their profession in scientific evidence, technology and explanation. The developments in biological psychiatry, including neuroimaging and psychopharmacological treatments, have been regarded as a ‘tribute to the triumph of biological psychiatry in the late 20th century’ (Stone, 1997: 1874). For some, however, ‘psychiatry can best be understood as a profession, seeking to apply science, but best defined by values located in a human context’ (Dyer, 1988: 75).

Human society is held together by fine wires of sympathy, fairness, self-control and duty, built into us through evolution. Psychiatry has for too long put these on the back burner. And our enthralment with biology has begun to put human individuals, our one-at-a-time psychiatric patients, on the back burner (Stone, 1997: 1874).

Yet psychiatrists are still socialised to assume the central role and overall responsibility for the treatment of their patients, and to expect unchallenged leadership of mental health services and facilities (Rosen, 1998: 612). This socialisation may perpetuate ‘the capacity of medical power to be – or appear to be – positive and benign rather than oppressive’ (Jones and Porter, 1994: 11). Psychiatrists are a part of contemporary society – the postmodern – where their
notion of self has multiple identities and group affiliations, and is entangled in heterogeneous struggles with multiple possibilities for empowerment (Seidman, 1994: 136).

The interconnections of knowledge and power asserted by the postmodern perspective ‘troubles the boundaries between science, rhetoric and narrative’ (Seidman, 1994: 9). This is problematic for psychiatrists because they are caught between science, art, the story telling or the rhetoric of peoples’ lives, their desire for people to have better lives and to regain a place in “normal” society.

Defining Mental Disorder and Mental Health

Mental disorder has been variously described as irrationality, deviance, illness, madness, disorder, rule breaking, lack of normality, insanity, delinquency and myth. Foucault, in his historical theorisation of madness, *Madness and Civilization* (1967), described madness as “unreason” or behaviour involving a rejection of reason (Gutting, 1994: 52; Foucault, 1967; cited in Busfield, 1996: 69). Foucault saw madness as distinct from mental illness. However, ‘precisely what counts as unreason is socially variable, changing over time and differing between societies’ (Busfield, 1996: 232). For Foucault it was apparent that the diagnostic categories constructed ‘did not exist independently of the definitional work of those who “make up” the area’ (Foucault, 1987: 12; Hacking, 1992; cited in Kendall and Wickham, 1999: 41). Mental illness is complex, controversial and misunderstood. Any definition is influenced by who is doing the defining, and why (Wilson, 1999: 249).

Foucault (1987) describes each culture as setting its own threshold of tolerance for the existence of madmen within society by ‘dividing up social space according to the lines
of valuation and exclusion’ (Foucault, 1987: 78). In recent times in Australia, the medical perspective presented in the Australian National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, defines mental disorder to be ‘a diagnosable illness that significantly interferes with an individual’s cognitive, emotional or abilities’ (Commonwealth Department of Health and Aged Care, 2000a: 5). In this document, the term mental illness is regarded as synonymous with mental disorder. Another medical perspective, from The Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV-TR), is that mental disorders have been defined using a number of concepts that serve as useful indicators, but none is equivalent to the concept of mental disorder in all situations. These have included, distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, aetiology, and statistical deviation. Importantly the DSM IV states that its classification is of the disorder, not the people having the disorder (American Psychiatric Association, 2000: xxxi).

A sociological view sees mental illness as a reflection of ‘problems in personal adjustment or problems of living ... emanating from interpersonal processes and social arrangements’ (Gupta, 1993: 1).

Mental illness relates to a condition in which a person manifests behaviours, feeling, ideas and/or thought processes that are seemingly, and at least relatively, unusual, irrational, illogical, incoherent, unacceptable, undesirable and serious enough to cause personal anxiety, discomfort, and problems in functioning (Gupta, 1993: 3).
Mental disorder refers to a state of personal distress or discomfort, leading to impairment that threatens interpersonal relationships and individual well being (Gupta, 1993: 6).

This distinction between illness and disorder seems to be saying that illness refers to the diagnosis, a condition that could be had, whereas disorder is the having of an illness(es) and how it is manifested in the individual. Despite a history of divergence in understanding of mental disorder, the current medical and social perspectives documented appear to have in common a concern for the individuals’ ability to cope in the world. Maybe this is because ‘diagnosis in psychiatry is still mostly phenomenologically based’ and 'a diagnosis of mental illness or disorder does not say anything about a person’s capabilities, personality, or future' (Wilton, 2001: 71).

Just as the meaning of mental disorder or “unreason” is variable, so are its boundaries. This variability is related to the values attached to reason and rationality (Busfield, 1996: 73). Gender, social class, race, marital status, age, religion, morals, physical health, time, place and urbanisation have been shown to contribute to the setting of the boundaries of unreason. That is, the judgment of unreason or disorder is related to culture, is socially constructed and therefore contestable (Gupta, 1993: 46; Pilgrim and Rogers, 1993: 13; Busfield, 1996: 37). This contestability is because the ‘body becomes a product of knowledge which cannot exist independently of the practices which constantly produce it in time and space' (Turner, 1992: 61). The idea of the lived body was described by Merleau-Ponty using the term “embodiment” to explain that bodies are never merely extensions in space, but a complex interaction between all aspects of our physical, cultural and social environment and our ongoing intentionality (Turner, 1992: 43).
Mental health is often used to mean the opposite of disorder. Gupta (1993: 3) suggests that 'mental health refers to the so-called normal state of mind of a person'. It has also been suggested that it is not a psychiatric, medical or scientific concept at all, but a moral and political judgment (Mechanic, 1993: 48, 62; Ellard, 1994: 53). The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, defines mental health as:

The capacity of the individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational), and the achievement of individual and collective goals consistent with justice and the attainment and preservation of fundamental equality (Commonwealth Department of Health and Aged Care, 2000a: 5).

Consistent with the social perspective of health presented by Fox (1999), this definition describes mental health as not fundamentally a biological attribute but a capacity of individuals that has economic, political and social ramifications (Fox, 1999: 2). The individual becomes the stage for the reproduction of the crisis and disorder of political and cultural activity.

**Diagnosing Mental Illness**

From the medical perspective, the current era of psychiatric diagnosis is underpinned by, and relies heavily on, the comprehensive diagnostic criteria and classification systems first pioneered by Kraepelin in Germany in the late 1800s. 'Because of Kraepelin's emphasis on precision and objective criteria, current editions of the DSM
are considered neokraepelinian’ (Stone, 1997: 1862). The DSM is the *Diagnostic and Statistical Manual of Mental Disorders* produced in the United States. The DSM has expanded exponentially from Kraepelin’s initial diagnostic criteria into the most recent version published, which is the DSM-IV-TR (Text Revised). The World Health Organisation (WHO) produces a competing volume to the DSM’s, the *International Classification of Diseases, Classification of Mental and Behavioural Disorders*, currently at version ten (ICD-10). All these volumes present a process of diagnosis based on decision-tree-like decisions, aiming to categorise the individual’s disorder through a multitude of “if not then” responses. The wide range of behaviours covered makes it quite plausible that the majority of individuals could be classified into one psychiatric problem area or another. It appears that, gradually, the ‘psychiatric enterprise has designated even the most trivial behaviours as mental disorders’ (Gupta, 1993: 76).

These taxonomic reference manuals divide mental disorders into types based on criteria sets with defining features. The origins of the DSM system also come from the USA in the 1840s as a tool to collect statistical information on frequency of occurrence of categories of mental illness. Later, the nomenclature was developed by the US Army to include the problems experienced by World War II servicemen. Earlier versions of the DSM largely ignored the individual cultural contingencies that set the boundaries to unreason and so operated in the interest of maintaining existing social structures and continued legitimisation of the psychiatrist as our social guardian.

Both DSM-IV and ICD-10 attempt to provide a metanarrative for diagnosis of disorder and have attracted criticism from both within and without psychiatry. These criticisms relate to the problem of ascribing the disorder to the individual. The ‘DSM-IV classification system assumes all people are alike and should be functioning effectively
in most areas of their personal and social lives’ (Gupta, 1993: 76). The DSM-IV has been referred to as a partial inventory with inclusion rules for clinical categories originating from scientific and social sources. Some categories, however, owe their inclusion more to pressures from the USA pharmaceutical or medical insurance industry than to science (Berrios, 1999: 148). ‘It is an atheoretical polythetic system’ (Rodney, 1998: 773).

The DSM-IV-TR discusses its own limitations as a categorical classification system. It does not assume that each category is discrete with absolute boundaries or that individuals with the same mental disorder are alike. It also advises against its use 'in a cookbook fashion', without training and exercise of clinical judgement (American Psychiatric Association, 2000: xxxi). For forensic use it recognises that, because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis, additional information to a DSM-IV diagnosis is usually required (American Psychiatric Association, 2000: xxxiii). The DSM-IV-TR now includes a culture-specific section with descriptions of culture-bound syndromes and outlines for cultural formulation. This is to enhance cross-cultural applicability of the DSM-IV, increase the sensitivity on how culture may effect the expression of disorders and to raise awareness of the possibility of bias stemming from the clinician's own cultural background (American Psychiatric Association, 2000: xxxiv).

Despite addressing the concerns about the specificity and sensitivity of the DSM-IV-TR and ICD-10, the diagnostic criteria used by these classificatory manuals still offer hierarchical classifications that focus and operate power over the body in local and intimate ways. The power is local and intimate because its focus is on the sites of

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24 Polythetic definitions are based on the idea of family resemblance. That is, each member of a class just having some of the characters in question (Berrios, 1999: 148).
action of power. These sites are the spaces a body inhabits, the physical, social and psychological spaces (Fox, 1993: 31; Jones and Porter, 1998: 11). Additionally, these classificatory diagnostic manuals help reinforce a broader aspect of medical power that concerns the identity of the medical practitioner, in this case the psychiatrist.

It was felt that ICD-10 gave a lift of quality to clinical psychiatry, reinforcing the identity of the psychiatric discipline as belonging to the medical sciences, counteracting recent developments to place psychiatry under the administration of the social authorities (Bertelsen, 1999: 167).

It is generally agreed however that diagnosis is not a goal in itself but rather one step in the care of the mentally unwell, which may involve a variety of treatment methods.

Treatment and Control of Mental Illness

Since the seventeenth century – what Foucault (1996: 8-9) described as the beginning of an “Age of Confinement” – individuals thought to have a mental disorder were diagnosed and incarcerated. The institution serves to ‘name, regulate and control behaviour according to a legitimated discourse-specific vocabulary’ (Flax, 1993: 40). These institutions have progressively been called lunatic asylums, madhouses, mental hospitals and, more recently, clinics. The evolution of names of these institutions mirrors some of the historical changes in perceptions of mental disorder by sections of society, governments and the psychiatric profession, reflecting shifts in perceptions of mental illness from being a supernatural phenomenon to a place where individuals are less stigmatised. However, it could be questioned how much of this change in name is
symbolic, rather than resulting in actual changes in response to mental illness. A consequence of deinstitutionalisation has been homelessness in the community for the chronically mentally ill. Homelessness could be considered the most recent manifestation of incarceration.

The practice of psychiatry is based on intervention in people’s lives. All psychiatric institutions are still able to detain and treat individuals – voluntarily or involuntarily. For example, a Community Treatment Order (CTO) is authorised by legislation that allows administration of medication to outpatients living in the community who are deemed at risk to themselves, and potentially non-compliant, if left to administer their prescribed medication on their own. The medication is referred to in a CTO as a ‘legally required injection’. It is used mostly for psychotic conditions. Statutes provide for ‘reviews and appeals’, presumably by patients or carers with respect to this “need”. Dignam (1998: 890) suggests that the CTO is no ‘worse than any other psychiatric infringement of liberty’. The larger social questions here are: Who are involved in the setting of boundaries of disorder? And, when symptoms “need” treatment, how is this achieved? Who decides what constitutes an acceptable infringement of liberty?

The psychiatric enterprise both embodies and has the full weight of governmental, economic and public legitimacy ... all lend authority to, and thus gain public approval in, substantiating psychiatry’s claim to represent social reality (Luske, 1990: 113).

Modern psychiatry has a vast array of diagnostic and treatment possibilities. It also has a diverse literature giving both advice and critique on psychiatrists and the practice of psychiatry. Biological treatments are often used in combinations with the other non-biological treatments, commonly referred to as “talk therapies”.

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Combinations may include a variety of complex-acting pharmacological interventions, polypharmacy, brain scanning and magnetic field techniques. Also available is a much more refined Electro-Convulsive Therapy (ECT) procedure, which is explained as a "controlled fit". Although electricity was first used in the late 1800s, for ECT, the mechanism of action of ECT is still not understood. Szasz (1994: 166) suggests that psychiatry's eclectic collection of treatment methods is the result of psychiatrists 'not having any therapeutic methods of their own, [and they have] tended to imitate prevailing medical fashions'.

The impact and use of the "advances" provided through science is both applauded and criticised from those within and outside the profession. The degree of dissonance within the profession is mirrored within the comments of individual psychiatrists themselves.

Most observers would concur that the profession has made enormous strides in recent decades ... we have learnt more in this century than during any other period in the history of psychiatry (Bloch, 1997: 174).

Yet the advances attributed to science also incorporate elements other than the biological, namely the psychological and the social, and this model of mental illness, the biopsychosocial, has emerged ahead of others (Bloch, 1997: 174). As the name implies, it speaks of mental illness as resulting from combinations of biological, psychological and social factors. In contradiction to Bloch, McLaren suggests that in its present form, the biopsychosocial model is so seriously flawed that its continued use in psychiatry is not justified (McLaren, 1998: 86).
Most psychiatrists would agree that the development and use of drugs in psychiatry has been one of the most significant “strides” since the 1950s. Szasz (1994: 166) describes these as, perhaps, inevitable, because psychiatrists and other experts on human betterment, Inspired by the miracles of antibiotics, undertook to remedy every personal and social ill with a drug.

In debating the level of use of pharmacological agents in psychiatry, two contemporary Australian psychiatrists ‘suggest appropriate caution before general physicians embrace this “brave new world” of effective and safe pharmacological treatments for treatment of mood disorders’ (Boyce and Hickie, 1994: 627). Boyce and Hickie (1994: 630) advise that ‘a range of effective non-pharmacological strategies are just as effective and safer’. It may be that advocates for each type of therapy base their belief in that therapy on the expectation of seeing a certain type of behaviour from the patient to whom it is applied. Alternatively, psychiatrists may be choosing to treat only those patients whom they know will respond to their favoured methods. This meant that for the practitioner, ‘each therapy ran the risk of becoming a self-fulfilling prophecy’ (Viscott, 1972: 362).

Durkheim (1987) suggested in Le Suicide that behaviour, including suicide, cannot be understood fully in individualistic terms; it must be understood within the larger social context in which it occurs (Durkheim, 1987: 15-17). The question needs to be asked: Does psychiatry choose to regulate society as a whole, through a system of definitions of disorder, diagnostic processes and implementing policies of intervention, prevention and detention? Additionally, does this chosen “system” place the power of control and influence increasingly in the hands of psychiatrists, a sub-profession of the medical profession? Or, does the system place it at the level of the health care policy decision-makers? Alternatively, is psychiatry and mental
health policy not involved in regulation to control disorder, but rather the pursuit of the recognition of disorder in society? Within this interpretation of the psychiatric enterprise the overwhelming concern is for mental health and the provision of alternative understandings of order/disorder to enable individuals to cope in their times of disorder. The later possibility mobilises the boundaries of mental disorder through the recognition of the “multiple realities of unreason”. However, many scenarios may exist simultaneously. Relationships exist, in the realm of illness and health between psychiatrists, patients and policy makers that use power, knowledge and control of bodies in space and time, where no single understanding of the whole is achievable.

The psychiatric process of diagnosis of mental disorder still attributes diagnosis to the disorder. Consequently, the management of the disorder often concentrates on addressing or alleviating the biological symptoms. Less attention has been paid to addressing the social environment within which the disorder may have arisen. While psychosocial factors may be taken into consideration in the diagnosis of disorders, unfortunately, they may not be incorporated into the management of the disorder. This could be the result of a lack of incorporation of non-psychiatric services at the diagnosis stage. It could also be attributed to a lack of coordination of all services and insufficient funding at the level of ongoing patient management in a “deinstitutionalised” mental health care system.

While it is acknowledged that service provision in the community is a critical issue for policy makers, the continued imperative of “owning the mental health problem” within the confines of some professional and bureaucratic elites, limits the impact of any policy reform (Plant, 1997: 75).
This “bio-politics”, which is concerned with the regulation of the spaces that are the body, is a part of the discourse of psychiatry and mental health policy in Australia today.

The Changing Discourse of Psychiatry in Australia Today

The above review of the development of modern psychiatry, its definitions of mental health and illness, and its use of diagnostic and treatment options, situates the current theory and practice (or the discourse of psychiatry) within the historical and social context of Australia today.

For Foucault, to speak of discourse means locating the conditions of possibility for knowledge, and enabling the reconstruction of the material conditions of thought and knowledge (Kendall and Wickham, 1999: 35-37). Discourse is a fluid network of statements with rules for production, limits on space and the creation of new spaces. Discourses are productive in a material and discursive sense, that is, in the practices they produce. They are dynamic and interdependent with other discursive complexes and, through the operation of rules, they both delimit the sayable while providing space for the unsaid, the innovative and the new (Linstead, 1993: 63; Mills, 1997: 6-7; Jose, 1998: 19, 77; Kendall and Wickham, 1999: 40-41). Also, the developments in the discourse of psychiatry in the twentieth century demonstrate that ‘it is central to the concept of discourse that it is reproduced, can be resisted and is subject to change’ (Linstead, 1993: 64).

Some of the conditions of possibility, the material conditions resulting in a discourse of psychiatry that led to the deinstitutionalisation of psychiatric patients during the second half of the twentieth century, are:
• The introduction of an expanded range of effective pharmacotherapies;

• The rise of evidence-based-medicine;

• The expense of maintaining independent psychiatric hospitals and asylums;

• The changes in social and cultural attitudes towards mental illness and individuals diagnosed with mental illness.

Some of the key conditions of possibility that are producing the discourse of psychiatry for the twenty-first century given below were identified by Adler and Mathieson (1998: 296-301).

• The rise of the well informed patient and information or misinformation gained from the internet;

• Economic imperatives leading to the reduction of government provision of mental health services;

• Emphasis on best practice and development of practice guidelines to facilitate routine care;

• Implementation of managed care and case management by mental health care teams;

• A movement for the provision of mental health services by primary care physicians;
• The continuing education and social awareness about mental illness;

• A mental health policy that expresses a commitment to empower the users of mental health services;

• Inclusion of consumers and carers in service planning;

• Education campaigns aimed at reducing the levels of patient associated stigmatisation and mythologising;

• Continuing expansion of the pharmacotherapy options available;

• The increasing popularity of alternative and complementary medicines;

• Funders of mental health services asking whether psychiatrists are really necessary for certain services;

• Growing debate within the psychiatric profession over the boundaries of psychiatry in terms of clinical scope and role of psychiatrists.

How are psychiatrists in Australia responding to these conditions?

The continuing emergence of the discourse of psychiatry shows a psychiatry of modernism, of definition, diagnosis, rationalisation towards biological causes, use of pharmacological therapies and implementing an economic rationalist policy based on surveillance and intervention to regulate and control perceived abnormality.
However, it also is a postmodern psychiatry. Psychiatry is concerned with the criticisms that psychiatrists in the past have had unchecked power and control over individuals. Psychiatry is concerned with de-mythologising madness and the image of the psychiatrist. There are supporters for any range of concomitant psychological therapies and an acknowledgment of the fallibility of any system of definition, diagnosis and control. Psychiatrists’ role within psychiatry ‘is both part of the ideological and coercive mechanisms of industrial society and at the same time are committed to the resolution of the very tensions and strains which that society and its institutions produce’ (Penfold and Walker 1984; cited in Busfield, 1996: 1).

In the postmodern, psychiatrists also recognise that there is a reality of structures, interests and power beyond the multiplicity of “voices” to which they must attend (Busfield 1996: 60). How the Australian government proposed to deal with the multiplicity of voices was to construct a National Action Plan for Promotion, Prevention and Early Intervention for Mental Health. How this policy has been implemented and how it is changing the face of psychiatric practice is the topic of the next chapter, People, Policy and Purpose.
CHAPTER FOUR
MENTAL HEALTH IN AUSTRALIA

People, Policy and Purpose

And so we arrive at the present scene, drugs and deinstitutionalisation. Once again politicians and psychiatrists clamour for mental health reforms (Szasz, 1994: 196).

Surveys, Surveillance and the Burden of Disease

In contemporary Western society the increase in life expectancy and shift in disease burden, from life threatening infectious disease to chronic conditions, has led to the rise of surveillance of populations for incidence of health and disease states. This has meant a change in emphasis from intervention for cure, to the need for long-term care. This is reflected in a decline in peoples’ faith in western medical knowledge and shifts in health policy that has taken responsibility for health away from traditional western medicine and institutions, and directed it toward administrators and their collaborators (Petersen, 1994: 14; Nettleton, 1995: 11, Hancock, 1999: 15). However, public policy remains tied to the idea of the expert, knowledge-led progress and to the whole gamut of assumptions inherited from the Enlightenment (Hillyard and Watson, 1996: 324-325; cited in Gibbins, 1998: 35).
Spicer (1998: 4) describes an assumption inherited from Enlightenment as faith in the powers of reason, which produce a rationalist worldview.

Those who tend to be optimistic about the ability of men and women to work cooperatively through government for common purposes or ends also tend to be optimistic about the ability of science and experts to provide guidance in this regard (Spicer, 1998: 38).

The Enlightenment dream is that fulfilment, well-being and security can be attained in this life through the rational, scientifically-based organisation of society (Falzon, 1998: 60). Currently, in western societies, public health reforms have meant the development of science-based policies that provide benchmarks by which individuals are monitored, classified and measured. Whiteford, writing about mental health policy, cites the following definition of public policy:

Public policy is deciding at any time and place what objectives and substantive measures should be chosen in order to deal with a particular problem, issue or innovation (Dimock, Dimock and Fox, 1983; cited in Whiteford, 2001: 428).

Critical to this modernist view of the public policy process are steps to identify the problem, develop policy options and adopt an option (which is a political decision), then implement and evaluate. Increasingly seen as valuable are the results of “scientific” survey and epidemiological research. Proponents of the value of survey results, in informing policy objectives, believe ‘it can determine whether the issue matters’ (Whiteford, 2001: 430). This has meant that, like physical disorders, the incidence and effects of mental disorder are measured in physical and economic
terms. People unable to work create a social productivity burden described as “disability-adjusted life-years lost” (DALYS) or “out of role” days. A survey by the Australian government found that ‘people with mental illness were three times more likely to be “out of role”, that is, unable to undertake normal activity including going to work’ (Commonwealth Department of Health and Family Services, 1998: 1).

The use of these economic measures raises the question: productive for whom and in whose judgment? These are questions about ‘how the normal (and abnormal) person is signified in a given society and how these significations relate to the broader values of the society’ (Barrett, 1998a: 618). The answers seem to lie with those who identify and treat mental illness, those who design, promote and profit from treatment interventions to restore “normality”, and those interested in surveillance of mental health and illness and the social and economic burden of disease. These are respectively: the psychiatrists and mental health care teams; the pharmaceutical industry and other therapeutic enterprises; and governments and policy makers. This chapter is concerned with government legislation and the implementation of mental health policy that contributes to a politics that concerns the administration of life – a biopolitics (Dean 1999: 99).

Dean describes biopolitics as ‘a form of politics, conducted largely since the eighteenth century, concerned with the administration of the conditions of life of the population’, with interventions made into health, education and urban environment (Dean, 1999: 209). For Foucault (1996), Turner (1992) and Fox (1993), bio-politics is concerned with the regulation and the control of the space that is the body. Petersen and Lupton (1996: 11) describe the set of discourses focusing on bodies and the regulation of how

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25 The DALY measure was developed within an economic rationalist framework, but it does acknowledge the social and economic costs of disability (Eckerman, 1999: 243).
those bodies interact within time and space, not as biopolitics, but as the “new public health”.

Our major political preoccupations are how to regulate the space between bodies and to monitor the interfaces between bodies, societies and cultures (Turner, 1992: 12).

The need to monitor these interfaces has led to a rise in popularity and use of the survey to obtain information on people, what they do, how and why. The survey is considered a reflective activity and has come to assume a central role in the ‘establishment and operation of forms of social and political regulation’ (Falzon, 1998: 66). As previously referred to in Chapter Two, Spicer (1997) describes the operation of such regulation as a purposive association in government.

The substantive ends sought by a purposive association consist in some tangible and specific outcomes or states of affairs (Spicer, 1997: 91).

The role of government is to identify these specific outcomes, or common ends, for the community and to manage the actions of various individuals and resource towards the attainment of those ends (Spicer, 1997: 91). Government officials’ vision for mental health as a purposive association suggests a therapeutic state. It is a vision of a hospital with patients to be cured. However, the interviewees reveal in Chapter Six that this vision is not defensible in the light of the postmodern conditions of deinstitutionalisation and financial constraint that characterise mental health service provision in Australia today.
The setting of, and progress towards health policy outcomes by government, also depends upon the enumeration and surveillance of the public through epidemiological methods. These methods of measuring risk have been developed to explain associations between health outcomes and the perceived predisposing risk factors. Some contemporary risk factors regarded as leading to poorer health outcomes are: smoking, poor diet, lack of exercise, environmental pollutions and excessive alcohol consumption. The health policies formulated from epidemiological research to ascertain levels of risk factors in the populations incorporate national goals and objectives. Examples of goals and objectives are: to increase the amount of exercise of school children at school, to three hours a week. Or, raise taxes on tobacco, and ban cigarette advertising at sporting events. The policies also incorporate measurements of these objectives to achieve desired “outcomes”, such as, reduction in childhood obesity by x% by the year 2010, or, reduction in smoking related cardiovascular disease by y% by the year 2020.

The use of the survey in the area of health has resulted in the perpetuation of ‘rational processes of standardisation, regulation and control’ that operate in a somatic society (Turner, 1992: 10). Through the use of such rational, standardised, controlling processes, achieving health policy goals becomes akin to that of achieving safer driving and fewer road fatalities, as regulated by the police. This has enabled health policy promoters to forge collaborative alliances, like community self-help groups, to implement the policy goals and targets, while not being seen to be directly intervening or coercing the community. Dean (1999: 71) sees the forging of these alliances as the formation of subjectivities through which government can work. Importantly, many of the reforms sought through policy implementation require voluntary conformity by individuals to the policy norms and goals set.
Integral to the policy process are the expert assessments in the identification of risk factors and the development of predictive risk profiles through the data gathered in health assessment and promotion surveys. However, Castel believes that with the advent of the survey to assess risk factors, the need for expert opinion is reduced. The survey data produced is now under the control of administrators to formulate their policy objectives, rather than practitioners to deliver individual health goals (Castel, 1991: 293; cited in Petersen and Lupton, 1996: 22). At the formulation stage of mental health policy, some psychiatrists have questioned the level of consultation extended to them, and, therefore, the adequate representation of the psychiatrists’ perspective. Plant (1998: 76) suggests that consultation is limited to Ministerially appointed advisory groups, who are limited to working to a government agenda.

For the Australian National Mental Health Strategy 2000 Monograph, Promotion, Prevention and Early Intervention, surveillance means continual watchfulness, systematic collection, consolidation, and evaluation of relevant data, with dissemination to those who need to know (Commonwealth Department of Health and Aged Care, 2000b: 133). There is a view, however, regarding the rise of the increased use of survey, which results in discourses on prevention and health promotion, as a new form of surveillance, with its use perpetuating pre-existing medical categories (Fox, 1993: 30). Simpson (1995: 37) suggests that ‘through that which is surveyable reality would be secured, and experience would be predictable and retrodictable’.

For one psychiatrist, Dr Ellard, the outcome of such surveillance, is:

Pages of statistical analysis of the answers given to a series of leading questions, assembled into a questionnaire (Ellard, 1998a: 746).
The emphasis on surveillance as a means to gauge the need for and monitor the performance of Australia’s current mental health strategy derives partly from the World Health Organisation (WHO) and World Bank 1996 report, *The Global Burden of Disease*. This report estimated that, by the year 2020, depression will be:

The number two cause of disability-adjusted life-years lost, with mental disorders a major and rising cause of disease burden, in both the developing and developed world (Whiteford, 1998: 432).

The 2020 prediction is based on data from 1990, published in 1996. The extrapolation from 1990 to 2020 cannot be considered without reference to the bio-political objectives, including the ways of observing, measuring and naming disorders.

In the nineteenth century, social ‘degeneration was used to explain the apparent increase in the rates of mental illness and their incurability’ (Barrett, 1998a: 619). Today, the prediction and explanation for an increasing rate of mental illness appear to be born out of economic fears for declining social progress and productivity. History can provide us with examples of progress and uniformity, informing the way we think about the idealised person. What is new is the extent to which this idealised person and their social space has become ‘invested with the values of progress and productivity’ (Barrett, 1998b: 632).

Some psychiatrists, pharmaceutical companies and mental health policy strategists in Australia, seem to have appropriated the content of the WHO prediction as a universal given and a threat to human productivity. They warn that unless the trend for increased levels of depression in society is reversed, the increase in the proportion of
burden of disease from mental health will increase significantly, as suggested in the following quote from the Australian Department of Health:

Importantly, predictions suggest that by 2020 the disease burden of mental health conditions may increase to almost 15 per cent [of the total burden of all diseases combined] (Commonwealth Department of Health and Aged Care, 2000b: 4).

This assertion, of such a high disease burden, has been used as the platform to formulate mental health care policy. But it may also have provided a possibly inflated and unprovable referent for any activity or progress made in the field of community “mental health”.

In 1970, it was considered that psychiatry was ‘now where internal medicine was maybe thirty years ago. It’s new, it’s developing, and it’s going to offer a real opportunity’ (Rogow, 1970: 91). In 2003, the supremacy associated with the increased efficacy of procedures for screening, detection and treatment in internal or physical medicine, continue to elude psychiatry and the treatment of mental disorders. The successes in physical medicine imply that psychiatry and mental health remain “left behind” and have yet to “catch up” to physical medicine. An outcome has been to recommend the adoption of a “successful” strategy used in physical medicine, surveillance, promotion and early intervention for prevention. It is hoped that this will result in an increase in the mental health of society, thereby averting the WHO predictions for 2020.
Deinstitutionalisation and Mainstreaming

Australia's first five-year National Mental Health Strategy was developed in 1992, evaluated in 1998, and then renewed as the second five-year strategy in 1998. Fortuitously, the 1997 post-hoc questions, about the state of mental health and use of mental health care services in the Australian population, posed in the Australian Bureau of Statistics (ABS) survey, Mental Health and Wellbeing: Profile of Adults, Australia, produced a report that ‘confirms a theme stressed under many of the National Mental Health Strategy’s 1992 communication activities’. One would have expected a survey about mental health to be conducted prior to formulation of a national mental health strategy. Nevertheless, the results of the ABS survey also ‘supported the general thrust of the current national focus’ (cited in Commonwealth Department of Health and Family Services, 1998: 1-2). However, one psychiatrist notes that the ABS survey figures lead one to:

Suspect that potential patients who don't feel a need for treatment, and who are not requesting it, are being counted in figures for unmet need (Grant, 1998: 256).

Grant is also sceptical of the use of the ABS figures to support existing policy objectives. In reviewing the ABS discussion of the survey figures, Grant (1998: 256) comments that there appears to be the suggestion by the ABS that:

All of the people who might qualify for a diagnosis in a survey should be treated whether they want to be or not.

Yet, two other psychiatrists, Singh and McGorry, are supportive of the use of the ABS figures representing the state of mental health in Australia to legitimate reform of
mental health service provision, under the current policy. Singh and McGorry (1998: 437) concluded that, ‘Australia and the Australian public have benefited from a consistently political bipartisan approach to mental health reform’. The joint objectives of the first five-year policy were “mainstreaming” of patients into the general health care system and the acceptance of this “integration” of care by the community. The second five-year strategy implemented from 1998 was to continue “mainstreaming” and “integration”, with additional attention on prevention, early intervention, and “value for money” outcome measures. It also targeted “at-risk” groups and focused on depression (Singh and McGorry, 1998: 435; Whiteford, 1998: 432).

Mainstreaming and integration are the current words used to describe what is essentially a continuation of the deinstitutionalisation of patients out of asylums. Deinstitutionalisation is a process that started with the pharmacological revolution in mental health in the 1950s and 1960s.

Deinstitutionalisation is essentially a policy designed to reorganise mental health resources away from institutions and into the community (Wilson, 1999: 253).

There are numerous arguments for and against deinstitutionalisation; a major problem has been one of sufficient reallocation of funding within the community to fulfil its allocated responsibility.  

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26 Concerns have been expressed about the existence of adequate funding to support care in the community. In particular the issues of family support, security risks, need for acute and full time care, and the real cost not being less expensive than alternatives, have been raised. Arguments in favour of community care focus on the opportunity to provide as normal a life as possible, with decreased dependency, isolation and potential for institutional abuse and domination by coercive medical practice (Wilson, 1999: 254-256).
The stated benefits of mainstreaming and integration focus on the reduction of stigma associated with the historical isolation of those with mental illness. Whether it is called deinstitutionalisation or mainstreaming, achieving some form of community integration and care of the mentally ill ‘has a long history and has been one of psychiatry’s elusive ideals’ (Wilson, 1999: 255). Implementation of the mainstreaming and integration policy decision has advocated the team approach to the delivery of mental health services. Psychiatrists see the team approach as contributing to a loss of their medical autonomy. Psychiatrists consider this to be essentially a deskilling through substitution of their services by community workers or general practitioners, and as an attempt to control the number and types of services psychiatrists provide (Elston, 1991; cited in Wilson, 1999: 259).

Words like “integration” and “mainstreaming” in government policy suggest a unified continuum of care that will be provided by the state. Rather, these social policy objectives advocate the consumerised and fragmented provision of mental health care. It is a mental health care provision that perpetuates social division and social exclusion through definition and identification of “at-risk” populations, which is magnified by consumerised care. This type of social policy has emerged in response to the disorienting effects of globalisation, new technologies and the ascendency of the new right (Carter, 1998: 1-5). All health services in Australasia have ‘been effectively rationed’ in recent years and the provision of mental health care services is for those who cannot be provided for elsewhere, that is, ‘from another cost centre’ (Wright, 1998: 764). “Consumers” are encouraged to seek help from departments dealing with other aspects of community welfare such as housing and employment.
Policies Promoting Prevention and Intervention

Policy can be considered as text and discourse. The text in policy documents focuses on the process; it is constructed, evolving and open to diverse interpretation. The discourse is what can be said and thought, and who can speak, where and when, and with what authority (Hancock, 1999: 24). Policy as text and discourse has no effect without implementation. How policies come to be written is contextual and based on a series of choices about inclusion and exclusion that revolve around perceived hypotheses and outcomes. Importantly, policy implementation is not a matter of choice. How policy is implemented is.

The second five-year plan of Australia’s National Mental Health Strategy embarked upon and implemented in 1998, advocates public awareness campaigns in mental health and increased general practitioner education and training in the recognition of mental illness. The aim is to facilitate early intervention strategies that could involve counselling, social intervention, behaviour therapies, psychotherapy and psychopharmacology. This is directing the focus of mental health care away from the psychiatrist, where possible. The rationale given for early intervention by general practitioners is that the recognition of symptoms and provision of diagnosis, as soon as possible, will help reinstate a normal individual back into society as quickly as possible. The reinstatement of the individual back into society will enable the resumption of productive social roles, minimise the loss of production and cost burden to the health and social welfare system. It is assumed that this will also lead to a speedier improvement in the said individual’s quality of life.

An additional justification behind this push for treatment by general practitioners is that diagnosis and early intervention will minimise the need for referral to a psychiatrist and will lead to a better long-term prognosis and prevention of chronic
disorder. Again, this will reduce the burden on psychiatric clinics, with respect to the
cost of hospitalisation and treatment by psychiatrists who, as a result, will
increasingly see only the chronically ill who require long-term support. Such policies
promoting early intervention and prevention are the result of combinations of
surveys, surveillance, expert advice, statistical calculations, and risk profiling
The predictions of the WHO, that depression will be the number two cause of
disability-adjusted life-years lost and the response of the government to produce this
policy of early intervention, suggests that the government considers mental illness, in
particular depression, to be a major potential social problem in need of management.
Yet methods of intervention in social problems could be considered a form of
management and control of society's human resources (Jamrozik and Nocella, 1998:
204). It is recognised that the very classification of what is and what is not mental
illness involves political decision-making (Spitzer, 1991; cited in Wilson, 1999: 248).

Social problems 'arise out the structural and cultural arrangements in society that
cause social and economic malfunctioning of those arrangements', according to
Jamrozik and Nocella's (1998: 199) theory of residualist conversion. These types of
problems are perceived to be a threat to the established order and power structures.
The dominant social power structures enable problems perceived in the social
sphere to become the residue of personal problems experienced by negatively
affected populations. Interventionist policies, determined by the dominant coalitions
and implemented through the helping professions, are aimed at these identified
populations to control the problem. In turn, the compliance of these populations
legitimates the power structures, their policies and the role of the helping profession
in the management of social problems.
For the social problem of depression, in particular, the *National Mental Health Strategy* aims to provide the prescription of a personal, tailor-made, early intervention package (a product of “evidence-based” medicine), with the measurable outcome of being able to place the individual back in the community to assume a productive role as quickly as possible. Yet, ‘evidence-based medicine presumes that diagnoses are correctly made and that applicable treatments are delivered’ (Walter, Kirkby and Marks, 1998: 253). The history of psychiatry, discussed in the previous chapter, reveals that consensus over diagnosis and treatment has been problematic for the profession and remains so today.

The history of fragmentation of knowledge and conflict over definition, diagnosis and control of mental illness by psychiatry is a difficulty for mental health care policy design and implementation. This conflict and debate has become a part of the discourse of psychiatry; a discourse of difference, what psychiatry is, through reference to what it is not; what psychiatry does, through reference to what it does not do. Psychiatrists are the script-writers (in more ways than one); producers and directors of the psychiatric performance, enabling them to hide in their own level of theoretical discomfort over cause, effect and cure. Psychiatrists’ admissions of the conflicts, and the fragmentary nature of psychiatric “knowledge” appear to have hindered many of their voices being heard in formulating a public policy for mental health with meaningful and realistic outcomes as evidenced by the following government statement.

Most risk and protective factors for mental health lie outside the domain of mental health and health services (Commonwealth Department of Health and Aged Care, 2000b: 9).
An implication for mental health care has been the establishment of paradigms of management based on disorders seen within demographic community groups — "the population health approach". This approach is used in the *National Mental Health Strategy* and derives from the second five-year plan. Emerging from this strategy and the demographic divisions of the community is the *National Action Plan 2000*, which 'provides the policy framework for prevention and early intervention for mental health 2000' (Commonwealth Department of Health and Aged Care, 2000b: ix). This, in turn, is linked to all funding allocation decisions. The population health approach divides the community into seven differentiated age groups, and into priority populations.\(^{27}\)

For some, the emphasis on groups is misplaced, as the population is made up of individuals and 'health status is the most individual of all private possessions: always attaching to a single patient, never the property of a collectivity or a group' (Reisman, 1993: 5). One of the consequences of the use of epidemiological survey data in setting policy objectives is that this private possession — our health status — is now the subject of public scrutiny. This endorsed policy must enable individuals to resume productive social roles and improve individual quality of life, while also minimising the loss of production and cost burden to the collective health and social welfare system. It could be questioned how this policy aimed at intervention in peoples' lives, especially the involuntary return to the community for previously institutionalised individuals, is different from the involuntary admissions to the asylums of the past. Without an adequate redirection of resources, community-based care quickly becomes community-based neglect (Wilson, 1999: 264). The degree of agency for the individual transitioning the boundaries of "normal" to "not normal", and back again, may be no greater under this policy, than it has been historically.

\(^{27}\) Age groups are Infants 0-2, Toddlers 2-4, Children 5-11, Young people 12-17, Young Adults 18-25, then Adults and older adults. Priority populations are defined as: individuals, families and communities experiencing adverse life events; rural and remote communities; aboriginal
As in other countries, the cost of health care is of concern to the Australian government. The conflict between the population versus individual health approach surfaces when the cost of healthcare perspective dominates the analysis of mental health policy. Left-wing public policies 'are often considered to be associated with the realisation of the values of social justice, equity or citizenship rights. In contrast, right-wing views are associated with the securing of personal freedom, national efficiency and military strength' (Dean, 1999: 34). For the right, in situations where 'rising costs require containment ... private agencies can do much of the work' (Reisman, 1993: 248). The current Mental Health Policy is a policy of the right as evidenced by the adoption of the trend to promote the necessity of private health care insurance and to provide a "USA style" managed care service (Wilson, 1999: 259-260).

Australian public health care regimes are now dominated by the imperatives of economic rationalism: to outsource services; cut staff; reduce running costs and waiting lists. A diagnosis must be made to be able to give a numerical "code" to the individual's disorder and so assign a remuneration amount for the cost of care. The categorisation of the individual, the space and time that is their disorder, determines their cost-based management. It also involves the restructuring and implementation of multiple levels of fee schedules and reimbursements, together with a redesigning of the composition and roles for members of mental health care teams. The private sector is increasingly a substitute for the state. The government's rationale is based on dollar cost of patient care and profit margin expectations of privately-funded clinics. The rhetoric is 'strong on the individual and the firm, but weak on the integrated matrix and the organic community' (Reisman, 1993: 248). The current mental health care

peoples; and people from diverse cultural and linguistic backgrounds (Commonwealth Department of Health and Aged Care, 2000: 114).
policy does not place successful health care management within the long-term health gain objectives of a community, or population, into which the individual has to fit.

Achieving community well-being and mental health is the stated priority for Australian mental health policy. Through promotional programs about the existence of mental illness, it is forecast that the idealised concept for early recognition, timely treatment and therefore “mass” prevention of mental illness will be realised and sustained. It would be a mistake to disguise the conflicts that exist concerning mental health and disorder within the guise of a unifying policy for community mental health. Many in the community, including psychiatrists, are not convinced by political rhetoric and promise to deliver mental health under the existing policy. The community is not ‘totally unaware of how pathetic are the alternatives being presented by politicians and by people posing as thinkers’ (Curtis, 1997: xxx).

The National Mental Health Strategy is operating, on the one hand, under increasingly individualised privatised health care arrangements, whilst, on the other, it espouses the value of a population health approach. How are the psychiatrists, general practitioners and mental health care workers responding to this conflicting situation? How are psychiatrists treating the individual with mental illness now?

Mental health care policy provides an exemplary area to consider from a postmodern perspective. The postmodern view alerts one to the problematic quest of eliminating the uncertainty and ambivalence that is common to modern projects (Jun and Rivera, 1997: 138) – such as policy making for the mentally ill. Like the postmodernism Fox describes, mental health is ‘by its very nature, impossible to delimit and define’. In caring for mental health, ‘there clearly is an attraction in a fairly eclectic approach’ (Fox, 1993: 70). This places mental health care workers, including psychiatrists, in a position
to espouse the ‘values of fragmentation, openness and multivocality’ (Fox, 1993: 70). Psychiatrists have the potential to be postmodern medical practitioners. Rather than continue with the disguise of offering normality, with the promise of a resumption of control over one’s life, psychiatrists could acknowledge that, at best, mental health care policy and their role in it, are involved in narratives of how life might best be understood.

The current public policy perpetuates a “pretense” of mental health within a virtual reality of population normality, together with the promise of a resumption of control over one’s individual life through participation in early intervention and prevention programs. But ’individuals often fail to conduct themselves according to the goals of public health’ (Peterson and Lupton, 1996: 179). ‘Intervention methods … are influenced, if not determined, by ideological, political, financial and cultural constraints’ (Jamozik and Nocella, 1998: 41).

I therefore express reservations that the current policy, based on appropriations from models of physical disorders, survey statistics, thirty year predictions and health trends in other countries, using terminology premised on culture-bound, economic rationalist judgements, is unlikely to provide the hoped-for outcomes in community mental health. As expressed by Peterson and Lupton (1996: 179), ‘public interventions are liable to produce outcomes at variance with what the experts may have intended’. It is the postmodernist openness to the “other” – such as those with mental illness – the preference for diversity, the opposition to metanarratives and an opposition to the established order (Farmer, 1998a: 6) that has encouraged the use of this perspective in the context of this research, which encouraged the methodological choices explained in the following chapter.
CHAPTER FIVE
METHODOLOGY AND METHODS

Interview and Interpretation in the Postmodern

As far as research methods are concerned, their merits and shortcomings can be reasonably judged solely in light of the volume and competence of the information they lead to (Bauman, 1976; cited in Beilharz, 2001: 45).

The Methodological Debate

The social research literature presents many methodological options, with advice and justifications for choices that could be made. As Bauman, cited above suggests, consideration of value and suitability of any particular method is best based on the assessment of the outcomes of the research. The choices of method are responses to the questions of why, what and how best to conduct research. These questions are seen as pivotal to the research process and a starting point to begin to provide any understanding of individuals and social structures. The reality of the research experience, though, is that the answers to these questions may not always precede the research act, but grow with and out of the experience (Johnson, 1998: 11).
The methodological literature debates many issues at length. Two debates of interest and relevance to this research emerge from the historical evolution and place of methodologies in the many fields of study, conducted by people about people and things. The first issue concerns the reciprocal influences between research theory and methods. Related, is the relationship of methods and theory to research activity, and the information generated through the process (Denzin, 1989: 1-5; Bourdieu and Wacquant, 1992: 224-229; Sarantakos, 1993: 8-9; May 1993: 20-23). The debate about this could be summarised by two notions:

Theory cannot be judged independently of research activity [and] research methods are of little use until they are seen in the light of theoretical perspectives (Denzin, 1989: 1).

Theory's use is also in the interpretation and understanding of the phenomenon being experienced or researched (Denzin, 1989: 38). The choice of specific theories and concepts is critical to the depth, uniqueness and generalisability of the story (Goodwin and Horowitz, 2002: 43). In this research, the choice of a theoretical perspective – the postmodern – preceded and therefore influenced the methodological choices made. For this research, the "empirical" technical choices made cannot be disentangled from the "theoretical" choices (Bourdieu and Wacquant, 1992: 225). It is also acknowledged that the choice of methods to be used was based upon the researcher's own value judgements (May, 1993: 37).

The second major issue that is debated is the use, validity, value and "truths" produced by qualitative versus quantitative research methods. The methodological angst generated by this concern for truth has long been a part of qualitative research (Charmaz, 2002: 321). The concern is summarised by the statement:
Two major research approaches, quantitative and qualitative, were identified as a result of the nineteenth-century debates about the source of truth (Grbitch, 1999: 15).

The conflict and multiplicity of perspectives presented in this ongoing debate suggests a lack of confidence by researchers in choosing a social research method (McCracken, 1988: 11). Qualitative research has been accused of lacking methodological rigour and, as such, truly reliable or generalisable findings are considered a problem (Goodwin and Horowitz, 2002: 33). These criticisms are not necessarily relevant in a qualitative postmodern research paradigm because truth and reliability are subjective assessments. Postmodernism's rejection of metanarratives, critique of society's fundamental assumptions, acceptance of multifaceted truths and multiple perspectives, emphasises researching the world from the perspective of the interacting individual (Lincoln and Denzin, 1994: 575; Scheurich, 1997: 2; Grbich, 1999: 50). The choice of method should be 'in support of the ultimate objective of finding explanations for social behaviour in the real world' (Millen, 1994: 137).

It is acknowledged that the concerns of the quantitative versus qualitative debate 'have led to different ways of utilising both approaches in an attempt to gain the advantages of combining both forms of data collection' (Grbich, 1999: 17). For critical theorists, the distinction between quantitative and qualitative methods is seen as a false dichotomy as the distinction focuses on techniques of research and analysis and not the process of representing social reality (Morrow and Brown, 1994: 207). Morrill and Fine suggest that most qualitative studies are more about what people actually say and do in a social and temporal context, than focusing on

Some researchers regard social research today as pursuing renewed methodologies. The motivation behind the development of renewed methodologies comes from living in the complex, fragmented, pluralist societies of postmodern times (O’Neill, 2002: 74). Renewed methodologies deal with the contradictions of oppression and the complexity of current lived relations within the context of what some see as ‘the permanent crisis of the totally administered society’ (Piccone 1993: 3; cited in O’Neill, 2002: 76). This has encouraged hybrid theorising and reflexivity to better understand contemporary culture and society as a process of meaning-making with power relations setting the boundaries to these processes (O’Neill, 2002: 74). For the reflexive social researcher Bourdieu, defining the object is the crucial research operation (Bourdieu and Wacquant, 1992: 224, 227). Once defined, the most relevant and practically usable techniques can be chosen, qualitative, quantitative or mixed.

The object of this research is the practising psychiatrist. In conducting this qualitative study, my concern was to generate information that would address the research challenges set out in Chapter One. The methods used were solely qualitative and focused on the psychiatrists’ telling of their stories. Interpretation of psychiatrists’ stories placed them in the broader context of mental health policy.

As a reminder, the research challenges identified in the introduction in Chapter One were:
1. To listen, question, document, interpret and present the experiences shared, and issues raised in conversation and interview with practising psychiatrists.

2. To consider the relationship between motivation, rationale, medicine in psychiatry and the identity of psychiatrists. This is through presenting an interpretation of their stories and experiences about the meaning and consequence of what psychiatrists do.

3. To place the research interpretations within the context of the current mental health policy in Australia. To ask the question: Is there, or can there be, a postmodern psychiatry?

To meet the above research challenges, the research method focused on talking with psychiatrists and presenting an interpretation of what they said as the best way to understand psychiatrists as individuals, and their social structures. The information generated in trying to meet the research challenges, would contribute to existing knowledge about psychiatry and psychiatrists. The following section explains why the interview method chosen was considered the most appropriate to answer the research questions.

A Postmodern Methodological Perspective

The implications of a postmodern perspective for methodology were introduced at the end of Chapter Two. This section expands on those implications. I discuss the reasons why interview was chosen as method, and what might constitute a "postmodern interview". This is followed by a discussion of the rationale for the interpretation of the interview material that was consistent with a postmodern perspective. Intrinsic to these discussions and addressed in the following sections in
this chapter are considerations of the issues of sampling as well as reliability and validity of the research material produced.

**Postmodernism and the Interview**

The literature discusses the range of interview types placed along a continuum, from structured or formal, to unstructured or informal. Further distinctions have been made between interviews that are combined with participant observation, ethonography or life history. Modes of interview have also been further categorised as in-depth, creative, gendered, recursive, long, serial or ones influenced by postmodern tendencies (Denzin, 1989: 102-120; Minichiello, 1990: 88-103; Fontana and Frey, 1994: 361-367).

Because of the diversity of types and uses of interview as a method, the concept and definitions of the interview presented in the literature do not always have the same emphasis. Most agree it is a form of conversation. However, for some, being face to face is just as important as the purposefulness, getting information, or the interviewer being in control (Denzin, 1989: 119; Shipley and Wood, 1996: 1-7). The emphasis I prefer is interview as a form of conversation that creates knowledge or generates a mode of knowing. This ‘emphasis on conversation as a mode of knowing is particularly strong within postmodern and hermeneutical philosophy’ (Kvale, 1996: 37).

However, the research interview, as distinct from a casual conversation, is ‘characterised by methodological awareness of question forms, a focus on the dynamics of interaction between interviewer and interviewee, and a critical attention to what is said’ (Kvale, 1996: 19-20). The influence of postmodernism is to give
increased attention to the context of the interview in time and space, the intentions and desires of participants, the voice of the respondent, the relationship with the interviewer and a concern for membership, language and understanding (Fontana and Frey, 1994: 363; Kvale, 1996: 36; Scheurich, 1997: 62). Kvale summarises the postmodern approach to interview as one that:

Focuses on interrelations in an interview, on the social construction of reality in an interview, on its linguistic and interactional aspects, including the differences between oral discourse and written text, and emphasizes the narratives constructed by the interview (Kvale, 1996: 38).

This research is not about seeking objective truths but, rather, to gain an understanding and present an interpretation of how psychiatrists see their role within the institution of psychiatry and within society though emphasising the narrative, or story constructed from interview. This understanding is inseparable from how the knowledge was gained and why – the interrelations in an interview. The interrelations and narratives constructed from the spoken word in the form of interviews – dubbed oral history by historians – ideally ‘provides information that advances the understanding of the subject being examined’ (Webster, 1996: 188). The psychiatrists approached could talk, or not talk, to me as any person(s), and with any voice they chose. The nature of the knowledge gained was constructed through a combination of the conversational, narrative, linguistic, contextual and interrelational features of the interview material and experience and the interpretation of them (Kvale, 1996: 42-44).
Passages of questions and answers are features of interview dialogue. However, there are no “correct” questions or answers, just questions and responses that will enable stories to be told. Then, one has to resolve how best to interpret and represent psychiatrists’ voices together with the filter of one’s own voice, and then construct the interpretation as text. ‘Voice is a struggle to figure out how to present the author’s self while simultaneously writing the respondents’ account and representing their selves’ (Hertz, 1997: xi).

*Interviews, Interpretation and Story Telling*

The holistic-content analysis of field texts (eg transcripts, documents and observation field notes) includes more than description and thematic developments, as found in many qualitative studies. It involves a complex set of analysis steps based on the central feature of “restorying” a story from the original raw data (Ollershaw and Creswell, 2002: 330).

The debate in the literature over methodological approaches and methods used in qualitative research continues with the question of how best to “analyse” qualitative data. Much of the advice on this topic reported in the literature is highly prescriptive and suggests that, “magically”, through analysis meaning can be found. ‘The aim of data analysis is to find meaning in the information found’ (Minichiello, 1990: 285).

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28 With respect to telling one’s story, a postmodern perspective does not privilege questions designed and asked by interviewers, thereby considering these questions more valuable to story telling than the questions interviewees would pose for themselves.
While Jaruinen (2000) agrees and sees interviewing as an occasion for reality-constructor and meaning-making, she also warns that ‘meaning-making and identity construction in qualitative interviews is a risky enterprise’ (Jaruinen, 2000: 384, 389). What can happen ‘in all qualitative interview studies [is] the researcher seems to have a number of favourite interviews that are quoted far more often than others’ (Jaruinen, 2000: 374). The criteria for choosing these may be because of the density of the information, the good contact made with the interviewee, the similarity of views, or the coherence of the interview. Coherent interviews give us immediate meaning and are often regarded as, therefore, the most credible and useful’ (Jaruinen, 2000: 389).  

Acknowledging the possibility of a variety of analyses and interpretations is consistent with a postmodern perspective on analysis or interpretation because one believes there is no idea of “correct”, let alone a correct interpretation (Hollinger 1994: 101). The reason for this, in part, is that postmodernism values understanding, as distinguished from having “correct” information as scientific knowledge. Understanding is a complicated process which never produces unequivocal results (Arendt, 1994: 307-308; cited in Gross, 2001: 1081). Additionally, postmodernists consider all writing is intertextual or, interpretation of interpretation, where there is no origin, no hope of getting a final reading, no such thing as the complete story. Any interpretation is temporary (Hollinger, 1994: 98; Boje, 2001: 78). Therefore, the meaning of any text may be individual and transitory.

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29 An easy option would have been to choose interviews that most neatly provided information towards the predefined research challenges. However, a postmodern perspective, and the “richness of the data in qualitative studies, permits a variety of analyses and interpretations” (Goodwin and Horowitz, 2002: 43) to occur and encourages the presentation of a multiplicity of experiences.

30 Boje describes intertextuality as antenarrative (or preceding narrative). Instead of a homogeneous narrative, each text is regarded as a network of fragments that refer to still other narrative texts (Boje, 2001: 74).
because there is no self-knowledgeable agent capable of direct access to reality and truth (Rattansi, 1995: 251).

The information exchanged in each interview, the interview experience and the interviewer can be considered as discrete, unitary events in time and space. Yet, because all the interviews are brought together during the interpretation process and represented as text, they also could be regarded as part of a continuous event unified through the research challenges set out in Chapter One. This does not, however, devalue the content and interpretation of the individual interview. Rather, it acknowledges that within each is embedded a unique, joint construction of the interaction to understand and make meaning of the interaction (Lillrank, 2002: 113). The interview interaction is fundamentally indeterminate, with 'no stable “reality” or “meaning” that can be represented' (Schurich, 1997: 73). The lack of structure in the unstructured interview makes the task of unifying the interview content or experience through comparison between interviews difficult because the questions, responses and issues raised will not be uniform (May, 1993: 104). The "analysis" or interpretation of more than one interview does not necessarily require a comparison of each interview to reveal consistencies, inconsistencies or emergent themes although this may be part of the process. Nor does it necessitate the arrival at some generic message from the content because:

The assumption that there exists something beyond the accounts that people give is abandoned. Instead, what are examined are the regularities and features of the account ... a form of "discourse analysis" (May, 1993: 107).
The interviews are a resource for understanding how the psychiatrist makes sense of their social world. Also of interest, is the social encounter in its own right (May, 1993: 108). The whole experience of the interview became included in the interpretation and offered additional insight on the interview material (May, 1993: 108; Kvale, 1996: 43). In this way, 'interpretation is seen as a dialogue with the text produced by the interview' (Kvale, 1996: 296). Applied to this research with psychiatrists, interpretation required one to look at how psychiatrists constructed their talk and texts and, secondly, how this discourse of psychiatry has produced the image of the psychiatrist (Potter and Wetherell, 1994: 48). This is the investigative side of data analysis but, simultaneously, it required a subjective approach where the researcher's subjective experiences were inseparable from the analysis. In the interpretation 'both the researcher's and participants' voices are usually heard' (Grbich, 1999: 223).

Consistent with a holistic-content analysis the interpretation incorporates the concept of antenarrative analysis as described by Boje, 'to look at how to analyse fragmented and almost living stories' (Boje, 2001: 17). To think about the interpretation of stories told as antenarrative meant considering how the individual stories told were influencing the larger narrative of psychiatry. It was also important to consider each individual story as a microstory, or stories of the “little people” and, as such, part of an intertextual analysis approach that presents each story as a fragment that refers to other texts (Boje, 2001: 74). It also meant taking an antenarrative approach to theme analysis, allowing the stories their space and time, non-linearity and fragmentation. Antenarrative also allows storytellers to dispute the primacy of any one theme that emerges (Boje, 2001: 135).
What the interpretation presented does not represent with respect to method is a semiotic\textsuperscript{31} approach to discourse analysis. I did not consider that what was communicated to me as interviewer could be considered as a sign that could be subjected to a "science" of semiotics. The interpretation was not a collection of highlights or events grouped into themes (Ochberg, 1996: 110). Rather, the term emergent theme is used to convey the underlying existence of areas of commonality in the stories told and interpreted. The interpretative method used consisted of a form of narrative study of lives\textsuperscript{32} and reflexivity to present the outcomes of the research.

The emphasis on interpreting the interview process holistically was a part of a reflexive methodology. Reflexivity is one approach. However, any methodological considerations from a postmodern perspective also need to address the possibility of applying deconstructive reading as a way of interpreting and presenting the voices heard.

\textit{Deconstruction or Reflexivity?}

For Derrida, deconstruction is not a method, but, rather, a matter of believing (Caputo, 1999: 166). For Derrida the very meaning and mission of deconstruction is to show that things – texts, institutions, traditions, societies, beliefs, and practices of whatever size and sort you need – do not have a definable meaning and

\textsuperscript{31} Semiotics is the science of signs and provides a set of assumptions and concepts that permits systemic analysis of symbolic systems. It considers that all human communication is a display of signs to be read or interpreted. In semiotics, the sign is something that represents or stands for something. A sign consists of expression and content linked by an interpretant or context and therefore by the perspective of the observer or interpretant (Manning and Cullum-Swan, 1994: 466).

\textsuperscript{32} Narrative analysis has a number of forms with varying levels of formality on how the internal coherence of the text is defined. My concern is with lives and the lived experience with the analysis from the perspective of the teller (Manning and Cullum-Swan, 1994: 465).
determinable mission. They are always more than any mission would impose and they exceed the boundaries they currently occupy (Caputo, 1997: 31). In this respect, deconstruction is a distancing, a questioning, scepticism and a suspicion concerning the ideas of truth, power, knowledge, reason, understanding, self, reality, identity, history, language, communication, representation, meaning – and probably more (Fox, 1992: 27). To be a deconstructionist means being particularly interested in the ‘strategies a work uses to claim its representational authority’ (Flax, 1990: 37-38).

Deconstructing a discourse is ‘to show how it undermines the philosophy it asserts, the hierarchical opposition on which it relies’ (Culler, 1983: 86; cited in Fox, 1992: 26-27). A deconstructivist interpretation, in the technical sense, would require the interpretation to be ‘an analytic strategy that exposes in a systemic way the multiple ways a text can be interpreted’ (Martin, 1999: 340; cited in Boje, 2001: 19). A deconstructionist interpretation of psychiatry would question psychiatry’s evolution within medicine and from the Enlightenment project. A deconstructionist perspective would ask the question: Is psychiatry a part of a political disciplinary society, based on appeal to scientific truths, providing yet another modern institution where power/knowledge relations dominate? Deconstruction might also ask the question of whether psychiatry’s texts evolved through the logocentrism underpinning the modernist and enlightenment project. Deconstruction starts by looking for discontinuity and contradiction, then focuses on paradoxes and silences within a discourse for its answers to these questions (Fox, 1992: 8, 27). However, despite the influences of postmodernism, the interpretation presented in this research is not deconstruction.
Reflexivity, on the other hand, means 'applying a critical perspective to one's own knowledge claims' (Kendall and Whickham, 1999: 101). In some respects, reflexivity has been considered a deconstructive exercise because it attempts to locate the intersections of author, other, text and world, and for questioning the representational exercise itself (Macbeth, 2001: 35). However, it is not deconstruction.

For this research with psychiatrists, reflexivity meant considering how order, fact and meaning in the everyday life of psychiatrists were produced as practical objectives, from an understanding of the social technologies that produced them. In the context of this research, social technologies meant the historical development of psychiatry as a profession, and the development of the texts and practices of psychiatry that have provided a diagnostic and management discourse about the truth of mental illness, and the current mental health policy. From this perspective, the meaning psychiatrists attribute to their everyday life and why they continue to do psychiatry can be presented.

Reflexivity was chosen not only as the methodology of interpretation but, also, as a method for participation in the conversations, providing insight into alternative perspectives on the experiences. It is at this point that 'reflexivity becomes a continuing mode of self-analysis and political awareness' (Callaway, 1992: 33; cited in Hertz 1997: viii). Interpretations emerge from the interview material rather than assuming in advance how to interpret the interview material and superimposing on it a structured schema for interpretation (Kendall and Whickham, 1999: 101). Reflexivity provides an interpretation, a 'snap shot', not a definitive study, or legislation, and without utopian aspirations, avoiding judgmental conclusions. The complexity of this reflexive interpretive perspective exists in its attempt to represent
multiple voices in the text. It is a question of how to present the author’s self while simultaneously writing the respondents’ accounts and representing their selves’ (Hertz, 1997: xi). Consequently, telling the story presented in this text became the author’s story of the respondents’ stories. However, telling something in interview does not make the interpretation mutually agreed. What is presented is my story of their story because ‘authors decide whose stories (and quotes) to display and whose to ignore’ (Hertz, 1997: xii).

Through reflexive interpretation of the conversations, a narrative evolved including the researcher, the psychiatrists and the collective experience. This narrative sought an understanding of the subjective meaning that the psychiatrists attributed to their world (May, 1996: 39). Kvale advises that, from the beginning, considering the whole research process as all part of telling a story is to have a ‘narrative conception of interview research, [and this] supports a unity of form among the original interview situation, the analysis and the final report’ (Kvale, 1996: 184). Focusing reflexively on the production of a narrative is consistent with postmodern thought that emphasises linguistic concerns, the social construction of reality, and the plurality of diverging interpretations (Kvale, 1996: 168). ‘When we interpret a life story, we do not simply report what our informant told us’ (Ochberg, 1996: 110).

A postmodern perspective on any research design replaces traditional concerns for objectivity, validity, reliability and subjectivity, with reflexivity and the co-constructed validity between researchers and researched through multiple possible forms of representation including consideration of the simulacrum\(^3\) (Grbich, 1999: 64).

\(^3\) The simulacrum is described as an image of an image for which there is no original, or a copy of a copy that subverts the legitimacy and authority of its model. In the context of social research and interpretation of research material, the interpretative problem presented by the simulacrum means less attention be paid to determining the ultimate meaning or effect of the texts, than the exploration of the object (Durham, 1998: 3-16).
Postmodernism rejects the view that there is one best way to achieve knowledge of the world because it regards all knowledge as contextual. People’s lives are complex and ‘it is not possible to tell a single and exclusive story about something that is really complex’ (Cilliers, 1998: viii). Postmodernism also advises that the ability to generalise research findings beyond the environment in which they were gathered is unlikely (Fox, 1999: 177). In this respect, the repeatability of the research to produce the same outcome is not something a postmodern researcher would see as valuable or possible. More important is that the research resides within the context of its own research challenges and its attempts to meet those challenges, are reviewed. After presenting the interpretation of this research in Chapter Six, a review of this research is given in Chapter Seven.

**From Methodology to Methods**

Understanding individuals, their identity and the meaning they make of their lives is complex and ‘when dealing with complex phenomena, no single method will yield the whole truth’ (Cilliers, 1998: 23). Within the chosen postmodern methodological perspective the choice of qualitative rather than quantitative methods was relatively uncomplicated. Interview was used as a means of collecting and documenting participant’s perspectives. The interview materials were then subject to interpretation.


*Interview Sample and Question Design*

At the time of initiating this research project, I had already personally met approximately seventy of Australia’s 1,796\(^{34}\) consultant psychiatrists at their places of work, or at clinical meetings, as a CRA. In my role as a CRA the content of conversations with psychiatrists varied. While these conversations were not documented, they had influenced my thinking and become inseparable from the formal interview material. Similarly, the research was also influenced by, and drew significant insight from, the published journal articles psychiatrists were writing about themselves, their practice and profession during the research period.

As mentioned in the introduction in Chapter One, I was uneasy about the *thought of* interviewing a group of "professional interviewers". My unease stemmed, first, from consideration of psychiatrists' training and years of experience in the clinical interview, which is the taking of a personal history. Secondly, given their experience in the role of interviewer, the question arose as to how *good* an interviewer one had to be to elicit answers to questions they may not be expecting or that they could skilfully deflect. Interviewing individuals in groups considered powerful and very busy (Gribich, 1999: 87), or made up of an elite (May, 1993: 37), could have been difficult. I was, in effect, reversing the clinical interview. My concern with this was underscored by so few interviews with psychiatrists having been reported in the literature.

\(^{34}\) Reported for the years 1999 – 2000. Of these 1,796 psychiatrists, 1,104 were practicing full time (Commonwealth Department of Health and Aging, 2002: 248).
In my chosen sample of interviewees, I felt it important to include psychiatrists that I had not previously met in the context of my work as a CRA\textsuperscript{35}. I was aware of the need to broaden my sample to include a wider range of clinical perspectives. To initiate contact with these psychiatrists I asked for a personal referral from the psychiatrists I knew. To these people, I then introduced myself as a doctoral candidate researcher, by letter, with the participant information enclosed (examples of these documents are shown in Appendixes 4 and 3 respectively). Interview appointments were made by telephone contact one week after sending introductory letters. All interviewees received a consent form (Appendix 2) to sign at time of interview. All participants received a thank-you letter following the interview (sample letter shown in Appendix 5).

The demographic characteristics sought of psychiatrists were: age and gender, subspeciality and practice type\textsuperscript{36}. Because of my experience with psychiatrists as a CRA I thought these characteristics would be important in influencing the stories told. The most referred to subspecialities of psychiatry are Child and Adolescent, Forensic, General or Geriatric psychiatry (Commonwealth Department of Health and Ageing, 2002: 220). The perceived influence of these different demographic characteristics, including subspeciality, meant that questions on practices choices were included in the initial question design, to be trialled in a pilot interview.

\textsuperscript{35} Those psychiatrists with whom I had met as a CRA mostly had an interest in furthering the science of psychiatry through the use of medication in clinical trials. This belief in scientific or biological psychiatry was not a perspective shared by all in the profession. Accessing a range of perspectives, beyond biological psychiatry, was thought necessary.

\textsuperscript{36} The reasoning behind this was the change in psychiatric practice and cycling of acceptance of psychiatry over time. It was thought that psychiatrists of different ages, gender and experience would not only have had different experiences, but might relate their experiences differently.
The ‘constant interaction between ideas about the social world and the data collected on it’ (May, 1993:3), meant that the methods used to document and interpret information evolved interdependently with the shaping of this text and the ideas presented about psychiatry. As a consequence, the interview and analysis methods chosen were the result of careful consideration of the following:

- The purpose of the research – the three research challenges to be met;
- The influence of the chosen theoretical perspective – the postmodern;
- An understanding of the methodological perspectives documented in the literature – both quantitative and qualitative;
- The philosophical and methodological choices made (qualitative, postmodern, reflexive interpretation), and their associated theoretical foundations, assumptions and history;
- The subject and object of the research – the psychiatrist;
- The roles of the researcher – CRA and social researcher;
- The intended audience for this text – the researcher, supervisor, academic examiners, other social researchers in healthcare, psychiatrists and mental healthcare policy makers.

The research design consisted of Two Phases:

- Phase One: Researcher Questions and the Pilot interview
- Phase Two: Interviews proper

The interviews in Phase Two were conducted in two parts.

- Part I: Generation of Questions
- Part II: Further Discussion of Issues Raised
Phase One: Researcher Questions and the Pilot Interview

From the specific research challenge, to consider the relationship between motivation, rationale and identity, and my experience with psychiatrists as a CRA, three question areas were identified. The questions on demographics asked: What was the nature of psychiatric practice and how had respondents come to choose their sub-speciality? The questions on formation asked: Had the respondents experienced in their formation as a psychiatrist, isolation, stigmatisation, or use of power and authority? Additional questions focused on the nature of psychiatric knowledge and the practices associated with that knowledge. Were psychiatrists, as Luske (1990: 67) asks, ‘the arbiters of what constitutes insanity or sanity in our culture?’ The questions on emotionality focused on what it meant to understand and treat mental illness. For these three question areas a combined total of twenty-one questions were proposed to be trialled in a pilot interview. These questions are listed in Appendix 1.

Phase One of the research method, to conduct a pilot interview, was planned to test these questions for three reasons. One reason was because I was concerned about rejection. This concern for rejection was for my request for an interview, my interview technique, the questions posed and therefore the process of question construction itself. The second reason was to practice interview technique. Third, was to test substantively the information I was getting from the questions. The planned questions, the composition of the interview entry, and the subsequent exit statements were the subject of several revisions. The revisions aimed to enable responses that were reasonably elaborate and provided insight into the lived experience of psychiatrists in a non-generic way.
Despite the revisions, the questions and structured delivery in the pilot interview narrowed and directed responses. The questions and answer format structured the interaction in such a way that other topics that the interviewee may have wanted to discuss, found more interesting or relevant, were not easily raised. The lack of deviations from the questions and answer format in the pilot interview also provided valuable learning about the dynamics and documentation of interviews. The pilot interview was taped and this, as a part of the interview method itself, was questioned. Taping an interview, just as the formality of a question and answer structure, could have been inhibiting for both interviewer and interviewee (May, 1993: 104).

**Interview Documentation**

The taping of interviews, as opposed to note taking, can produce a different volume and structure of information. Taping of interviews is regarded as helpful for recollection of the words as spoken though, and production of an interview transcript. However, Rhodes suggests that:

> The power of the researcher to shape and construct meaning out of interviews is hidden through the sanitised output of the interview transcript (Rhodes, 2000: 519).

Mischler also criticises transcription because it decontextualises the interview. It does not account for people, place and time (Mischler, 1986; cited in Rhodes, 2000: 519).
Note taking is a form of in-time editorial by the interviewer but, it also demands closer attention to the words when spoken, knowing they are not captured on tape for later review (Minichiello, 1990: 136). Contextual commentaries, as a part of the note taking, were written by the researcher after interviews. It is acknowledged, that methods for capturing personal narratives, and therefore giving clear representations of the unique experience of an individual, are not unproblematic (Rhodes, 2000: 519).

The recording process in taping interviews is also subject to potential technical problems such as poor sound quality, and the need to change batteries and tapes. Therefore, interruption to conversation and momentum of thoughts in the conversation sometimes occur. Conversely notes without interview transcripts, unless captured word for word, as in shorthand notation, means that source data becomes a more summarised version of the interview, focused on key words or concepts, as decided by the interviewer at the time.

The methods used in Phase Two of the research interviews were a consequence of the experience of the pilot interview trial questions, the predictable responses received and an awareness of the potential limitations that taping of interviews could have, as discussed above. It was decided after the pilot interview, not to adhere to the initially defined question areas of demographics, formation or emotionality, nor to the twenty-one itemised questions as listed in Appendix 1. This was unexpected.

Consistent with a postmodern perspective, the demographic categorisations chosen to pre-categorise psychiatrists, and to purposefully select out of referrals to interview,
based on age, gender and practice type, were all abandoned. Within the context of the interview, if the issues of gender, age and type of practice or sub-speciality were raised, they could be pursued at this time.

Also as a consequence of the taped pilot interview experience it was decided to not tape Part I interviews and to tape Part II interviews\textsuperscript{38}. All Part I interviews were documented with notes. In addition, a contextual commentary was written about the interview experience. All Part II interviews were taped and were transcribed with the additional notes appended for contextual reference, together with interviewer comments\textsuperscript{39}.

Many researchers use tape recorders in conjunction with taking notes. This is usually done in the hope that one can gain the advantages of both, and cancel out their disadvantages (Minichiello, 1990: 136).

In summary, the pilot interview in Phase One revealed the questions chosen by the researcher to be narrow, restrictive and predictable in the responses received. Phase Consequently, Phase Two of the research interview method was planned to ask psychiatrists to suggest their own questions to discuss.

\textsuperscript{38} Having experienced both the advantages and deficiencies of both note taking and taping as ways of conducting interviews, I certainly could not identify with the modernist perspective on interviewing that situates the researcher as a kind of God who consciously knows what she/he is doing, who (if properly trained) can clearly communicate meanings to another person (Scheurich, 1997: 64). Every interview was a new experience with respect to technique development and communication skills.

\textsuperscript{39} The change back to taping in Part II interviews was planned because taping was thought to be more suitable medium to capture the anticipated discussion. This was because in Part II interviews, no specific questions were asked, and no questions were called for.
Phase Two: Interviews Proper, Part I and Part II Interview Design

The unplanned and unexpected play a major part in almost all fieldwork and is often important in shaping the direction of the research and analysis (Muetzelfeldt, 1994: 41).

Part I interviews were planned to ask a number of psychiatrists to suggest questions to ask psychiatrists to discuss in interview. Part II interviews were planned using the content of the questions given in Part I interviews as prompts to initiate conversations, thereby dispensing with the traditional interview question and answer format as much as possible. Changing to an unstructured interview provided the opportunity to ask the psychiatrists to formulate their own questions and answers. Psychiatrists could elaborate on topics and issues of relevance for them. If agreed, the interviewer could also conduct a second interview with individual psychiatrists to clarify or pursue further questions, or chosen topics for discussion. Progression to Part II interviews was to provide an opportunity for the issues of interest raised as questions or explanation in Part I interviews to be pursued, elaborated on, corroborated or contradicted. This method was designed to access a range of perspectives, with or without a question format, and to utilise a number of techniques. The techniques used were: taping, note taking, interviewer contextual commentaries and second interviews.

It was not intended to compare the information generated using different interview techniques and documentation methods. Rather, the variety of interview techniques used provided confidence that the information generated did not suffer the limitations that a single interview method might impose on the stories told.
Kiesinger (1998: 88) imagined that her interviewee would have told different stories were she to have conducted the research as a detached researcher equipped with a protocol of questions; as a complete stranger. I can only acknowledge that being known to some of the interviewees before the interview, and not others, and not having a protocol of questions, produced the stories that it did. The interview method finally used, was 'squarely at the qualitative end of the research spectrum' (May, 1993: 93) because it attempted to allow interviewees to talk about the subject in their own frames of reference (May, 1993: 94).

But the real challenges and the greater surprises for me were the people I met, rather than the methods I used (Kellehear, 1994: 62).

The Interviews

A total of eighteen interviews were conducted with fourteen psychiatrists, over a period of eighteen months, excluding the one pilot interview in Phase One. Four psychiatrists were interviewed twice. Scheduling second interviews offered an opportunity to see what additional information two interviews could provide. Some authors have suggested that second interviews can be used to check for reliability or validity of data (Shipley and Wood, 1996: 88). This is meaningless from a postmodern perspective. All “data” were considered valid and could vary over time.

The second interviews occurred two to three months after the initial interview and were arranged to ask for more possible questions additional to those that had been given in the first interview. Three of these second interviews were at the request of the researcher and one was at the request of the interviewee. The second interviews presented an opportunity to follow up on issues raised and for the
psychiatrists to elaborate further on the topics raised in the first interview. However, second interviews proved not as fruitful, in terms of generating new insights, as a larger number of first interviews with different psychiatrists.

Interview appointments were scheduled for approximately one hour each. The length of interviews ranged from twenty-five minutes to two and a half hours, averaging just over one hour. Despite the large variation in interview times, interviews were long enough to discuss an average of four or five questions or issues. Interviews were conducted either during, or immediately after, work hours. Interviews were held at the psychiatrists' place of work (consultation rooms).

In Part I of the Phase Two interviews, psychiatrists were asked to suggest questions that I could ask psychiatrists to understand what it means to be practicing psychiatry today. Respondents were then asked to answer and discuss their question and the issues it raised. Prompting for further questions followed each discussion. Apart from the initial request for questions, the timing of asking for additional questions during the interview was not rigid. This lack of rigidity was seen as necessary to allow the tendency of thought and conversation to flow across the questions or issues raised. Each interviewee did not have to provide a set number of questions. The timing of prompting, or asking for another question, was sensitive to the degree of closure, or lull in conversation, about the previous issue or topic being discussed.

In Part II interviews, psychiatrists were asked to tell of what it means to be practising psychiatry today; no specific questions were asked for. The conversations ranged across many areas of interest. However, the underlying focus returned to how they saw their role in psychiatry today and for the future: What gave psychiatrists meaning, motivation and identity?
Relating Questions to Answers and “Restorying” a Story

It is acknowledged that, as researchers, we are never neutral in our attempts to write about the lives of other people, because we start with the research participants ‘stories then tell them in another way’ (Rhodes, 2000: 511; Charmaz, 2002: 318).

To begin telling the respondents’ stories in another way meant immersing oneself in the interview texts and replaying the interview recordings as the first part of the interpretative process. The interpretative method used is closer to what has been described as experience orientated, using holistic-content analysis of field texts. Part of the holistic analysis process is ‘the reading and re-reading through the field texts, considering interaction, continuity, temporality and situation’ (Connelly and Clandinin, 2000; cited in Ollershaw and Creswell, 2002: 342). The holistic analysis process is personal and social, with relationships negotiated with participants as co-researchers. The analytical steps are aimed at restorying a story (Ollershaw and Creswell, 2002: 342-343). The negotiated relationship in this research was asking psychiatrists to suggest the questions to be asked.

While reading and re-reading the transcripts, the individual questions given by psychiatrists were extracted from the interview transcripts and simply listed as they occurred in each interview over time. The questions were re-contextualised with the original interview transcript to identify contextual similarities. The questions and key responses from respondents’ answers were summarised using a single word or quoting phrases. Examples of quotes that emerged from this process were: “first a doctor”, “role and future for psychiatry”, “funding”, “service delivery”, “relationship with patients” and “knowing your limitations”. This step in the method involved choosing and copying direct quotes from transcripts that were representative of the question being asked, or of the opinion, or sentiments being expressed, in relation to
a particular issue. This process involved ordering thoughts and words by selecting, collecting and physically highlighting the quotes from transcripts.

As progress was made through the transcripts, the number of quotes grew and reoccurring words or phrases encapsulating the topic of concern were identified. Some examples of words or phrases that repeatedly occurred across a number of interviews were: “funding”, “service delivery”, “patient advocate”, “medical doctors”, “understanding patients”, and “believing patients”. From the words and phrases, four focus areas emerged:

- Becoming a Psychiatrist;
- Being a Psychiatrist;
- Challenges and Issues for the Future;
- Patients and Treatment of Mental Illness.

Using the focus areas as headings enabled two further processes to occur. First was the grouping of questions under the relevant focus area, with suitable clusters of narrative being identified. Frequency of occurrence counts of words and phrases used with and between interviews were conducted. This was helpful for the reasons described below.

The process of physically separating, ordering, selecting, grouping and rating key words or phrases could be criticised as a very modernist analytical tool, at odds with a postmodern philosophical perspective. However, it was regarded as simply that – a tool. It was a tool that enabled the researcher to focus on key words and phrases in the questions, answers and issues each psychiatrist chose to discuss. This tool also allowed easy identification and tracking of the same issue across interviews. As
describer by Kiesinger (1998: 85), this is choosing segments that do the work of
telling an intelligible and coherent story. As mentioned in the introduction in Chapter
One, presenting research material in ways that are meaningful, is aided by the
drawing of boundaries. Identifying the focus areas helped draw necessary
boundaries around the “analysis” to enable the interpretation of the interview
material.

Within the focus areas, summary questions emerged. The summary questions
provided the basis on which to re-read the transcripts and look for the range of
opinions expressed on the issues these questions raised. This method was applied
to interview transcripts from Part I and II interviews. The transcripts were then re-
read with the focus areas, associated summary questions, representative words,
phrases and quotes, and their frequency of occurrence in mind. This re-reading
revealed another level of commonality between the respondents’ stories. From this
part of the interpretative process three storylines, or themes, emerged, which are
detailed in the next chapter.

In summary, the first step of the analysis and interpretation involved separating and
listing the questions given by psychiatrists from each interview transcript. Second,
choosing and grouping key words and phrases from the questions and re-readings
of full interview transcripts was undertaken to identify focus areas. The use of
chosen representative words and phrases was attributed to each respondent in a
third step, together with scores for frequency of occurrence of these words and
phrases. The fourth step was to place the words and phrases quoted in each focus
area back into the context of the full set of transcripts to derive the emergent
summary questions. A fifth step was to review again, the questions, answers and
discussion in full transcripts, together with the extracted words and phrases, and
their frequency of occurrence. This revealed three themes. The three themes were considered in the context of the research challenges and their meaning for a postmodern psychiatry, to enable a restorying of psychiatrists’ stories.

The stories shared were a heterogeneous mix, fragments of lives and thoughts. The results of the process of relating the researcher’s questions to the psychiatrists’ questions, and interpreting the responses given to the questions and issues discussed, is presented in the following Chapter Six – Outcomes and Interpretation. These interpretations document the insights shared by fourteen Australian psychiatrists about themselves, their profession and their own potential deinstitutionalisation. They offer their choices, judgements and reasons for practising today and tomorrow. Together, they tell a story of psychiatry as Medicine, Money and Madness.
CHAPTER SIX
OUTCOMES AND INTERPRETATION

Medicine, Money and Madness

Essentially every story is informed by other stories that the writer and reader have heard or read, and their respective cultural contexts (Boje, 2001: 91).

Focus Areas and Emergent Summary Questions

Using the methods described in the previous chapter, four areas of focus emerged from the respondents’ interviews40: Becoming a Psychiatrist; Being a Psychiatrist; Challenges and Issues for the Future; and lastly; Patients and Treatment of Mental Illness. The similarity of the questions and responses within each focus area, while variously expressed, enabled a number of summary questions to be posed. The following emergent summary questions were formed from the original questions given in Appendix 8.

40 From Phase Two, Part I interviews, where psychiatrists were asked to suggest interview questions, a total of thirty-six questions were given. The questions given by psychiatrists are grouped in their associated focus area and shown in Appendix 8.
Appendix 9 groups the constituent questions below the emergent summary question. Together, the focus areas with the emergent summary questions represented the topics of interest for discussion by practicing psychiatrists about what they do and who they are. These are given below.

**Becoming a Psychiatrist**

- How was it that I came to be a psychiatrist?

**Being a Psychiatrist**

- What influence does society have on me?
- What is my view of society as a psychiatrist?
- From a psychiatric perspective, do I look at other things in a psycho-social way?
- What is the role and place of psychiatry in society?
- What are the enjoyable and not-so-enjoyable aspects of psychiatry?

**The Challenges and Issues for the Future**

- What are the future challenges for psychiatry in the twenty-first century?

**Patients and the Treatment of Mental Illness**

- What is my relationship with patients and how does this change over time?
- How can we better understand the experience of mental illness and its treatment?

Interpretation of the interview experience and transcripts in the context of the above focus areas and summary questions resulted in a narrative that sought an
understanding of the meaning that psychiatrists attributed to their world (May, 1999: 39). There were three themes in this narrative.

Themes

Interpretation of the interview transcripts revealed the theme associated with the focus areas, Becoming a Psychiatrist and Being a Psychiatrist to be about:

Medicine:

- This focused on the importance of psychiatry as a medical discipline and psychiatrists as medical doctors.

The third focus area, Challenges and Issues for the Future, revealed a second theme:

Money:

- The respondents expressed a concern for service delivery, the future of psychiatry and the future funding of mental health care. This theme also expresses the psychiatrists irritation at government interference in the identity of psychiatry, and its role in delivering community mental health now and in the future.

The third theme emerged from the fourth focus area concerning Patients and Treatment of Mental Illness. This theme is about:
Madness:

- This theme stressed the importance of the relationship with the patient, and an understanding of mental illness or, as the respondents freely referred to it, "madness".

The juxtaposition of the first theme (medicine) and third theme (madness) suggests a possible contradiction. The medicine theme, concerns the psychiatrist thinking about self and their own identity in society as medical doctors. The theme of madness concerns the identity of the patient and their illness. The contradiction comes because psychiatrists, when considering their relationship with patients, acknowledge the importance and influence that the patient's identity has on the psychiatrist's identity, which goes beyond being a medical doctor. Yet, as the medicine theme attests, psychiatrists considered themselves medical doctors first. The second theme of money, also impacts on the identity of the psychiatrist. Without adequate funding and support from the health care system, private or public, the identity of both psychiatrists and patients, the work of psychiatry to heal the mentally ill, cannot be sustained.

Interpreting Questions, Answers and Stories

The following section presents an interpretation of the questions, answers and stories shared. It is useful at this time to again acknowledge the two inseparable roles of the researcher, as social researcher, and CRA, when meeting with psychiatrists and considering mental health. Consideration of these two roles was important when trying to relate the psychiatrist's questions to those initially formulated by the social researcher to use in interview. Acknowledging the existence
of the two roles is also important to recognise the influence it may have had when interpreting the answers and stories given. As Goodwin and Horowitz explain:

The I in the text is important to permit the reader to know where the researcher was at the time the data were collected and to explain the role of the researcher (Goodwin and Horowitz, 2002: 45).

While it is acknowledged that the stories told in this text did not evolve in a linear sequence, it is also helpful at this time to reiterate some of the initial influences on this research. First, there were the research challenges that were identified in Chapter One and, again, when considering the choice of methods in Chapter Five. In summary, the research challenges were to document and interpret the issues raised by psychiatrists and then consider the relationship between motivation, rationale, meaning and identity for psychiatrists, within the context of Australia's current mental health policy.

After stating the challenges, the choice of using interviews was made as the primary research method. This was followed by the design of questions to ask psychiatrists in a pilot interview. It was anticipated that, when asked, these questions would provide stories about psychiatrists and their practice, and provide a further understanding of psychiatrists that would meet the research challenges. A postmodern perspective informed both the challenges and the choice of the final interview method, which was deliberately unstructured. The postmodern perspective not only informed the interview method but also the interpretation of the stories and the construction of this text about psychiatrists and psychiatry.
Interpreting Questions

The death of interpretation is to believe that there are signs, signs that exist primarily, originally, really, as coherent, pertinent, and systematic marks ... the life of interpretation, on the contrary, is to believe that there are only interpretations (Foucault, 1982: 12).

Foucault's thoughts on interpretation remind us that approaching the interview texts with the expectation that the emergent story revealed would be anything other than an interpretation is salient. There can be many interpretations of the same experience, all having different consequences.

A number of psychiatrists initially approached the interview experience and the request for questions to ask of psychiatrists in a depersonalised way, as if they were outside the profession. They did this through prefacing their questions with phrases like 'Ask them...' (Malcolm, #1: 49); 'When were they first aware...' (Frank, #1: 9); 'You should ask ...' (Kym, #1: 28); or, 'Remembering psychiatrists are doctors first, at what point in their medical career did they...' (Lindsay, #1: 3). Alternatively, they advised that I should talk to someone else (another psychiatrist); 'You should speak to XX. He has just written a book of some relevance to your project' (Peter, #1: 58); 'You should talk to at least five different ethnic backgrounds ... see if they have understanding' (Kym, #1: 28); and 'You should ring Lifeline at two in the morning and ask to speak to an Italian ... see what help you get' (Kym, #1: 29). For some, the distinction between psychiatry generally and their personal experience of being psychiatrists was continually being blurred, despite attempts by the respondents to maintain a depersonalised approach. The distinction between speaking of psychiatry generally, rather than telling a personal story, was not consistently maintained.
The reasons for this could possibly stem from their training as medical doctors that focused on finding out information about patients, asking questions in a formalised clinical interview format. Being “medical doctors first”, was important to the respondents. The maintenance of a neutral doctor figure conflicts with the objective of an understanding, empathic psychiatric consultation. I saw these two conflicting presentations of psychiatrists as the major precipitating cause for the vacillation between giving the general, as opposed to a more personal perspective in interview. This is evident in Rene’s response to the question below.

**EK:** Do you leave part of yourself at the door before you walk in here?

**Nicola:** The training very much trains you to be a more neutral figure. I mean, I’m very particular about not giving any person details of my life, of my marital or family situation, or my background. Umm, sometimes I will, it, it’s rare, extremely rare, umm … there isn’t an exchange. I mean, inevitably people think, winkle things out, you know, they find things and, ah, yes.

Relating the questions given by the psychiatrists (Refer Appendix 8) to those initially formulated by the researcher (Refer Appendix 1) reveals both similarities and differences in what was perceived to be a topic of interest to question and discuss. The first similarity was in the demographically orientated questions, which asked why past choices were made with respect to doing psychiatry. This was not surprising because it enabled both researcher and psychiatrist to put their current position as a psychiatrist in historical context. It is an easy place to start for both interviewer and interviewee to understand their current role in psychiatry. As such, demographic questions were not especially threatening or challenging. Additionally however, the psychiatrists’ questions focused on the initial and continuing influences in being a
psychiatrist. Both researcher and psychiatrist were interested in the satisfactions, or rewards, that being a psychiatrist afforded. Interestingly, psychiatrists equally wanted to speak of what they disliked about psychiatry, as well as what they enjoyed. Questions about what was wrong with psychiatry were not included in the researcher questions. A likely reason for this was that the researcher questions were too timid, possibly unconsciously designed not to elicit potential extremes of emotion. This was particularly evident in the responses received in the pilot interview.

Further consideration of the researcher’s versus psychiatrists’ questions revealed that, while choosing a sub-speciality and the type of patients seen was of interest for the researcher, this was not an issue raised by the psychiatrist in the context of choice in being a psychiatrist. Rather, questions about patients were more general and concerned the importance of the relationship with and understanding of patients and their illness, in the context of a therapeutic alliance. When talking about patients and mental illness, the respondents’ emphasis was on the relationship of the psychiatrist, both with individual patients and within broader society. The respondents’ talked of their multiple and changing social roles and the changing use of their expertise. Once again, the reason for the differences was considered to be an over-sensitivity by the researcher to being perceived as confrontational in interview. It was felt to be safer to approach the question of types of patients and how psychiatrists presented, through questioning psychiatrists’ chosen sub-speciality. The timidity of questions about patient-oriented questions was misplaced. Psychiatrists were quite open when discussing types of patients, their illness and the limitations of their knowledge. The issues of where the cutting edge in psychiatry was today and who respondents regarded as mentors, were also not raised as specific questions by psychiatrists.
Questions about the future trends in psychiatry were in the researcher's list, but were subsequently regarded as too narrowly focused. One researcher question concerned psychiatrists' experience using telemedicine\textsuperscript{41}. Another question asked respondents about potential future personal ambitions. These concerns for the future, the stories of their individual choices and how psychiatrists did psychiatry, including the emergence of new technology, emerged in the context of the discussion. The respondents' discussion of their choice of psychiatry as a career also included consideration of other career options. When comparing the interview content with the questions the researcher posed in the pilot interview, other topics of commonality included public versus private practice, the interface of psychiatry with the law, the impact of government legislation on practice, and the cost of care in psychiatry.

In summary, the researcher's questions were generally too narrow. The variety of topics mentioned by psychiatrists ranged widely when they were asked for their own questions or asked to talk about what it means to them to be practicing psychiatrists today. Generally, for psychiatrists, what the profession is facing in terms of the challenges today and in the future was of most interest. Also of interest for psychiatrists was how they saw their social role and how, in turn, society viewed them.

\textsuperscript{41} Telemedicine is the use of technology such as video conferencing, web casting, telephone conferencing or the internet, to interact with patients. It can be used to take medical histories, make diagnoses and present treatment options to both doctors and patients in remote communities.
Psychiatry is the most self-reflective sub-profession within medicine and this is evidenced in psychiatrists’ training\textsuperscript{42}, purpose and concern for their social image. The concern for social image was also likely to be the consequence of being the medical sub-profession most stigmatised in society. This stigmatisation derives from multiple sources (Gabbard and Gabbard, 1992, 113). One source is the mentally ill patient’s stigma being transferred to the psychiatrist as ‘crazy, disturbed, sexually preoccupied, aloof and distant’ (Dichter, 1992: 204). The respondents’ experiences of professional stigma are discussed later in this chapter.

\textit{Interpreting Answers and Stories}

The stories told by psychiatrists about themselves and their profession were partially revealed in the questions posed by them, and the subsequent answers and stories. Through the process of interpretation, the psychiatrists’ words and the researcher’s interpretations became interdependent. The three themes (medicine, money and madness) that emerged from the questions and the stories shared were placed within the context of one particular research challenge, which was to consider from a postmodern perspective the relationship between motivation, rationale, medicine in psychiatry and the identity of psychiatrists practicing under the current mental health policy.

\textsuperscript{42} The basic undergraduate training of medical doctors in Australia is the same for the first 5 years. The specialist training that occurs after that for the additional 5 years differs significantly among the sub-professions. It is this later training that distinguishes psychiatry. It is here where trainee psychiatric doctors begin to learn their psychiatric clinical skills, which includes the capacity to listen and reflect on what they hear from patients, and themselves, in their role as healer. As in any profession, the skill level is not uniform across all practitioners over time and Continuing Medical Education (CME) is a requirement for continued practice. CME and Maintenance of Professional Standards (MOPS) schemes are administered by the Royal College of Australian and New Zealand Psychiatrists (RANZCP).
Each theme cannot be exclusively related, or tell the story of motivation, rationale, medicine or identity alone. There are, however, some closer associations. For example, respondents spoke of their motivation and rationale for what they did as helping people from within the context of medicine. A less close association is the relationship between motivation and rationale to experience and the formation of identity. The formation of identity was regarded as continual and indeterminate. Furthermore, from the interpretation of the interview texts it became clear that considerations of identity meant three things. First was the identity of the psychiatrist. Second, was the psychiatrist in society and third, psychiatry as a medical profession. These aspects of the psychiatrist’s identity became intertwined with the identity of patients and the identity of madness itself.

Identified as relevant for this research in psychiatry from a postmodern perspective, were concerns about science, government, society and identity, as discussed in Chapter Two. Briefly again, the primary concern of the postmodern perspective on the use of science in medicine is its implications for knowledge and truth production about mental illness by psychiatry. With respect to government, postmodernism’s concern is the role of government in biopolitics, and the desire to create utopian “normal” societies. The concern for society is its domination by consumerism in the contemporary West. Last is the perspective on identity, as multiple, contextual and culturally constructed.

The observation expressed above about the inability to derive neat, discrete and exclusive alignments of the themes to the issues in the research challenge concerning motivation, rationale, medicine and identity, equally apply to the postmodern perspective on science, government, society and identity. There were however, as with the research challenges, closer associations. For example,
science is more closely associated with the theme of Medicine, government with Money and identity with Madness.

The following three sections of this chapter present the interpretation of the interview texts. Though this, an interpretation of what psychiatrists said about motivation, rationale, meaning and identity, together with postmodern considerations of science, government, society and identity, is provided. This constitutes the larger story of medicine money and madness.

**Medicine**

The postmodern concern for the use of science in medicine, in particular in psychiatry, and how this relates to the construction of the psychiatrist's identity in society, is examined below.

The emergent summary questions in the focus areas of Becoming and Being a Psychiatrist were combined because of the related theme, medicine. These questions were:

- How was it that I came to be a psychiatrist?
  and,

- What influence does society have on me?

- What is my view of society as a psychiatrist?

- From a psychiatric perspective, do I look at other things in a psycho - social way?

- What is the role and place of psychiatry in society?

- What are the enjoyable and not-so-enjoyable aspects of psychiatry?
The stories told in response to these questions revealed a number of sub-themes that are discussed below.

**Medical Doctors and Motivation**

It was not always possible to separate what psychiatrists said about themselves as psychiatrists and what they said about psychiatry as a profession generally. This was especially the case when the respondents were considering their roles and perceived roles in society. There was, however, one point of strong agreement. Psychiatrists considered themselves first to be medical doctors. Psychiatrists talked of psychiatry as a profession within medicine and that being a psychiatrist meant first being a medical doctor. This underpinned how psychiatrists thought of themselves when they considered the question of how they became psychiatrists. ‘One enters the profession basically to be a doctor’ (Sam, #1: 61). ‘They were doctors first’ (Frank, #1: 12). Beyond the largely agreed upon medical explanation, further opinions on the motivation for becoming a psychiatrist varied:

**Rene:** Why do people go into psychiatry? Surely they go in because they like the relationship with the patient!

**EK:** Is that why you did it?

**Rene:** Oh I went in because I ran out of other things to apply for, um by default but, but um . . .

**EK:** Why did you choose forensic in the first part of your career?

**Rene:** Oh --. Oh accident. My career is always accident (Rene, #1: 4).
Rene went on to describe how she had considered other specialities and eventually just “fell into” psychiatry. While Rene was certainly the only respondent to use the word “accident” and emphasise it, she was not alone in her deliberations about choice of specialty. Two respondents, who had previously been general practitioners, also reported changing to psychiatry. A number of respondents came from families where their father had been a medical practitioner of some sort, including being a psychiatrist. As Malcolm described it, ‘I grew up in a mental hospital’ (Malcolm, #1: 49). Rene’s current position was more administrative than clinical. I suspected her dismissive response, that her career was accident, was more a comment on her frustration in her current situation involving implementation of government policy. Rene expressed certain exasperation, even desperation, regarding the role of the psychiatrist in mental health care.

In all the interviews, the relationship with the patient was not mentioned as a reason for going into psychiatry. Rather, patients were mentioned as something that became very important in being able to practice well. For Nicola, it was that she ‘was just fascinated by what made people tick’ (Nicola, #1: 9). ‘I mean obviously it’s to make a difference to people’s lives’ (Nicola, #1: 28). A number of similar comments were made by respondents along these lines:

And the one useful thing psychiatry does is it tries to be helpful. It tries to be at least kind and protective and, at most, tries to figure out what the hell is going wrong for, for people umm, who just have such terrible, terrible lives, I can tell you (Jasmine, #1: 41).
The project is to be useful to people I see ... the psychiatrist is involved in narratives of how [madness] might be understood (Jeremy, #1: 16, 18).

In contrast, Kym regarded the seeing of patients as “just a profession”. What patients tell him stays within the rooms and he does not think of the patients beyond this (Kym, #1: 31). I found Kym’s comment unusual, given other respondents emphasis on the role of psychiatry in helping people regain wellness. Additionally, given the need for doctors of all specialties to be available after hours for emergencies for “on call”43 rosters, I found Kym’s comment difficult to fully believe.

With psychiatrists’ own explanatory impreciseness over what they do, it is not surprising that the public image of psychiatry contains elements of superstition, confusion, suspicion, respect and disregard.

Combined with acknowledging and valuing their identity and role as medical doctors, respondents also identified themselves as somewhat different from other doctors. They provided a variety of explanations:

Psychiatrists are special (Lindsay, #1: 3).

The critical capacity for judgement makes us different to our colleagues (Malcolm, #1: 49).

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43 Most hospital based clinicians, of whom Kym was one, have a roster system. This roster is called “on call”, whereby the clinician needs to be contactable after hours. This inevitably must mean periodically considering patients “beyond the room"
Psychiatrists are healers; this is the social role they want to have (Lindsay, #1: 3).

We take responsibility for healing broken selves (Ian, #1: 55).

Psychiatrists are some of the best-educated people on the planet (Jeremy, #2: 24).

[We have] to be an expert in a whole range of fields ... As a profession our role is constantly changing (Sam, #1: 61, 63).

The conversations also described a struggle with identity, to be different but accepted by other medical colleagues and by the community, and be valued for what they are trying to do. In the past, psychiatry had not been able to satisfactorily differentiate itself from other medial specialities, define and describe what it was. This problem still exits for psychiatry. Consequently, the urge to be similar to other doctors and rationalise what psychiatrists do with medical, scientific explanations was a strong crutch to fall back on, but was not supportive enough. This might be because of the ‘dissonance between the “science” of objective measurement and the “art” of clinical proficiency and judgement’ (Greenhalgh, 1999: 318).

You start in a medical model; you start very much from the notion of pathology (Nicola, #1: 3).

The psychiatrist is a typical doctor, a scientist and artist, and the brain is a template on which the psychiatrist works (Ian, #1: 57).
In contradiction, when psychiatrists talked about psychiatry as a profession (discussed later in this section) they regarded themselves, as anything but typical doctors:

The practice of psychiatry gives a ‘privileged view of human existence and human suffering ... life as worth living and death as something to arrive at are universal concerns (Jeremy, #1: 17).

The unanimity of opinion about the importance of recognising that psychiatrists were doctors did not, however, extend to how respondents saw the practice of psychiatry. There was agreement that there were significant differences between practices in the public versus the private system, but the role of each type of practice in mental health, and the benefits of each in treating the mentally unwell, was frequently raised with considerable emotion, as the next section reveals.

**Public versus Private**

Malcolm believed the finer qualities of expert psychiatrists were a questioning mind and keeping up with the developments in the field. He also claimed that you need a critical mass of people to help keep up to date with contemporary practices. Malcolm also discussed the problem of isolation in private practice being immense, unless psychiatrists took steps to form a network, and work at maintaining good communication networks (Malcolm, #1: 49-50). For Rene, morale in private practice and complete care of the patient was the distinguishing feature of private, compared to public practice.
Rene: If you say to the doctor, “Your job is to prescribe the drug”, that's not very exciting. It's not, not mentally stimulating, and so, I think if you go too far down that track umm, ah, that effects morale. And I think that's why public psychiatry suffers lower morale than private ... the private psychiatrist retains that complete care of the patient. So they retain, not just the drugs, but they retain the psychotherapeutic and psychosocial aspects, and in public psychiatry, a lot of that has gone to the case manager (Rene, #1: 3-4).

Integral to morale and complete care of the patient was the role of case managers.\(^{44}\) This issue was raised in the context of private versus public practice but, also, when the topic of funding care and service delivery was mentioned.

Ian was a strong advocate of the private system. In the private system there is a 'level playing field between psychiatrists and other mental health care workers' (Ian, #1: 55). He continued:

I feel more liberated in a free market ... don't have to apologise for my success and performance (Ian, #1: 55).

There are plenty of people in private hiding away and avoiding issues. There are also those cloistered in public ... not prepared to speak out and take a stand (Ian, #1: 58).

Nicola was currently also relatively happy in the private system, having experienced both public and private practice.

\(^{44}\) Case management is discussed further in the next section on Money in Psychiatry.
The public system is strapped for cash; the people who get the services have pretty severe clearly defined difficulties ... umm, because there's more choice involved, if you like, on the other side, the private system (Nicola, #1: 17).

Psychiatrists practicing in the private system are often criticised by their public sector colleagues for taking the soft option, treating the "worried well", "neurotic" women, or just being greedy. The reality is that many psychiatrists combine both types of practice, treating the severely ill and not so severely ill, and for just the reasons Nicola advanced. The motivation to combine private and public practice includes aspects of both personal choice and consideration of funding.

The critique of those practising in public versus private was part of a larger story within the profession. Several psychiatrists, like Jo, expressed similar sentiments. Jo thought that, as a profession, psychiatrists 'were critical of each other' (Jo, #1: 35). However, Walkenstein, an American psychiatrist practising in the 1970s, was more specific in her criticism of doctors and psychiatrists than the view expressed in interview.

I guess I could put my attitude towards doctors in a few nutshells like: they're people like anyone else. Most doctors don't act as if they make mistakes and they've got a great vocabulary for covering up their ignorance and errors (Walkenstein, 1972: 31). What shits most psychiatrists are. Most of them are robotized businessmen on ego trips, supporting their vested interests and properties on the patient's blood (Walkenstein, 1972: 66).
Two issues may explain Walkenstein’s vehemence. One was that she was a woman practicing in the 1970s in a male dominated profession. Second, the 1970s was a time of anti-psychiatry sentiment in the USA, when one of psychiatry’s lead critics was one of their own – Thomas Szasz. Walkenstein’s comment may reflect ‘the real world of clinical practice involving intentions, meaning, intersubjectivity, values, personal knowledge, and ethics’ (Miller and Crabtree, 1994: 341). Once again, despite any differences in opinion on motivation for doing psychiatry, or types of practice, respondents always confirmed their view of psychiatry as a special form of medicine.

**Psychiatry as a Special Form of Medicine**

What makes conversations about psychiatry so complex and contested ‘is that [psychiatry] belongs both to the natural sciences and the humanities’ (Shea, 2000: 226). Jeremy’s description of psychiatry included trying to ‘understand how human beings have structured their world’ (Jeremy, #2: 24). The respondent’s language spoke of psychiatry as unique, different, special, interesting, a curiosity, exciting, frustrating and emotionally tough. This sentiment could best be summarised by Jo’s description of psychiatry:

> It offers a *unique* opportunity to practise a *very interesting* form of *medicine* (Jo, #1: 34; my emphasis).

Lindsay’s suggested that:
The degree of acceptance of psychiatrists has cycled through history, which has led to a cycling of their social value and perception of their own self worth and performance (Lindsay, #1: 2).

This comment by Lindsay refers to the history of psychiatry, the use and abuse of asylums in psychiatry, the anti-psychiatry movement, and a local Australian event concerning deep-sleep therapy. Lindsay told the story of one psychiatrist, Dr Bailey, practicing in the 1980s in a Sydney geriatric nursing home. He was reported to have slept with patients and to have obtained money from patient’s wills. He was disgraced, “struck off” and later he committed suicide during his court trial. This type of occurrence was very negative for psychiatry’s social image and acceptance. Lindsay distinguished the “fringe” psychiatrists in Australia at the time as ‘mad but good at what they do’, from people like Bailey as ‘mad and bad’ (Lindsay, #1: 7).

The situation psychiatrists describe for themselves today maybe a product of their own making. Psychiatrists’ indecisiveness, or presentation of contradictory opinions, about medical science holding all the answers to mental illness has left many psychiatrists avoiding considering the possibility because of the potential changes to their practice that would result. Psychiatrists, like Kym, follow without question biological psychiatry’s faith in science when it concerns disorders like schizophrenia:

The chemical pathology of schizophrenia will be understood and enclosed in capsules as a treatment, like one prescribes antibiotics (Kym, #2: 71).

However, Kym does acknowledge other problems exist, for which biological psychiatry will have no answer:
On the other hand, the erosion of the fabrics like institutional marriage, which has numerous causes, will cause problems of maladjustment between people, and children will manifest [mental problems] more. This will not be curable by pills (Kym, #2: 71).

Kym refers above to patients having maladjustment problems and admitted avoiding treating these patients. Kym then commented on the treatment of lifestyle problems, like drug and alcohol abuse, and then asked me the question:

The effort put into a patient has to be meaningful. Who would you choose to treat, a new young first time patient, or a patient who had a history of non-compliance and reversion to a detrimental lifestyle after successive attempts to treat?

An analogy to this avoidance behaviour, towards certain disorders and patients, exists in a disorder named and categorised within psychiatry's own *Diagnostic and Statistical Manual of Mental Disorders*. Psychiatry has identified, defined and named a mental disorder called "the Bowerbird symptom". This syndrome identifies 'a form of avoidance behaviour' (Fitzgerald, 1997: 598). The clinical picture for patients with this symptom is defined as: 'despite having significant insight, the patient has ambivalent feelings about changing his [sic] behaviour' (Fitzgerald, 1997: 597). Some psychiatrists' response to the changing social conditions in which they find themselves practising in psychiatry suggests the presence of the bowerbird symptom within: avoidance behaviour, a significant degree of insight and a reluctance to change. The presence of the Bowerbird symptom may not be restricted to psychiatry, but could apply to a number of professions that do not question their fundamental beliefs. For psychiatry, this points to a need to question
the psychiatrist's role as medical doctors and their desire for science to explain, and provide treatment for mental illness:

Belonging to a professional group brings into play an effect of censorship which goes far beyond institutional or personal constraints: there are questions that you don't ask, and that you can't ask, because they have to do with the fundamental beliefs that are at the root of science, and of the way things function in the scientific domain (Bourdieu, 1990: 8).

Psychiatrists' tenacious adherence to their medical training, while concurrently acknowledging that their profession is different and unique, has resulted in schools of thought, like biological psychiatry, that constantly turn to science to provide answers to support psychiatrists' place in medicine. This is at the expense of asking the question that they cannot ask: What if science cannot provide all the answers? Psychiatry fears that an affirmative answer to this question would undermine the place of psychiatry in medicine and contribute to another period of scepticism of psychiatry's ability to treat mental illness. This scepticism is related to the cycling of acceptance of psychiatry throughout history noted earlier. On reflection of his years as a psychiatrist, Pargiter suggested that:

If psychiatry has any use in the world, it is to teach the medical profession as a whole to tolerate the lack of closure, that the universal allure of the magic of something for nothing does not exist and that we and our patients have to learn to live with fallibility (Pargiter, 1998: 747)
There was agreement among the psychiatrists interviewed that the legacy of this cycling of acceptance has resulted in the stigma and marginalisation, more usually attributed to psychiatric patients, periodically being extended to psychiatrists and psychiatry as a profession. The respondents' experience of stigma and marginalisation are detailed in the next section of this chapter.

**Stigma and Marginalisation**

Mental illness, psychiatry and the personality of the psychiatrist have histories peppered with myths, stigma and secrecy, as discussed in Chapter Three. These have developed variously to provide both explanation and meaning for flawed perceptions of reality, but also to conceal a lack of understanding and knowledge over cause and effect of mental illness. In Luske's discussion of psychiatry, developed through talking with the ward staff of one psychiatric institution in the USA, he suggested that the staff's working activity consisted mostly of attributing symptoms of psychosis to the problematic behaviour of residents. Ward staff were spending most of their working time constructing and maintaining stigmatised identities. Therefore, it follows that one's own identity will also show evidence of stigma (Luske, 1990: 113).

On the practice of psychiatry, Luske (1990: 93) describes 'the helping relationship ostensibly at the heart of psychiatry as, in reality, a parasitic relationship'. Yet further:

> In its unwillingness to allow for the potential viability and value of alternative realities, psychiatry becomes an ersatz totalitarian religion
employed as a rigid and narrow defence against the threat of the unknown' (Luske, 1990: 69).

Symbiotic, rather than parasitic, may better describe the psychiatrist-patient relationship, where the stigma has come to be seen as shared. Certainly, a number of respondents stressed the importance of the relationship with the patient in enabling effective psychiatry. It seems that when discussing psychiatrists and their work, established myths are sometimes perpetuated, sometimes rewritten as criticisms and sometimes new ones are formed, as Jasmine's comment below confirms:

"Psychiatry as a discipline is not that old. Yet, for the length of its existence it has a, a large and embarrassing umm story of fads and fantasies within its practice, that are just embarrassing (Jasmine, #1: 35)."

Describing the contemporary situation of psychiatry, Ian spoke, not of embarrassment, but of his frustration:

"There is almost a sense of psychiatrist-bashing in vogue. I think this is part of a much broader agenda (Ian, #1: 54)."

This broader agenda, it was revealed by a number of respondents, primarily revolved around the introduction of case management teams, funding of service delivery and psychiatrists being relatively expensive members of these mental health teams.\(^{45}\)

\(^{45}\) The issues of money and service delivery are discussed further in the following section on Money. Briefly though, managed care teams vary in composition across states in Australia. The teams can consist of social workers, mental health nurses, psychologists and psychiatrists.
Yet, having voiced his frustration Ian offered:

In general, it is the “golden age” of psychiatry ... it was at a threshold of potentially being elevated to a prestigious position in the medical fraternity (Ian, #1: 55).

These seemingly contradictory statements suggest confusion and, again, ambivalence about the position of psychiatry and its role in medicine. More generally, it also questions the role of the psychiatrist in delivering mental health care to society. 

Robert mentioned stigmatisation of psychiatrists directly and offered his views of psychiatry’s place in medicine:

**Robert:** In the 1950s in London, it was fashionable to be fairly contemptuous of psychiatry, psychiatrists and psychiatric patients.

**EK:** Has that changed, do you think?

**Robert:** Yes, to some degree, to a considerable degree. Ah, not all together ah, ah, to a considerable degree, umm.

**EK:** How has that change come about and why do you think —?

**Robert:** I think partly psychiatry is becoming more and more accepted as a medical speciality ... And I think as medical students come through, they see more and more, psychiatry as a branch of medicine and ah hence it's not stigmatised in a way that it used to be and marginalized in a way that it used to be.

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46 This confusion is also present in respondents' stories when they talk about their patients and mental illness. This is discussed in the last section of this chapter, Madness.
EK: Is it still a little bit though? Do you –?
Robert: Oh yes inevitably, inevitable (Robert, #1: 18-19).

When asked why Robert thought this was so, he told a story of a neurologist at medical Grand Rounds\(^\text{47}\) presenting videos of patients with ‘strange and unusual neurological diseases’ (Robert, #1: 19).

Robert: And they were showing one or two patients with very odd behaviours and people were laughing their heads off. And then he said, “Now this is the CT\(^\text{48}\) of this patient. She’s got a very large tumour at the frontal lobe of the brain”. Yet, when the next patient was shown behaving strangely, people were laughing their heads off again. Umm I think it’s got something to do with that. The patients are not sitting here in bed and behaving neatly, properly, obediently, as a good patient should do [he laughs].

EK: But that funniness associated with patient behaviour, is that being transferred to the psychiatrist?

Robert: I think, I think psychotic patients are, are, are – . The other thing is that we often tend to laugh at things we are afraid of so, ah, you know, psychotic patients can be a bit frightening for one reason and another and not, not necessarily because they are threatening but because, am I going to go that way, sort of thing.

\(^{47}\) Grand Rounds are conducted in most hospitals and are usually weekly events. They are opportunities to share, primarily with interested colleagues and medical students, new research findings, unusual features, insights, clinical practices or treatments regimes for medical conditions in a specific therapy area. They have a strong clinical focus and as such often showcase patients, or results of patient investigations, with the specific medical complaint in question.

\(^{48}\) CT Scans, or Computer Assisted Tomography Scans, are more detailed X-ray examinations. The films produced give a cross-section through the part of the body being examined. CT Scans are used as a diagnostic and assessment tool to detect evidence of any physical abnormalities.
EK: And that funniness in their behaviours is being transferred to their carers, the psychiatrists?

Robert: Yes, Yes. Oh yes.

EK: How have you dealt with that through your career?

Robert: Ah, when I’m dealing with other doctors I don’t try to take refuge in um ah too much, in the way of jargon, too much in the way of theory, particularly, sort of, psychological theory. Um and umm I think because I’ve got a background in ordinary respectable medicine, it’s, they’ll, they’ll often tend to accept and because I understand what they’re on about … they tend to accept what I say more readily because I’m, I’m fairly obviously one of them (Robert, #1: 19-20).

Another psychiatrist, Kym, explained this identity problem for psychiatry in medicine as the result of its functions being slightly divorced from general medicine and general surgery. The essential medical role of doctors disappears into the background. I asked Kym why he thought this was undesirable. He answered, telling me that, because psychiatry is a medical discipline, the 'essential terra firma should not be allowed to slip away, or the basic medical understanding' (Kym, #1: 71).

Respondents all agreed that psychiatry 'has never been a, sort of, high profile standard end of medicine' (Rene, #1: 2). Rene continued:

Rene: Psychiatry is not a popular speciality at the moment.

EK: Has it ever been?

Rene: Yeah.

EK: It has? Why?
Rene: I, I don’t think that it’s ever been, you know, neurosurgery or cardiothoracic surgery.

EK: Why not?

Rene: Oh, because, you know, that’s sort of drama, and psychiatry and psychiatric patients are often miserable and, and err mad, you know (Rene, #1: 3).

Another part of the marginalisation of psychiatry, was the demarcation between psychiatrists and other mental health care workers. This has been exacerbated through the current practices of increased community care, case management and funding shortages. In particular, the demarcation between the role of the psychologist and psychiatrist has contributed to the perceptions of marginalisation of psychiatry and the associated need to reaffirm the psychiatrists’ identity as doctors:

One of the ways psychiatrists try and stand firm and delineate their profession, is by saying, “we do drugs” (Jasmine, #1: 49)\(^49\).

**Women and Psychiatry**

As described above, marginalisation within the profession of medicine was a distinguishing feature raised by several respondents about psychiatry. A quite different distinguishing feature was the number of women in the profession and how their practice differs from that of their male colleagues. Of interest, I was advised to talk to women psychiatrists by four of the male psychiatrists interviewed Lindsay, Frank, Peter, Kym).

\(^49\) Psychiatrists, being medically qualified, can prescribe pharmaceutical medications. Psychologists are not medically qualified and cannot write prescriptions for these medications. In the mental health care teams only psychiatrists can prescribe drugs.
Jasmine estimated that currently, the Royal College of Australian and New Zealand Psychiatrists (RANZCP) has a female membership of ‘about one third’ (Jasmine, #1: 58). While this may seem low for some professional groups, it is still relatively high in comparison to other medical specialities including orthopaedics, cardiology, neurology and gynaecology, where percentages of full time women in practice struggle to meet ten per cent of the total\textsuperscript{50}.

This may be because ‘psychiatry is much more women friendly because you can do part time training and then also in practice’ (Jo, #1: 35). Nicola continues:

\begin{quote}
I mean, it is a speciality that attracts women because it gives you the option of doing part-time work when you have family. Maybe it’s again a part of medicine which isn’t so traditional in that sense (Nicola, #1: 12).
\end{quote}

However, the opportunities for women do not necessarily extend to the academic career positions:

\begin{quote}
Even though there isn’t a formal hierarchy, there is one, you know, and it’s, it’s a fairly rigid system (Nicola, #1: 6).
\end{quote}

This maybe because academic positions require primarily scientific quantitative research to be conducted, as well as teaching. ‘Clinical biomedical research has been dominated by positivism and a patriarchal bias that has ignored the qualitative and critical conversation’ (Miller and Crabtree, 1994: 340). Interestingly, none of the

\textsuperscript{50} Personal communication, Royal College of Physicians, Canberra.
male psychiatrists interviewed mentioned hierarchies. Lindsay, now a psychiatrist, had been a general practitioner before requalifying as a psychiatrist. Lindsay offered his perspective about women psychiatrists:

**Lindsay:** Women psychiatrists engage at a much more personal level. Talking to patients is to intrude upon them in a way that would not normally be done. Women psychiatrists can do this with a much greater sense of interpersonal connection ... They are more empathic and in tune. I can see a patient's illness, the symptoms and give a diagnosis, but a lot of the time it doesn't matter. The intense nature of the female relationship to patients to get through all the things is different and important. They have a lot of things to talk about – a lot to get through. It could take six months to work through things to get to a stage where you can go forward (Lindsay, #2: 40-41).

Patients with a history of sexual abuse were cited by Lindsay as an example of individuals with "a lot of things" to work through. Jasmine’s experience was similar, but had a more practical aspect from the patients’ perspective – money:

**Jasmine:** People have a belief – that women will be kinder; women will be small and –

**EK:** Will be, will be, what?

**Jasmine:** Will be smaller, kinder, better and maybe we will charge lower fees, and I think there’s something right about that. Women psychiatrist’s fees tend to be lower.

**EK:** Than the men’s?

**Jasmine:** That’s right. I think they’re a bit more affordable. I think that's part of the package too (Jasmine, #1: 55).
There are standardised minimum consultation fees each type of specialist doctor can charge patients that are set by the Australian Medical Association (AMA). Setting fees above these standards can be done at each practitioner’s discretion. Speculation on why women psychiatrists tend to set their fees lower than men raises several possibilities. Personal choice is a simple, but possibly simplistic explanation. A women-centred reality perspective, as offered by Hendricks (1992) suggests at least two more insightful, challenging reasons. First, women are different in behaviour because they are socialised differently. Second, women are disadvantaged economically and socially within male-privileged society (Hendricks, 1992: 461). An additional explanation, as Nicola referred to above, is self-sacrifice, because women value the options to work flexible hours or part-time, to accommodate family commitments.

As a woman, psychiatry has provided me with a good income working part-time and freedom to write plays on my days off (Achimovich, 1998: 742).

The practice of psychiatry by women psychiatrists was acknowledged to be different from that of their male colleagues. Again, Hendricks women-centred reality offers some insight here with respect to their relationships with patients as “other”. Women-centred reality seeks to be attentive, to nurture the potential of the other. It does not diminish, contain or stereotype or hold itself superior to the other (Hendricks, 1992: 455). Maybe this is what Lindsay was referring to above when he described the intense nature of the female relationship to patients, to get through all the things, as different and important.

Other differences in practice not influenced by gender, relate to type of practice and sub-speciality. One sub-speciality, forensic psychiatry, was of particular interest
because of its close relationship to the law, and judgements about behaviour and normality in society.

**Forensic Psychiatry, Power and the Interface with the Law**

It was in the two interviews with experienced practising forensic psychiatrists that the concept of power in the psychiatrist-patient relationship was particularly evident. Power became evident in the context of their forensic work because it was here that psychiatry interfaced most closely with the law and government regulations. Rene was almost nervous about the extent to which she was able to control her patients’ freedom:

Rene: Being ultimately responsible in many ways, in a medico, medico-legal level, makes you extremely thoughtful and cautious. What you do and how you do it, and you’ve got systems in place for reviewing what you do and relying on your colleagues for um, cross, cross-referral and peer review, and second opinions and things like that (Rene, #1: 4).

Robert liked forensic psychiatry because of the control it offered with respect to monetary rewards:

Robert: It is much more lucrative than treating people. It’s the last bastion of true private enterprise in medicine.

EK: In what way?

Robert: In that there is no government interference. Government doesn’t have any sort of “finger in this pie”, whatever. As they do in, in any ordinary medial treatment by way of um, Medicare, setting rebates – .

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EK: Is it generally acknowledged that it is the last bastion of private enterprise?

Robert: I think so. About the only other truly private enterprise is cosmetic surgery (Robert, #1: 12-13).

Psychiatrists' motivation and justification are rooted in medicine but combine with emotion about being both a part of – and yet apart from – the mainstream medical profession. Conflict and contradiction of opinion within the profession exists because psychiatrists consider themselves “special” doctors with a unique role in medicine. At the same time, psychiatrists acknowledge being marginalised by medicine and by society. The relationship with patients, the law and society, whatever the type of practice, were considered aspects of the enjoyable and not so enjoyable aspects of psychiatry. These contradictions within psychiatry suggest an ambivalence that mirrors contradictions in contemporary society. This ambivalence has been a focus for postmodern theorisations and is regarded ‘as an appropriate response to an inherently conflictual situation’ (Flax, 1990: 11). Postmodernism would advise that scepticism for the metanarratives of medical science and the expert knowledge of doctors would encourage tolerance for ambiguity, ambivalence and difference in an increasingly fragmented, contradictory world (Flax, 1993: 38; Fox, 1999: 8).

Conflict and Ambivalence in Psychiatry

Ambivalence has been defined as the coexistence in one person of opposite feelings towards the same object or situation (Sykes, 1976: 30). The ambivalence of psychiatrists towards their profession and their role in society has been depicted throughout the history of psychiatry. This history acknowledges the many unknowns about cause and effect in mental health, but concurrently, has tried to appropriate
science and the scientific method to try to explain mental disorder. The turn to science remains problematic because:

> The models derived from the physical sciences are not as reliable or as solid as they may appear. This is partly because scientific knowledge is never constant. It keeps changing, though not necessarily advancing (Shea, 2000: 226).

The discourse of psychiatry, as told by psychiatrists, is a mixture of medicine, science, art, myth and stigmatisation. Ambivalence towards the profession is a predominant sentiment; a social reality within psychiatry today. The questions and responses given in interview corroborate Bourdieu’s statements about representation of groups, that is, how psychiatrists see and represent their profession. The representation which individuals and groups – like psychiatrists – inevitably project through psychiatric practices and properties is an integral part of the social reality of that group. ‘A class is defined as much by its being-perceived as by its being’ (Boudieu, 1984: 483). The representations psychiatrists have of themselves – of their reality – define the limits of thought about who they are and what they could be. This is the “reality” of representation. In the above discussion, the representation of psychiatry in a number of contexts was also linked to money, either directly as “the last bastion of free enterprise” or indirectly, through relating psychiatry to the cost of mental health care provision in the public or private system. The following section tells of the place of money in the story psychiatrists tell of psychiatry.
Money

As mentioned in the previous section money was a recurring theme encountered within the practice of psychiatry. This was not always the money of personal gain in the practice of their profession but rather, that associated with government funding in the health system used to provide appropriate patient services. Sam explained the situation:

Why pay to see a psychiatrist when you can see a social worker for $25 (Sam, #1: 63).

The psychiatrists' question relevant to this focus area of The Challenges and Issues for the Future was:

- What are the future challenges for psychiatry in the twenty-first century?

Interestingly, these challenges seemed to revolve around money.

“Service provision” was the most commonly stated challenge for the future of psychiatry. Why this was so and what precisely was meant by the term “service provision” was always explained through reference to patients.

The passion of psychiatry is in the service of patients (Jeremy, #1: 18),

But,

The effort put into a patient has to be meaningful (Kym, #2: 70).
One area of psychiatry that was agreed by a number of psychiatrists to be unrewarding and not an attractive area to work in was Drugs and Alcohol (D&A) (Peter, Kym, Nicola, Rene, Robert, Frank). Kym explains:

You clean a patient ... then they go back to the same life style. There is no meaningful rehabilitation (Kym, #2: 70).

There was a further degree of powerlessness expressed concerning outpatient care:

In the practice of psychiatry, there has been the shift from inpatients to outpatients which has accelerated over recent years. The aim [of this shift] was to reduce the hospital stays, to have treatment in the community setting (Sam, #1: 62).

The trend to outpatient care has been facilitated by using the managed care or Community Assisted Treatment (CAT) team approach. It has meant a loss of control of whole patient care for psychiatrists, and a loss of choice about how to practice. Ian advised that in the state of Victoria, CAT teams were consisted of 16 to 20 nurses, a manager, half a psychiatrist and a psychiatric registrar\textsuperscript{51}. The psychiatrists are often only called on in emergencies, mostly for admissions associated with acute episodes. This loss of choice about practice would inevitably extend to income received, as CAT team wages are state-regulated.

Lindsay saw the shift in treatment of patients as outpatients as having caused psychiatry to struggle over the last 20 to 30 years. This struggle meant transitioning

\textsuperscript{51} A psychiatric registrar is a qualified doctor who has commenced his or her five year psychiatric specialist training. The registrar’s position on a particular CAT team would most likely be for a six-month rotation.
from social psychiatry in the mid 1970s towards the current community mental health centres, which 'were ideologically driven and run by social workers as a cost cutting exercise' (Lindsay, #1: 3-4). Ian, in private practice, was more optimistic as he advised that now and in the future:

Psychiatrists must be prepared to compete, compete in a constructive way, just like other business professionals (Ian, #1: 57).

The reason Ian gave was that the psychiatrist was practising in a more managerialist environment, where the pursuit of the economic rationalist enterprise demanded measurement of outcomes and performance, and the costing of service delivery. Tobin, a prominent Department of Health psychiatrist in South Australia, advised in 1999 that the professional context and "macro" environment in which psychiatrists existed had radically changed (Tobin, 1999: 197).

Ian saw the acquisition of business acumen to be part of the future discourse of psychiatry:

You are looking at highly trained people. Therefore, they are costly (Ian, #1: 55-56).

Psychiatrists need to be innovative, at the cutting edge and stand up for ourselves, and be confident to defend what we understand without being emptily arrogant (Ian, #1: 58).

The majority of the psychiatrists interviewed, however, saw the trend to being a competitive business operator as threatening to their clinical expertise and
leadership. This threat was not challenging their knowledge as doctors, but, rather, 'the role of the doctor – the official subject of knowledge' (Foucault, 1994: 49). It could be argued that the role of the doctor as healer has been internalised within the discourse of psychiatry. Having internalised its own repetition, some psychiatrists were now calling into question the authority and legitimacy of past models of practice (Durham, 1998: 3). Jasmine, for one, was quite defensive of their current position as leaders in mental health care teams and saw psychiatry’s leadership as something to fight for in the future:

**Jasmine:** I suppose what psychiatrists also don’t want to give up, and I’m in this kind of camp, is a view of ourselves as having more training than any other group. We have the medical training, we have the training both for the severe psychotic mental disorders and the more personality type disorders, assuming for the moment that all these things are legitimate and real um. And we have a breadth of expertise and length of training. Psychiatrists like to think that positions us best to lead clinically, not necessarily bureaucratically, but to lead clinically a mental health team and that, that the wider mental health profession would lose if psychiatrists somehow got shoved into a little corner. But they’re bloody well not going to be, because they’re not going to be prepared to um, to be side-lined like that (Jasmine, #1: 53).

Nicola agreed with Jasmine, also highlighting that “relevance” was the challenge for the future. Nicola felt that today, the relevance of the psychiatrist was being called into question from within its own institution. Foucault suggested that, since the end of the nineteenth century, all the big jolts that have shaken psychiatry have essentially questioned the power of the physician (Foucault, 1994: 45). This looks
to be what psychiatrists are saying still. The fundamental reason for the “big jolt” today is money. The funding of psychiatry is about social well-being and “social cost”. Sam and Ian comment:

The health funds are in a state of crisis (Sam, #1: 62).

and,

We are constrained now by expectations of funding bodies (Ian, #1: 55).

The Royal Australasian College of Psychiatrists (RANZCP) has defended the position that psychiatrists need to maintain their leadership in mental health care. This will be achieved, they argue, through education of psychiatrists in and for leadership and management. Tobin argues that this is not a strategy to “regain lost control”, but rather, is preparing forward-thinking resilient psychiatrists for reform (Tobin, 1999: 197). Anaf critiques this emphasis as a trend emanating from a "performance-control" model, a product of psychiatry operating in the current political framework. He suggests, instead, that this trend will ‘reduce the subtlety and nuance in clinical practice’ and will reduce the ‘centrality of the doctor-patient relationship’ and ‘clinical autonomy’ (Anaf, 2000: 1-7). Rene currently worked mostly in public administration of mental health. She agreed with the importance of clinical autonomy when asked about the challenges for the future of psychiatry:

Clinical, direct clinical responsibility, because I think that’s at the core of medicine’ (Rene, #1: 8).

Rene continued:
One thing for medicine in psychiatry, particularly in public psychiatry, is that there has been this sort of um, the rise of the "generic worker" which is effectively a deskilling. Deskilling means that so much more of the care in the community is under allied staff [not psychiatrists]. Although there is still primary responsibility and, I guess, clinical leadership [for psychiatrists], it's harder to see that and to sustain that, and I think that has an effect on morale (Rene, #1: 2-3).

This view expressed by Rene was not isolated. Wilson (1999: 259) confirms, stating that the team approach to the delivery of mental health services has led to a deskilling of the professional psychiatrist. Current statistics from the mental health services database show that in 1999-2000 there were just 1,749 medically qualified staff (included 551 consultant psychiatrists, 737 registrars and 379 other) employed full time in specialist mental health services. This is in contrast to 10,481 non-medically qualified nursing staff and 3,469 allied health workers (which included occupational therapists 610; social workers 1,071; psychologists 1,089; and other 699), (Commonwealth Department of Health and Ageing, 2002: 232). The complete care of the patient has gone to the case managers or allied help services:

Case management is a very good thing, but from the point of view of the psychiatrist it means that you are almost excluded from being involved in the care (Rene, #1: 4).

Another current shift is for more patients to be pushed towards the general practitioner, away from psychiatrists. This is confronting for the profession, challenging its role and its future within medicine:
What would this shift achieve, taking psychiatry away from its roots in medicine? Medicine loses psychiatry (Sam, #1: 83).

Yet, other members of the RANZCP view the situation differently. 'We will require a different set of skills, competencies and knowledge from our primary clinical base' (Tobin, 1999: 194). A question for the future place of psychiatrists is how best to make as transparent as possible the costs, outcomes, future relevance and usefulness or not, of the past practices of psychiatry within the evolving discourse of psychiatry. As in many other discourses, the discourse of psychiatry is neither definable nor determinable. It exceeds the boundaries it currently occupies (Caputo, 1997: 33). A way forward for the future might be for psychiatrists to acknowledge the 'fragmentation and disillusionment within their College' (Anaf, 2000: 30) and as an institution about who they are and what they do. Like the deinstitutionalisation of psychiatric patients from asylums in the mid 1900s, psychiatrists could be subject to their own deinstitutionalisation in the twenty-first century.

Psychiatrists could also rethink the value of who they are and what they do, not be replaced, but to consider re-placing themselves. No position is so well established that the power to assume another role, to become other than the self, is beyond experience and realisation (Rabinow, 1994: xix, Caputo, 1997: 33, Durham, 1998: 11-12). However, no matter how psychiatrists re-place themselves, it may be that society has the psychiatrists it deserves. Each culture, after all, has the madness it deserves' (Lotringer, 1996: 9). Clearly, Jasmine and Rene see psychiatrists have some work to do to achieve their re-placement:

The way psychiatry sees itself and understands itself gives you the trots sometimes (Jasmine, #1: 41).
How psychiatry will survive, that I don't know. Actually, it may not survive it very well. I think the end of the twentieth century is a very depressing time for psychiatry (Rene, #1: 9).

Madness

The third and final theme for Patients and Treatment of Mental Illness was Madness. Respondents challenged the identity of mental illness. They also questioned the identity of the patient and themselves as psychiatrists treating the illness of the patient. The researcher was surprised, when re-reading the transcripts, how often they referred to mental illness as “madness”. “Madness” is generally used as a colloquial, non-specific label for a large number of mental illnesses that psychiatrists as a profession have, over time, invested much effort in distinguishing, separating, naming and giving distinctive symptomatic profiles and identities in works like the DSMIV and ICD10. Despite psychiatry’s history of categorisation of mental illness, their use of this generic term madness, persists.

The summary questions in this focus area about Patients and Treatment of Mental Illness lead to stories about understanding and the impreciseness of psychiatry.

The summary questions were:

- What is my relationship with patients and how does this change over time?
- How can we better understand the experience of mental illness and its treatment?
Understanding

The impreciseness of treatment of mental illness was summarised by Peter:

The whole thing is being able to understand ... The frustration of clinical practice is that it is replete with gaps and inadequacies ... It's a trial and error approach of giving what to what patient (Peter, #1: 77).

Jasmine was equally unsure, and she expressed her concerns in terms of the treatment possibilities:

It's a real toss-up for the patients, on what to do (Jasmine, #1: 41).

Malcolm's focus was on being able to explain what was wrong with the patient. He did not see categorisations such as "abnormal", as helpful.

They ask, are they mentally ill? ... [It] conjures up images of mental illness ... insane, out of touch with reality. You do a little bit of excluding certain things. It is not helped by legal terms in contemporary use, like abnormality (Malcolm, #1: 52).

Peter and Malcolm both expressed concern about the spectrum of illness in relation to what was considered normal or abnormal. Interestingly, Malcolm could not help using the term "abnormal", then subsequently stated that its use was unhelpful.

There is an intriguing interplay of factors in mental illness including coping styles (Peter, #1: 77).
Certain reactions are regarded as “abnormal”, an interphase exists. And then there is “normal”. The divide is extremely subjective. We need to find some better way, a more valid way, less arbitrary (Malcolm, #1: 48).

Malcolm’s use of the word “abnormal” and his frustration to find less arbitrary, more valid ways to distinguish abnormal from normal was representative of the whole psychiatric project – to become something that it was not. Psychiatrists appeal to science and medicine for validity and identity. The rise and popularity of biological psychiatry was testament to their efforts.

The vagaries of clinical practice, as mentioned by the respondents above, have been identified by Miller and Crabtree, who regard the practice of patient care as one revealing the uncertainty and particularity of clinical praxis, turning one toward storytelling, relationship, and interpretation (Miller and Crabtree, 1994: 341). In support of this turn toward relationship and interpretation, Peter explained that psychiatry was about mapping the course of madness through believing and understanding the patients it afflicts. As Shea (2000: 227) explains, unlike general medicine, psychiatry is concerned less with disease entities and processes, than patients and people.

To arrive at treatments, the psychiatrists described the need to understand their patients, their patients’ stories about their illness, and how the illness was affecting patients in society. The emphasis on madness and understanding patients was specific. However, respondents’ explanations of what madness was and how understanding of madness occurred was more vague. This, I believe, relates back to the issues of identity and stigmatization, as discussed in an earlier section of this
chapter. The problem of identity was not being able to satisfactorily describe what it was they were doing as psychiatrists, having to be experts in many fields, and not being accepted by fellow medical colleagues.

To help him understand madness, Peter considered the views of both society and his patients with mental illness. Peter explained more about what madness was:

> Madness is a frightening reality. It is not attractive. It is distasteful to people. Madness is always unpleasant — madness is always somebody else — it is seen as a weakness, losing control (Peter, #1: 77).

How can psychiatrists then answer their question of: "How can I better understand the experience of mental illness and its treatment?" The respondents' focus on understanding patients suggested that their view of madness was at odds with their definition and classification system, which promotes the concept of a definitive unified object of a mentally ill person that can be diagnosed, treated and who can regain mental health. Madness appeared to the respondents to be very individual. The unified, defined mentally ill versus the mentally healthy patient was also at the heart of mental health policy objectives. Yet, using the term ill versus healthy was no more helpful to understanding and treating madness than saying abnormal versus normal. Rene suggested that psychiatrists were not so interested in the allocation and treatment of the patient and their illness to some diagnostic space, but of being the listener and co-interpreter of place — their patient's and their own:

> It is much less exciting to think about patients in terms of what drug do they need than how can I understand this person. How can, how can I
use that understanding to help them cope with or change how they're seeing themselves in the world? (Rene, #1: 3).

This is a complex agenda. As Malcolm admitted:

The challenge and beauty of psychiatry is ambiguity (Malcolm, #1: 49).

It may be that psychiatry has more elements of a postmodern medicine than most psychiatrists would recognise or admit. 'It would be misleading to suggest that psychiatry ever had a monolithic vision of its task and its domain. The fragmentation of psychiatric theory is evident in its history and texts' (Prior, 1993: 58-59).

**Uncertainty**

In its simplest form, the expectation of society is that psychiatrists treat and aim to heal mental illness, much as other medical practitioners aim to treat and heal physical illnesses. From the psychiatrist's perspective, this seems also to be the case:

Where it's a frank illness\(^{52}\) ... then you're more in the doctor-patient role (Nicola, #1: 2).

\(^{52}\) My understanding of the use of the term frank illness was where the psychiatrist could easily categorise the patient's illness based on the clinical presentation of the patient and the
The doctor-patient role is not so useful with other illnesses where treatment involves:

Engaging with people, um, around, um, their perception of the difficulties that they face in their life (Nicola, #1: 2).

Or where:

The psychiatrist is involved in narratives of how [life] might be understood ... future expectations (Jeremy, #1: 18).

And as for how psychiatrists do this:

You can learn responses, but some are spontaneous, just as they are when talking over the back fence (Lindsay, #1: 6).

Over time you see and relate to patients differently and they towards you (Lindsay, #2: 44).

Lindsay also believed that what happens to him personally has an effect on the way he views patients. The effect is usually positive:

It has expanded my acceptance of patients and their differences and expanded my interpersonal repertoire (Lindsay, #2: 44).
I asked Lindsay if other psychiatrists would feel the same. He responded by telling me that 'some commit suicide'. I asked why:

Mainly because of their progress in life, marital problems, alcohol abuse, and disillusionment with the way they work. They [psychiatrists] are just as vulnerable to depression. One's own depression can be very hard to recognise (Lindsay, #2: 44-45).

Unfortunately the often chronic and complex nature of mental illness means that many individuals’ mental illness remains unseen and untreated. Conversely, those perceived most in need may not seek or receive the treatment by psychiatrists that would benefit them.

You're faced with people who present to you. Or, often, actually the problem is that they don't present to psychiatrists in the first place (Jasmine, #1: 38).

Nicola expressed her concern for people who were not coping with life, yet were not seen by psychiatrists:

I think there's a lot of unmet need and, again, it's one of those problem interfaces. You know, the notion of treating the “worried well” (Nicola, #1: 30).

The terminology “worried well” has been used to describe patients who see private practice psychiatrists. The “worried well” are usually believed to be women who are financially stable and who are either considered just not happy, or not coping with
issues in their life, needing someone to talk to about their difficulties. In this respect, the “worried well” are not considered *truly* psychiatric patients, with some respondents considering that they are somehow less deserving of treatment by psychiatrists. The associated concern by some psychiatrists is that these “worried well” are consuming mental health resources at the expense of the *really* mentally ill patients.

Along with the “worried well” are a number of other disorders that psychiatrists see and treat that could also be considered as a drain on mental health care dollars. These were described by Jasmine:

**Jasmine:** I have a realistic and scientific view about psychiatry but that’s, you know, actually for quite a narrow range of disorders. There’s a high sort of constructed, co-constructed um area, set of conditions that, that are much more problematic and puzzling that, um, about which psychiatrists need to be a lot more self-aware I think, and self critical and self questioning.

**EK:** What do you mean by co-constructed?

**Jasmine:** Constructed by popular movements in our culture and by the psychiatric establishment, for example, things like alien abduction syndrome, multiple personality disorder, and a lot of these more chronic fatigue syndromes. There’s a sort of um symbiotic development between professionals, um suffering people, and the culture.

**EK:** The bigger broader culture of which those two are a part?

**Jasmine:** Yeah, Yeah. I’m, I’m thinking about, you know, the media and all the stuff that’s just floating around in our culture that um, psychiatry picks up on. How psychiatrists get caught up in all that stuff. I suppose I find the
profession generally kind of lacking in adequate skills sometimes (Jasmine, #1: 36).

In considering the reality and meaning of disorder or illness in psychiatry, many authors have written extensively and described it as constructed in some way (Szasz, 1987; Vice, 1992; Prior, 1993; Lewis-Fernandez, 1996). Most recently for disease in general medicine as well, the psychiatrist Ellard concluded that there is no satisfactory definition, and that both are social constructs (Ellard, 2002: 104). This is a shocking proposal for many, as adherence to evidence-based medicine and pursuing the scientific method in medical research has become big business for more than just psychiatry. A health policy review needs to assess how the "shrinking health dollar" is being spent on these social constructs. Psychiatry needs to ask if it is getting a fair share.

Jasmine's concern about disorders, like alien abduction syndrome, was that psychiatrists have not been asking why these co-constructions are occurring. Psychiatry needs to question what this says about Western society and how psychiatry has become involved. Psychiatry's understanding of madness is very individually based. If, as Jasmine suggested, there is a symbiotic development of disorders between psychiatrists, suffering people and culture, then, the origin of the disorder is not located in individuals (Prior, 1993: 111). This was what I believe Jasmine was struggling to understand when she spoke of the madness she sometimes saw.

A further complication concerning effective treatment for the appropriate types of madness was the perception that current therapies and therapists available, including psychiatrists, give variable results and levels of "healing". Gavin Andrews
(1999: 316) believes that, despite the increasing evidence of the efficacy of many treatments, psychiatrists are overwhelmed by criticism from consumers, funders and the media. The criticism is that psychiatric treatment does not relieve or cure.

During Kym’s treatment of patients with depression, he admitted having a ten to fifteen percent failure rate after twenty-one days of treatment. He qualified this by saying that a third of these patients were “maladjusted”, with problems of money, love, sex, relationships, or an inability to make “proper decisions”. The other ten percent of patients “come good” by the second or third round of treatment through additional drug therapy. Some patients improve with the use of ECT\textsuperscript{53}. Biological psychiatrists, like Kym, believe that depression, and a number of what were previously referred to by Nicola as “frank illnesses”, are a result of neurotransmitter or biochemical faults in the brain. For these illnesses pharmacological therapy, or other “physical” therapies like ECT or Transcranial Magnetic Stimulation (TMS)\textsuperscript{54}, are the most effective methods of treatment available today. Kym had convinced himself that the patients who responded to the biological treatments, as opposed to the psychological therapies like Cognitive Behaviour Therapy (CBT), were the only patients worth seeing, because he could “make them better”. The distress of the other patients, judged “maladjusted”, was trivialised. Kym’s comment is possibly the

\textsuperscript{53} ECT is Electro-Convulsive Therapy. A mild electric current is applied to the brain through attached electrodes. The mechanism of action on neuronal receptors and pathways is not fully understood but it is effective when used in severe depressive episodes. ECT has a relatively long history of use in psychiatry since the early twentieth century. Most people first became aware of ECT in the 1970s through seeing films like “One Flew Over the Cuckoo’s Nest”. ECT is still used regularly and routinely today to treat major depressive episodes. Psychiatry still does not know how, or why, ECT works on the brain to “jolt” patients out of severe depression.

\textsuperscript{54} TMS is a procedure in which electrical activity in the brain is influenced by a pulsed magnetic field. The field is generated by passing current pulses through a conduction coil, held close to the scalp so that the field is focussed in the cortex, passing through the skull. When this stimulation is delivered at regular intervals, it is termed repetitive TMS or rTMS. TMS and rTMS have been used to investigate aspects of cortical processing, including sensory and cognitive functions. The use of rTMS, combined with knowledge of how local cortical activity can change during various disorders, has raised the possibility of the use of rTMS as a therapeutic tool for psychiatric and neurological disorders.
result of his patients not behaving like “good consumers” and benefiting from their
collection of his psychiatric expertise and drugs. This may be a consequence of
a contemporary consumer society, where the inadequacy of the person as a
consumer leads to their social degradation and “internal exile” (Bauman, 1998; cited

In general, however, most respondents agreed that treating patients demanded the
coeexistence within psychiatrists of openness, empathy, understanding, compassion,
and believing what their patients told them. This is combined with their medical
training and an ability to objectify and disengage themselves from the reality of their
patients’ distress. Conventional medical training teaches medicine as science and
doctors are to be impartial, neutral investigators. Yet, for Rene, in her forensic
practice, the contact with patients was draining. Maintaining a “neutral figure” was a
challenge:

There is no doubt that psychiatric patients can be the most draining to
work with. I mean, psychiatry, psychiatric patients are disabled.
Psychiatric patients who commit crimes are even more disabled ... They're usually from the lowest of the low socio-economic groups,
usually have completely stuffed families and personal backgrounds
(Rene, #1: 2-5).

Respondents questioned themselves as psychiatrists, about what they could and
could not do. I disagree with Miller and Crabtree’s comment that clinical participants
rarely study themselves in their clinical context, failing to challenge their own situated
knowledge (Miller and Crabtree, 1994: 341). My experience was that the
respondents were quite willing to be reflexive about what they did as psychiatrists. This was revealed, in particular, by Jasmine’s comments:

**EK:** So what is it that you’re doing when you’re doing psychiatry?

**Jasmine:** Well, I spend a lot of my time as a psychiatrist being absolutely tormented about what I am doing and um, I mean, one of the things um, that makes it even harder is my background in philosophy um ... It’s very confusing, my desire to defend a profession against those who say it is kind of nothing but evil repressive, unhealthy thing. I mean, I’ll stand with any other psychiatrist and say, “You go and spend, you know, three weeks on the wards at Rozelle Hospital, Prince of Wales Hospital and be with the patients and see what it is that ails these people and then come back and tell me that it’s all just made up” ... I think the best way to put it, [is] they are very, very, sick, disabled, vulnerable people (Jasmine, #1: 39).

Interpretation of the respondents’ stories revealed the coexistence and depth of opposing feelings — ambivalence towards their practice and possibly their patients. This ambivalence, combined with the uncertainty and impreciseness of the profession of psychiatry, seemed to be unique to psychiatry within the medical profession. Psychiatrists are mostly able to maintain the neutral figure with their patients. However, I have been privileged to hear some of their personal reflections about who they are and what they do, and about the limitations they experience and are tormented by:

Your part is to relieve the patient of pain and distress, but without a superior knowledge of where one’s limits are, we will needlessly prolong a patient's suffering (Malcolm, #1: 53).
Experience and Knowing One’s Limitations

Experience was acknowledged in a number of ways by the majority of respondents as being very important to good practice. Experience enabled the realisation of one’s limitations:

Learning skills to help people manage those areas of their lives takes a lot of time and, I suppose, over twenty years, you know, you work to develop those skills (Nicola, #1: 3).

For Kym and Lindsay, the patients also need to understand that psychiatrists have their limits:

I am not God, divine. They expect psychiatrists to be non-human, superhuman (Kym, #1: 31).

They think you know what they are thinking and that all their dark secrets will be known (Lindsay, #1: 5).

This is a part of the stigmatisation of the image of the psychiatrist who may, in fact, be more vulnerable to transferential distortions than most people would realise:

They can so easily be regarded as omniscient mind readers who understand the dark workings of the human psyche in a manner unavailable to others. This dimension is often depicted in movies about psychiatrists (Gabbard and Gabbard, 1992: 212).
Taking some of the blame for these distortions, or at least admitting psychiatry does not contain all the answers, was something Malcolm was comfortable with. He admitted that, sometimes with patients:

You pretend you know all about them on the basis of some answers they have given you (Malcolm, #1: 48).

There are however, many sources from which the psychiatrist usually derives knowledge about the patient before the first interview, including the letter of referral, phone calls to the referring doctor, or to members of the patient’s family, social workers or police (Bergmann, 1992: 145).

The reality Peter and Frank described was:

Knowing what you can offer and what you can't (Peter, #1: 78).

and,

We don't know if we are not told by the patient (Frank, #1: 11).

For Nicola, psychiatry had limitations:

Psychiatry's only fairly limited actually in what it can offer. It teaches you a lot about individuals and small systems, perhaps the dynamics of couples and, to some extent, families. But it doesn’t have a strong sociological perspective um, at all, so it doesn’t tell you a lot about groups and about large social groups of cultures. You can’t be all
things. So, I suppose, you work within the framework you are given but very aware of the limitations (Nicola, #1: 9).

Nicola’s comment also touches on the issue Jasmine raised about the co-construction of disorders in society. Psychiatry is largely individualistic and consideration of the broader social world from which psychiatrist’s patients come and to which they return after a consultation, would help psychiatrists’ understand and expand the limits of their craft.

A final word about madness comes from Frank:

You can learn from patients, can be inspired by them. It can also be a threatening experience (Frank, #1: 11).

Despite common perceptions that violence is concomitant with mental illness, physical threats from patients towards their psychiatrist are not often an issue of serious proportions. What I believe Frank was referring to was the threatening experience of having a mental illness, because mental illness threatens peoples’ lives in ways that can be highly disruptive or, at worst, fatal. Mental illness is also threatening because, despite all the best intentions and talk of science in psychiatry, the causes and cures remain largely unknown. As long as madness remains an unknown quantity, the identity and role of the psychiatrist is also threatened.

Where does this leave psychiatric practice for the twenty-first century in Australia? In the next, final chapter in this research, the outcomes and interpretations presented here will be placed into the context of Australia’s National Mental Health Strategy.

The question is asked: Can there be a postmodern psychiatry?
CHAPTER SEVEN
REVIEW

Postmodern Psychiatry

Becoming requires the multiplication of affect, not the intensification of a single affect or relation. It is an opening-up to difference, to possibility and to the “rightness” of the many rather than the few or the one (Fox, 1999: 209).

Becoming Someone Else

At the beginning of the abstract for this research I quoted the following from Foucault:

The main interest in life is to become someone else that you were not at the beginning ... The game is worthwhile insofar as we don’t know what will be the end (Foucault, 1988: 9; cited in Sawicki, 1994: 286).

Foucault brings to our attention our self-formation and the question of identity. At the outset of this research, this was a poignant comment directed at my self, regarding the re-education that this research experience would provide. Now, at its end, the researcher has met the first challenge of having listened, questioned, documented,
interpreted and presented the experiences given and issues raised in conversation and interview with practising psychiatrists. The stories shared by psychiatrists about their self-formation and identity suggest that Foucault’s comment is also relevant for them, to be interested in becoming someone else. As the respondents have said, psychiatry is being challenged to become something that it was not in the beginning. The clinical autonomy of the psychiatrists is being challenged and they have to contemplate becoming someone else. Fox advises in his quote above, that becoming requires experiencing a new range of emotions, ‘opening-up to difference, to possibility and to the “rightness” of the many rather than the few or the one’ (Fox, 1999: 209). Foucault expressed this, acknowledging the contingency of our practices of self-formation, which leaves us free for new possibilities of self-understanding, new modes of experience, authority and political identity (Sawicki, 1984: 288). As mentioned in the abstract to this research, postmodernism is committed to the consideration of the possibilities beyond our usual frame of reference.

This research has shown that psychiatrists are finding it difficult to look beyond their usual frame of reference – medicine. Psychiatry’s appeal to the metanarratives of science and medicine to provide knowledge and truth, with promises to deliver progress and improvements in society’s mental health status, developed out of the Enlightenment period. The Enlightenment was premised on the rightness of the few to deliver knowledge and social progress. Psychiatry’s appeal to science is exemplary of a belief in the rightness of the few – psychiatrists – to apply expert knowledge(s) and technologies. Postmodernism is sceptical about science to deliver any unified understanding of the world and ourselves. If psychiatrists want to be relevant today they could consider freedom from their narrow tribal loyalties to medicine, assume a postmodern perspective and become someone else.
Motivation, Rationale, Medicine, Identity and Policy

The second challenge of this research was to consider the relationship between motivation, rationale, medicine in psychiatry and the identity of psychiatrists through an interpretation of their stories. The interpretation of the relationship given in Chapter Six was a story of psychiatry as Medicine, Money and Madness. As mentioned in the preceding section on becoming someone else, the psychiatrists' loyalty to medicine was integral to their identity and was a major theme in this story. The third challenge, addressed below, was to place the research interpretations within the context of the current mental health policy in Australia. Then, to have asked the question: Is there, or can there be a postmodern psychiatry?

In summary, the interpretation of the interviews presented multiple stories of psychiatry. Primarily they were stories of concern for psychiatry and the place of psychiatry in society. The respondents spoke of the inseparable relationship between psychiatry and medicine, the value placed on this by psychiatrists, and the need to maintain and strengthen this relationship for their survival. This inseparable relationship was in contradiction to their acknowledgement that, as psychiatrists, they had been marginalised and stigmatised by other medical colleagues, and misunderstood by the broader community, just as their patients were. Psychiatrists' appeal to medicine, with the methods and "truths" science provides about illness and health, was also contradicted by the respondents' admissions of the fragmentation of knowledge, the identity of "madness", and the uncertainty concerning the treatment of patients.

The psychiatrists spoke of the challenges and changes they experienced when operating under an economic rationalist, ideals-based policy. The current climate of change is promoting more ambivalence in the profession through undermining
psychiatrists’ role as doctors of medicine and as clinical leaders of mental health. The respondents felt they were losing their identity, motivation and morale, being subsumed within the labyrinth of bureaucratic social service provision. Some respondents contemplated that the identity of the psychiatrist would eventually merge and be indistinguishable from the image of a generic mental health care worker. The undermining of any sense of the unique indivisible identity through the supremacy of the image is captured in Foucault’s comment below on the series of soup cans and celebrity portraits painted by Pop-artist Andy Warhol that represent the postmodern culture of the simulacrum.\(^{55}\)

A day will come when, by means of similitude relayed indefinitely along the length of a series, the image itself, along with the name it bears, will lose its identity (Foucault, 1982: 54).

Jasmine questioned her identity as a psychiatrist and her feelings of ambivalence to her chosen profession. She was almost apologetic as she challenged her initial and ongoing commitment:

I’ve always felt quite indifferent about psychiatry as my profession. I now think there’s a certain split within me that I am still trying to sort out, between having a very genuine belief that what I do is helpful to people and, and useful and not destructive, and theoretical concerns that effect it. My gut feeling is that I help people that I see. It’s alright to do what I do (Jasmine, #: 40).

\(^{55}\) The culture of conspicuous consumption, commodification and packaging produced Andy Warhol. What he extracted from mass culture was repetition. ‘Warhol loved the peculiarly inert sameness of the mass product; an infinite series of identical objects – soup cans, Coke bottles, dollar bills, Mona Lisas, or the same head of Marilyn Monroe silkscreened over and over again’ (Hughes, 1991: 348).
At the same time, Jasmine was prepared to fight for psychiatrists' place to be helpful to people:

Psychiatry has a depth and breadth, and we're well positioned to be leaders of the mental health team and we want to remain involved in our patients in a holistic way. We refuse to, to become sort of technicians (Jasmine, #1: 53).

Treating mental illness and caring for ill patients takes time and costs money. Government interference is shifting funding and the burden of illness away from psychiatry, despite psychiatrists' vocalised concerns. As the respondents explained, what psychiatrists do, how they do it and to whom, includes many things, not just treatment of the severe disorders like schizophrenia and delusional paranoia with drugs, a frequently-flawed government assumption. The reality is that:

The majority of patients currently under the umbrella of psychiatry, don't have those sort of things [severe disorders], they are not being funded, for want of a better word, by government (Jasmine, #1: 53).

Psychiatrists stressed the importance of their relationship with patients as individuals and the help they gave was reliant on understanding their patient's “madness”. One respondent suggested that the future for mental health involved 'preventative strategies and therapeutic strategies [that] will have to be tailor-made to individual needs with appropriate rehabilitation measures' (Kym, #1: 71). In contradiction, however, the improvements to mental health to be delivered under the current Australian National Mental Health Strategy, as explained in Chapter Four, are based on a population health approach. This approach assesses the needs of the whole
population then implements interventions supported by appropriate monitoring and evaluation (Rachael, 2000; cited in Commonwealth Department of Health and Aged Care, 2000a: 9). The story of madness the psychiatrists told would suggest that this policy still has significant challenges ahead of it.

The problem of using generalised whole population health status criteria is not specific to Australia’s particular mental health policy. It is relevant to many contemporary attempts to achieve public health objectives. All health policies remain modernist in that they employ medical, scientific, epidemiological and social scientific “truths” to construct public health problems and, then, to find solutions for dealing with them (Petersen and Lupton, 1996: 8). In this modernist project of public health, expertise plays a crucial role in the system of power through the creation of knowledge about the “normal” subject (Petersen and Lupton, 1996: xii-xiii). For psychiatry, in particular, Foucault’s history of madness in Madness and Civilisation alerts us to how considerations of power have been, and remain, central to understanding how health policies have come to be implemented (Hancock, 1999: 19).

Yet, the power of expert knowledge in mental health is not coming primarily from the psychiatrist. Rather, it derives from the administrators and subsequent legislators of the epidemiological survey data collected about degrees of “normality” and “abnormality” in the community. This is the expert “evidence” used in policy formulation today. Today’s regime of government administration over health is an exemplar of the complex interdependence that exists between the knowledge produced by the human sciences and its uses (Dean, 1999: 71). The psychiatrists interviewed felt excluded and almost disinterested in the policy formulation and government decision-making process. They were frustrated with the developments
occurring in the provision of mental health care after the implementation of the current *Promotion, Prevention and Early Intervention* policy. Of particular concern was the government’s administrative dominance in mental health and in society more broadly, with the perceived supremacy of an economic agenda. The respondents concurred:

There’s much good intention around but it’s good intention around at a time when the health dollar is being stretched further and further. And, and, and, and, the whole of public [service provision] is changing, so that the government has changed from being a provider to being a purchaser and that makes an enormous change, to purchase something from a competitive market rather than to provide to an equal market (Rene, #1: 9).

I mean, the public system is being stretched enormously in terms of funding. And the services are often inadequate when it comes to matching the demand made on them (Nicola, #1: 15).

What is happening in society at present is damaging. Society is going down a road driven by money and the stock markets, economic rationalism and this perpetuates a narrow bigoted view of the world that operates on greed. The agenda, which is listened to, says nothing about social issues but rather how much money is available to fix it. This manifests itself at an individual level as unemployment, disfranchised spin on effects … almost anomic in a Durkheimian way. We are loosing civil society. Hopelessness is the best predictor of suicide (Frank, #2: 66-67).
The overwhelming sentiment from these three comments above culminates with Frank's thinly disguised disgust with government's and society's pursuit of money at the expense of other social values. The frustration with – and sometimes resignation to – the delivery of mental health care services under the Australian government's National Mental Health Strategy is eroding the fundamental core of psychiatrists' identity. The challenge to their identity as medical doctors with psychiatric expertise mounted by this policy was undermining their motivation and rationale to continue practising psychiatry.

Drawing on Farmer's (1998b: 427) explanation of deconstruction as "good reading", one can see that psychiatrists practise deconstructive readings, or interpretations, to understand situations, events and lives. The psychiatrists recognised their limitations. This is psychiatry as a postmodern activity. Why psychiatrists do what they do – interpretations, to gain an understanding of documents, situations, events and lives – are subject to control through the implementation of mental health policy. However, policy formulation and implementation is not a postmodern activity. Rather, it forms part of the modernist Enlightenment progress myth.

The relevant elements for a postmodern view of psychiatric practice are: an opposition to metanarratives and established order; a preference for diversity; the acceptance of multifaceted truths and multiple perspectives; and gaining an understanding of the world from the perspective of the interacting individual (Denzin and Lincoln, 1994: 575; Scheurich, 1997: 2; Farmer, 1998b: 428; Grbich, 1999: 50).

So does, and can, a postmodern psychiatry exist? I don't believe so yet, or, at least, not easily.
Psychiatrists are not only constrained and controlled by conforming to government policy agendas but also by their own history and practices – the discourse of psychiatry and its roots in medicine cannot be separated by psychiatrists. Yet, the motivation to continue practice is tinged with sentiments of reflection and reflexivity uncharacteristic to scientific medicine and suggestive of new possibilities for some psychiatrists in the future. For example:

**EK:** Any other issues important to you?

**Nicola:** Relevance,

**EK:** Relevance?

**Nicola:** Mm, mm, to, to maintain an input that's actually useful to the community rather than sitting in a room doing things which are personally satisfying but not necessarily making a considerable difference to the well-being of the community as a whole. Yeah. So I think the scrutiny of what psychiatrists do is well founded (Nicola, #1: 32).

**Future Research Possibilities**

The challenge in this research was to consider the relationship between motivation, rationale, medicine and identity for psychiatrists through listening, questioning and documenting their stories. A postmodern perspective was applied to the methods used and the interpretation of the interview material. Considering the research challenges from a postmodern perspective demanded a continual concern for who and how we are in the world. The postmodern perspective drew from the respondents stories about medical science, government, society and identity. The relationship between psychiatry, science, government and identity was also considered within the context of the current *National Mental Health Strategy.*
Nicola's comment above suggests that research focusing on psychiatrists with a concern for "who and how they are in the world" is of value and research to continue the scrutiny of psychiatrists is of interest and ongoing importance. It is critical for this type of research that the experiences of psychiatrists are shared with the wider community. To further pursue and share psychiatrists' stories of what it means to do psychiatry is important to provide a contribution to our understanding of mental health.

Two areas of potential further contribution to be pursued emerged from this research. One area of future research derives from Nicola's comment about relevance. The research question is: What is the relevance of psychiatry in postmodern society? Underpinning this question is the additional investigative question: Are psychiatrists being equipped to understand the mental health issues that present today? To research this, one possibility would be research experience to understand the education and training of psychiatrists today. How do they start to become the psychiatrists of tomorrow? The emphasis on medical education stems from the respondents' emphasis on themselves as medical doctors and their stories of marginalisation and stigmatisation by fellow medical colleagues. How are medical students being equipped for a career as a psychiatrist through their training? How much emphasis is placed on the biological, as opposed to the social and psychological aspects, in the current, popular biopsychosocial model of diagnosis? How does psychiatry place the spiritual component of human existence? Is the training consistent with, or in conflict with, the mental health policy agenda? At what time do trainee psychiatrists feel they are being treated differently by other doctors, or is this something of the past?
Participant observation with medical psychiatric trainees would be an insightful method to gain an understanding of the options and knowledge presented to potential new psychiatrists. In this research, the continuing existence and extent of stigmatisation of psychiatrists could be observed and followed in a number of situations. These situations include: depictions of psychiatrists in the media and film; in general medical training; in specialist psychiatric training; in their literature; and at psychiatric conferences. Additionally, following newly qualified psychiatrists in a longitudinal study would provide information on the choices they make, as they establish their practices in the business of psychiatry.

For this research, in the training of psychiatrists, using a more quantitative positivist approach via the use of questionnaires, to obtain an overview of trends in practice establishment, could also be useful. The questionnaires could be followed by a number of selected interviews. The aim of this research would be to present the perspectives of the interacting individual where the generalisability of results was not necessarily possible or desirable. The insights generated from this research would be important for the psychiatrists of the future. As Nicole advised above, it could give insight into how psychiatrists can “maintain an input that’s actually useful to the community rather than sitting in a room doing things which are personally satisfying”. The findings could also be used for consideration of improvements towards appropriate and meaningful training for a postmodern psychiatry.

Another research proposal that would flow on from the current research project might be to pursue in-depth interviews with non-psychiatrist mental health care workers about the impact of the National Mental Health Strategy. There are many stakeholders, with possibly very different concerns, in the mental health care field.
These other care workers include psychiatric nurses, social workers, volunteers and carers working in clinics, hospitals, the community and the home.

This current project presented the psychiatrists' perspective on their role. The new proposed research would be an opportunity to redress the imbalance and speak to other mental health care workers. The new research would broaden the context of the current research findings and ask the question: Do other mental health care workers have a similar story of Medicine, Money and Madness\textsuperscript{a} to tell?

The respondents in the current research project expressed a number of varied opinions on the role and success of non-psychiatric members in the delivery of mental health care services under the current policy. The focus of this new research would be to identify the success, or otherwise, the National Mental Health Strategy has had in achieving its objectives for better community health. The perspective presented would be from the non-psychiatrist members of mental health services. The perspectives of the non-psychiatrists could then be related back to the psychiatrists' perspectives given in this current research project. The new research would require interviews of members with mental health care teams, but also documentary research methods using data collected from government's Health Insurance Commission (HIC) on the incidence of use of mental health care services by the public. The questions could be asked: Do the governments figures present a similar story of need and service provision, to those told by the mental health care providers?

The findings from this proposed research would provide an understanding of what other mental health workers are doing to achieve community mental health, from their perspective. Following on from this current research project, it could provide
the opportunity to hear new, alternative opinions to those expressed by psychiatrists in the current research, concerning the clinical autonomy, and the medical leadership of psychiatrists in mental health. This new research would also, therefore, offer some understanding on how the members of mental health care teams are working together to achieve Australia’s mental health policy objectives. In combination with the HIC data, the research could provide a number of interesting, possibly divergent, perspectives on how successful Australia’s *National Mental Health Strategy* has been in reducing the “burden of disease” from mental health since its inception. In the words of Nicola: ‘I think the scrutiny of what psychiatrists do is well founded’ (Nicola, #1: 32).
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APPENDIXES - SUPPORTING DOCUMENTS

APPENDIX 1

Interview Routine and Questions designed and used in Pilot Interview

I am interested in hearing accounts of being a psychiatrist in practice today. The questions relate to your formation and that of others in your profession. Your responses to the issues I want to explore will remain absolutely confidential between you and me, preserving anonymity. I am interested in broad sociological areas, although I will explore them in some depth. If, at any time, you wish to relate any formative experiences, critical incidents, anecdotes or stories as examples, these would be very helpful to me.

Some of these questions, especially the initial one's, with a more demographic focus, may not be surprising.

Demographics

CHOICE OF PSYCHIATRY

1. Why did you choose psychiatry?

2. What sub-speciality within psychiatry do you see yourself taking on?

OR,

You have chosen ................................., how many years ago was this, and why?

3. What sort of satisfactions has your choice afforded you?

OR,

Which of your contributions to psychiatry, in your experience so far, has given you the most satisfaction?

4. Where are the cutting edges in your chosen field of psychiatry at the moment?

AND,

Who are the leading figures and what sort of significance do you give to those you mention?
CHOICE OF PATIENTS

5. About the different patients you see, do you prefer to consult in one type of setting over another, and why is that? What proportion of your patients are private?

6. How does this mix of public and private practice meet your professional interests?

7. How many, and what kind of patients are referred to you, for example in terms of age and gender? How has this happened, from GP referrals, or possibly your own cultural or religious affiliations?

8. Do you freely refer patients on, and under what circumstances? What types of patients would you share with, say, a neurologist?

FORMATION

SIGNIFICANT FORMATION EXPERIENCES

9. Tell me about the significant developments in your clinical approach since your formal psychiatric training? Why are they significant for you?

OR

What would be one of the significant developments in your clinical approach in these final registrar years? Why is it significant for you?

10. Beyond therapeutic techniques, are there styles in psychiatry? How do you describe your style? Tell me what are essential to the style of your approach?

11. Which diagnostic tools do you use and under what circumstances do you feel the need to go beyond them? What do the diagnostic guides you employ contribute to your ongoing practice?
PERCEPTIONS ON ISOLATION, STIGMATISATION, MYTHOLOGY, POWER
RELATIONSHIPS

12. I could well understand that professional isolation could be a problem in the
private practice setting. Is it for you and how do you overcome it becoming a
problem?

13. There is literature that suggests that psychiatrists feel stigmatised, by other
medical colleagues and the general public, especially those dealing with chronically
ill patients. Do you sense this?

14. Statistics suggest that psychiatrists have a higher suicide rate than other medical
practitioners (with the exception of dentists), would you confirm this? Is this statistic
an issue of the profession at all?

15. The literature suggests that the concept that the psychiatrist has of mental illness
before medical and psychiatric training is not changed by this training, has this been
your experience?

16. How important was the use of the clinical vignette in the teaching of psychiatry to
you and why, can you give me an example?

17. Many of the psychiatrists I have talked with deal with legal referral work. I want
to know about the extent to which the practices of psychiatry and legal
considerations intersect. Have you done any work cover referrals or presented
evidence in court?

Emotionality

Some final questions thanks

18. Are you heavily regulated by government agencies in your practice, if so, which
agencies? The increased emphasis on commercialisation may be impacting on your
practice are you experiencing this?
19. Economic performance is one thing, what other measures of performance are important to you?

20. Thinking towards the future, do you think telemedicine will be applied and popular with psychiatrists and patients?

21. What (further) ambitions do you have for your own practice of psychiatry?

EXIT

Thank you very much for your time and the responses you have given. This has been very interesting and useful for me. When I have had some time to reflect on our discussion, I may have some particular supplementary questions. Would we be able to meet again?
APPENDIX 2

CONSENT FORM

UNIVERSITY OF WESTERN SYDNEY NEPEAN
RESEARCH PROJECT CONSENT/INFORMATION FORM

Title of Research Project:          Ethics Committee Protocol No:  

A Sociology of Psychiatrists, An exploration of THEIR Voices

Name of Researcher/s:             Elizabeth Keirnan

I agree to participate in the above project and in so doing acknowledge that:

1.  I have read the attached Information Sheet outlining the nature and purpose of the project and the extent of my involvement, and have had these details explained to me. I have had the opportunity to ask further questions and am satisfied that I understand.

2.  I am aware that, although the project is directed to the expansion of sociological knowledge generally, it may not result in any direct benefit to me.

3.  I have been informed that I may withdraw from the project at my request at any time.

4.  I have been advised that The University of Western Sydney Ethics Committee has given approval for this project to proceed.

5.  I am aware that I may request further information about the project as it proceeds.

6.  I acknowledge that I have received a copy of this form and the participant information sheet, which I have signed.

I understand that, in respect of any information including audiovisual records obtained during the course of the project, confidentiality will be maintained and that, in the event of any results of the project being published, I will not be identified in any way.

Name of participant

Signature of participant

Signed ______________________ Date _______________ Time _______________
APPENDIX 3

PARTICIPANT INFORMATION

PARTICIPANT INFORMATION AND CONSENT

You are invited to participate in a research project under the auspices of the University of Western Sydney, Nepean

Project Title
A Sociology of Psychiatrists, an Exploration of their Voices.

Researcher
Elizabeth Keirnan, PhD student, UWS Nepean, Graduate School of Management.

Ethics Committee Approval
The University of Western Sydney Ethics Committee has given approval for this project to proceed. Registration Number: HERC 1997/60.

The Research Project
This study is an exploration of the formation of psychiatrists through interviews of psychiatrists practising in Australia today. The thesis explores the formation of psychiatrists as an influential group of managers of mental disorder within our society. Research has historically focused on the patient. It needs, however, to be recognised that psychiatry and the management of mental illness is a mutual process between psychiatrist and patient. While studies of patients take illness as a given, this taken-for-grantedness does not acknowledge the psychiatrist as part of the social construction of illness. This research provides a space through which an understanding of the voice of psychiatry, from psychiatrists, can be heard. The sociological interpretation of the information provided by this research may contribute to the design of more effective health care policy and management therapies through an understanding of the context and role of the psychiatrist in society today. This research may also contribute to the development of sociological theory and praxis in biomedicine.

Approximately 10 to 20 psychiatrists will be involved around Australia. Provided you consent, you will be asked to participate in one or more interviews. Obviously you are free to withdraw from the study at any time with no pressure or explanation required. The location and time of interviews will be decided by mutual arrangement. Interviews will be conducted over a period of 18 months. Provided you agree, interviews may be recorded and then transcribed. In every case, the tapes will be destroyed at the completion of analysis of the interview material. The interviews will be semi-structured to unstructured in nature. The focus of the interview questions will be on your experiences as a practising psychiatrist today. The interviews will include questions about what choices you made in becoming a psychiatrist, specialisations within psychiatry that you have chosen, positive and also negative experiences and perceptions associated with being a practising psychiatrist. We may also address policy and management issues arising from documents such as the McKay report.

Referrals
You may be asked whether you would be able to refer me to colleagues who could be willing to participate in the research. I would ask you to provide a telephone contact number. After contacting your colleague in the first instance introducing me, I will follow up any such referral.
Consent
If you agree to participate in this study you will be asked to sign and date this information sheet.

Confidentiality and Results
The results obtained from this study may be published in a refereed journal; however, no information which may identify you or any other participant will be released. Interview transcripts will be identified by an assigned interview number only, and will not make reference to the identity of any individual.

Interview Transcripts
If requested, the interview transcript(s) will be made available to the interviewee requesting transcripts. Interview transcripts will be kept for 5 years by the researcher in locked storage.

Other Information
If any significant new information about the study becomes available during your participation in the study, and that information might affect your willingness to continue the study, you will be given that information by me.

Contact numbers for Elizabeth Keirnan are (02) 9624 9375 or 0412 464 045.

Thank you for the consideration you have given to participating in this research project.

If you are in agreement to be involved, would you please sign and date below.

Signature:................................. Date:.................................

Name:........................................
APPENDIX 4

SAMPLE LETTER OF INTRODUCTION

May 1999

Dr XXXX
Address

Dear Dr ______,

Re: PhD Research Project Protocol Number: HERC 1997/60
‘Managed Disorder: A Sociology of Psychiatrists Exploring THEIR Voices’

I am currently enrolled as a PhD candidate in the Graduate School of Management, UWS Nepean and conducting the above referenced research project.

I have had the opportunity to speak to several general psychiatrists to date, one being Dr ------ who suggested that you, as a specialist, may also be interested in expressing your considered views on being a psychiatrist in Australia today.

I would like to contact your office in the next week to seek confirmation of this and to arrange a possible interview time should you be interested in participation. At this time, I will also post to you a participation information and consent sheet. Alternatively, I can be reached on the contact numbers below.

Thankyou for your consideration of this request.

Yours sincerely

Elizabeth Keirnan BSc.Agr, BA, M.Mgt.

Phone: (02) 9624 9375 or (02) 4782 7570
Fax: (02) 9838 9986
APPENDIX 5

SAMPLE LETTER OF THANKS

4 May 1999

Dr
Consultant Psychiatrist

Dear Dr,

Re: PhD Research Project Protocol Number: HERC 1997/60
'Managed Disorder: A Sociology of Psychiatrists Exploring THEIR Voices'
I would like to extend my more formal thanks for agreeing last year to contribute your personal perspective to the above referenced research project. Your considered opinions will make a valuable contribution to this research thesis.
To enable me to explore the possibilities of further opinions and perspective, I would like to conduct interviews with the colleagues you mentioned might be interested in expressing their views. During our interview you mentioned Drs _____ and ______. Might I send a letter introducing myself in the context of this research project and mention your referral to them?
I would like to contact your office in the next week to seek confirmation of this. Alternatively, I can be reached on the numbers below.
As documented in the participant information sheet, I will keep you informed of any information that may be of significance to you as a result of this study.

Once again many thanks.

Yours sincerely

Elizabeth Keirnan  BSc. Agr, BA, M.Mgt.

Phone: (02) 9624 9375 or (02) 4782 7570
Fax: (02) 9838 9986
Email: Keirnae@wyeth.com.au
APPENDIX 6

INTERVIEW TRANSCRIPT (NON-TAPED INTERVIEW)

Interview # 10: Public Hospital.
I had asked Peter if he could help me with my PhD research at a previous visit conducted in my role as a CRA. I started to feel uncomfortable as I initiated my explanation of the study and handed him the participant information sheet because he looked slightly confused. I was putting him in the role of helper by participating in this conversation, asking him to tell me what I should be concerned with in a study of issues associated with the practice of psychiatry. Consequently, Peter asked several times for clarification of what I wanted from him and it took him a while to “warm up” and talk about his experiences and feelings. He eventually did, and the half hour allocated to our interview, turned into an hour, without too much effort.

We sat in Peter’s office as he considered the conversational issues he raised. He looked at his bookcase returning his gaze to me at the end of each considered explanation of the topic being discussed.

His first response to my explanation about wanting to know about psychiatry at the end of the twentieth century was to say I should speak to Dr ... who has just written a book of some relevance to my project. I thought at this point that Peter was not going to talk about his experiences, but rather refer to the practice of psychiatry in general. I emphasized that I wanted to hear about the issues that he thought were important. I felt I needed to look at him as much as possible and not take too many notes. Interestingly this was similar to the conversational atmosphere and note taking I experienced with the other three academic psychiatrists I had talked with.

The first issue Peter raised was the nature of the illness and the treatments in the context of the private versus public system and the role of staff specialist services. For private practitioners, funding was an issue because of the role of government in giving rebates for patients for cost of treatment incurred.

Isolation in practice was also an issue. Peter said, of the 500 psychiatrists in NSW, 400 would be in private practice and very isolated. In the public system, the health department funds the system and the organisation. The public system is where the majority of the academics were practising are and therefore the concentration of research.

For Peter, psychiatry is both intriguing and frustrating. He sees the mix of teaching, administration and his clinical role as a desirable mix. Getting the right balance in a practice requires dedicated time. He enjoys teaching. I gave a little praise here, saying he was good at it, citing his preceptorship lecture to pharmaceutical sales representatives. In the preceptorship lecture he gave an historical perspective to individuals who had been diagnosed with mental illness and how mental illness and psychiatry has been variously represented through art over time since the ancient Greek civilization. Understanding psychiatry today in its historical context was important to him.

I asked when he first became interested in being a psychiatrist. He replied that it was during his residency. He became intrigued with mental illness and he enjoyed the humanity side – the combination of personality, illness and behavioural aspects. Peter did well at university and was attracted to research. Part of his registrar
training was in the UK. He mentioned a mentor figure who had encouraged him to pursue a research project. I asked what it was. Peter was slightly dismissive of the project, saying, it was in drugs and alcohol (D&A), not, he thought, an area that was clinically attractive to him, but it was a start. He mused on how one individual could influence one’s future path to such a great extent.

Now, his interest in research, we joked with sarcasm as if it was somehow easier than teasing out and understanding issues underlying D&A problems, was just as simple, the genetics of depression and bipolar disorder. For, Peter, the complexity and the end product of research overcomes the frustrations of clinical practice which is replete with gaps and inadequacies in its trial and error approach of giving what to what patient. The whole thing is thing able to understand. However, Peter did say that the basic sciences in their explanations, are experiencing limitations at present in their understanding of the possible genetics of some severe illnesses.

Peter believed that psychiatry would undergo a treatment revolution when syndromes – the patterns of signs and symptoms – are understood as biological disorders, just as different as renal syndromes. They can be seen to be the result of different biological problems. I mentioned a few diverse causes of renal disease by way of understanding his point. He enthusiastically agreed.

I asked what other issues were important for him. He continued, stating the existence of the intriguing interplay of factors in mental illness, including coping styles. This current segment of his career Peter described as dedicated to very complex disorders – this is part of the attraction. He is not involved with psychotic patients. I wonder about this, as psychotic disorders are complex. Perhaps his reference to complexity refers to his pursuit of the genetics underpinning bipolar disorder only.

I ask how common were the myths of mental illness. The chronic disorders can be frightening as a medical student. He remembers seeing chronically ill patients as a student. Madness is a frightening reality. It is not attractive, it is distasteful to people. People are suffering and healing is an important part. Services need to improve, as does the quality of care.

I ask, out of historical interest, where the names “shrink” and “loony bins” come from. He is not certain, but thinks “shrinks” is form “headshrinkers”, of Indian witch doctor origins, and “loony” from lunar, the moon, which has historically and mythically been associated with mental disorders and making people go mad. “Bins”, is an English term, not, he said, used much here.

As an academic, Peter recognises his influence in passing on information to training psychiatrists. Education is part of the rewards but also the frustrations of his role in his role as a psychiatrist.

Peter then mentioned a patient referred to him, who was himself an academic, because he was an academic. His problem was anxiety. Peter said that the freedom in academia is largely our own. Academics can be obsession types, questioning and continuing to pursue answers in the face of uncertainty. We need boundaries to limit anxiety.

Peter sees some patients who are easy and some who are difficult to help. He copes with this is through knowing what you can offer and what you cannot. I suggested that “knowing of what one can offer”, had been expressed by another
psychiatrist as “knowing one’s limitations”. Peter agreed, saying that this helps in learning to divorce work and from home, which he said he had done.

Peter came back to the concept of madness as understood by the general public. Madness is always unpleasant ... madness is always somebody else. Madness is seen as weakness and of patients losing control.

Peter then talked about the role of the media in the recent case of the Australian High Court judge Vince Bruce. Peter considered the interest of the press in the case had also brought the topic of depression into the open, the public arena. This would help to decrease the stigmatisation of depression.

Peter equated success as an academic with giving journalist interviews and using as many opportunities as possible to talk about mental illness in the media. Using the media to give positive, good messages about mental illness into the public arena, thereby legitimising of the whole experience of mental illness was important for the future of psychiatry.
APPENDIX 7

INTERVIEW TRANSCRIPT (TAPED INTERVIEW)

Nicola: You've ah, indicated that we could have a um, copy of the transcript and I've got yes please, plus obviously if and when you publish that it would be possible to have a copy of the paper? [Nicola is referring to the participant information sheet and covering letter].

EK: Of course, of course

Nicola: What got you, um, interested in this um, area ... mental –

EK: Ah,

Nicola: Mental health, um, and its provision –

EK: Ah, I guess through initially through my masters and um, reading Foucault. So it was a Masters of Management and the organisation I was in at the time was a health care pathology provider, and Foucault provided a very good paradigm for the way it worked. It has gone on from there and I'm still in the health care industry, so it's a post-modern perspective.

Nicola: Mm, OK.

EK: Now, I was wondering if I would start by asking you what is it that you do, when your doing psychiatry?

Nicola: The structure of what I do, the content?

EK: Ah, the doing I think I'm interested in.

Nicola: Yeah, Yeah, predominantly, I suppose it's engaging with people um, around um, their perception of the difficulties that they face in their life, um. It's a negotiated, as I see it, mutual process whereby I bring some skills knowledge and insights which, um, we work out what best helps the. Yeah.

EK: Right.

Nicola: Um, sometimes obviously people come because of problems in their lives and sometimes they come because of frank illness and that changes the nature of the relationship. Where it's a frank illness, like a manic depressive illness or a schizophrenic illness then you're more in a doctor patient role, um, although I think, striving to help the person cope and master their life as best they can around the illness um, where it's a more counselling style role it's again, is a much more negotiated process with perhaps, ah, yeah, counselling rather than doctor patient as such.

EK: How is that different then, to the counselling role?

Nicola: They don't need to come, there's nothing that they in a sense couldn't manage on their own. They may have significant problems but it's not like their life is
going to be devastated in episodes of frank illness, which you know, cuts across the normal process of their life without any choice of control by them.

EK: So why do they come then, if they don’t need to come?

Nicola: I don’t mean, in a sense, that something is out of their control, like an illness, but they may psychologically feel that there are patterns in their life that they don’t understand that lead them into recurrent difficulties, or they’re in a crisis and they need some assistance to sort out their priorities and get through. Um, so that the need is different, it’s not perhaps as compelling an illness. There is still a large degree of choice involved.

EK: Then the doing of psychiatry, would be in that counselling role? How different is that to the treatment of the ill person?

Nicola: Um, I suppose that’s very, very much different stages of one’s, my career, um. Initially it was floundering because I was no better off at helping people than I was, you know, sorting out my own difficulties. Because you start in a medical model, you start very much from the notion of pathology, and ah, where there’s no easy box to puts someone’s difficulties into. Learning skills to help people manage those areas of their lives takes a lot of time and I suppose over 20 years, you know, you work to develop those skills by learning ways of approaching, helping people change, in terms of assisting their understanding of their problems their insight, with resolving emotional problems from early on, that may be influencing things in the present. Ah, helping them change habitual self-defeating patterns, um and sometimes I suppose the other major area would be in terms of self, self-esteem and self-value, being able to help how to identify how much people’s lack of sense of personal value can influence enormous ranges of behaviour. Um, in their dealings with others, in their work place, um, in terms of how they handle themselves and the kind of the sort of symptomatic relief they’ll seek through drugs alcohol, food, relationships, so that, that, that, process is something which you acquire skills in as you go along, find what works for different people. So, I mean, I suppose I’ve built up what I see as a, a bank of different kinds of interventions and work with people around what, what, suits them, what kind of personality they’ve got and what kind of background and temperament and therefore what they respond to best.

EK: What sort of therapy and indications come under the umbrella of psychiatry?

Nicola: I suppose because, you know, what not to do, um, I mean, I think that there are a whole range of experiences as psychiatrists you encounter. You see the impact of fairly superficial and untested systems that people encounter. Um, EST groups and things like that over the years.

EK: EST is –

Nicola: It was, ah, one of those self-exploration groups that was sort of very much to the fore in the 60s and 70s. So you see a lot of the um, I suppose, limited interventions that people with, um, very short-term counselling kind of skills, or the, um, band-wagon of helping which takes many forms over the different decades. You, the, the impact of that on peoples lives, which can often be useless, if not destructive. So, you know, what doesn’t work, um, you also – the old argument about psychiatry – you do have a skill in differentiation. Frank illness, um, you might understand as having a neuro-developmental, biochemical background, um, in terms
of peoples presentations and teasing out sometimes, often the quite blurry interface between those two things, particularly with illnesses like anxiety and depression, um, so that, you know, where to put the emphasis in terms of dual intervention, medication and or counselling. And, I think, the other thing too is that being ultimately responsible in many ways in a medico, medico-legal level makes you extremely thoughtful and cautious. What you do, and how you do it, and you've got systems in place for reviewing what you do and relying on your colleagues for, um, cross, cross-referral and peer review and second opinions and things like that.

EK: And that wouldn't happen in these alternative therapy areas that you were –

Nicola: No, I think that the psychologists in recent times, for two decades have built up again a much stronger system of, of, both training and review and maintenance of standards. So I think that they've probably more or less, you know, an equivalent body, but I, I fear that there are many other, um, levels of, ah, service provision when it comes to counselling, that, that lack, that, ah, rigour.

EK: Sort of social work, are you talking about –

Nicola: Um, often more just people with, um, very superficial training. You know, a course in counselling, or I suppose some of the alternative therapies that mix up pseudo-somatic therapies with counselling skills. Social work I am not sure of at this stage, I mean, I think, again that there, that would depend to some extent on what's happened in social work training. I remember doing a review in the, um, in the 70's about social work training at the University of Queensland and it was fairly anti-medical model then and anti-psychiatry. It's probably changed a bit and there's a bit more of a cooperative approach now. I couldn't specifically comment on social work as such. I don't actually encounter social workers much in the private sphere.

EK: Your work is now predominantly private practice?

Nicola: Just about all of it, it is now, yes.

EK: What did you do before?

Nicola: I came from Queensland and there's a much stronger, um, historical, um, union between public and private psychiatry, so that even though you might have worked in private practice, most psychiatrists would do public sessions as well. So that you were, ah, working in a multi-disciplinary team within a hospital. There wasn't much community psychiatry there then. Um, but, um, so that you, you worked with, ah, nursing staff and social workers and psychologists and occupational therapists and registrars and a resident, very much a complete team in that sense.

EK: You mentioned, um, peer review and learning, and training in the context of this practice here. How many of you practice here?

Nicola: Well it's coming to an end, sadly. It's been up and running for 30 years and, ah, it's winding up as a partnership. There'll still be a smaller grouping that will continue, um, but the XX practice as such, has, um, reached the end of its days sadly. So –

EK: Is that because of – Is it XX?
Nicola: Oh XX is retiring, but it’s not his going into semi-retirement. He’s doing medico-legal consultancy mainly, but it’s not just that. I mean, one of the, the changes in psychiatry that it now takes, you know, after you do 6 years of medicine and 2 years of residency it’s 5 years minimum, um, in institutional settings. So that by the time people get out, they really don’t want to buy into another hierarchy. There’s a much stronger sense of people wanting to be independent and function because it’s a longer training. They’re not, as if you like, naive to the processes of, um, ah, psychiatry as perhaps you were with a 3 year course a couple of decades ago. And the practice is pretty heavy with top heavy, with older people, um, we are all well established. So that even though there isn’t a formal hierarchy, there is one you know and it’s, it’s a fairly rigid system. You’ve got to fit in. It was a fairly large group, so the flexibility and independence and autonomy that people, like you have to sacrifice that to a certain extent, to function within this group.

EK: Right

Nicola: The advantages of that, when you’re a fair way into, into your practice, is that you actually like the quality of life that that gives you. On the other side, the up side, um, you know, you don’t actually want to work your butt off constantly as you do when you’re starting out and climbing the mountain. You prefer to march along with both quality of life issues and other commitments meaning as much as your work.

EK: And so, you’ve going to be independent then?

Nicola: Um, I’ll probably join or stay with the smaller group of people, who are seen as curiously the younger group, although we are all pushing 50 in a couple of years, we are actually the younger members. So, so we’ll stay because we’ve got another 10 or 15 years of practice, you know, we want to maintain that collegiate environment.

EK: From, from a, um, mentoring and, and helping point of view is that helpful to be able to –

Nicola: Oh very much.

EK: Go and knock on someone else’s door?

Nicola: Yeah, the informal aspect of it is good in terms of debriefing sometimes. Um, and sometimes quite formally debriefing. You know, if you had a, a suicide, or something like that, there’s a system of both immediate support and help to deal with whatever the ramifications are, but also then down the track, you know, a kind of proper case presentation, post mortem of all the factors involved, a review of what happened. So that’s a formal one and then there’s also the more formal case presentations and discussions of, you know, difficulties that you encounter, or long term people, where you, you know, you hope you’ve not just got stuck and there are benefits for the person you are working with. Yeah, confusing diagnostic problems.

EK: Have you made yourself available to that kind of service within the group here?

Nicola: Oh yes, we all do that, yes.
EK: Is that, that sort of a compulsory activity, debriefing or, or something that’s optional, you choose for your own well-being?

Nicola: Luckily, it’s rare those, those particular circumstances. But, ah, I don’t think the issue of compulsory comes into it. It’s something we all gladly avail ourselves of, yeah. And I haven’t, there’s probably only been about 3 or 4 instances in the nine years I’ve been here. And, um, they, the issue of compulsion hasn’t arisen in that sense. It’s just what you do, because it’s been a do it, its a trusted group to, I mean its um, you know, people have built up working relationships over many years. That can be a downside. It can get a bit moribund in some ways too. That’s probably the other reason why it’s timely for it to finish, um, some of the spark and the drive has gone out of it in that sense. People are winding down their practices and moving towards retirement and some of that enthusiasm and curiosity and drive has also faded a bit, we hope we can reignite that in a different setting with a smaller group.

EK: What was your initial enthusiasm? – drive, that lead you into psychiatry?

Nicola: Into psychiatry, going right back, well I think I’m one of those fortunate people who as long as I can remember I wanted to be a psychiatrist. I wanted to be a vet for a while when I was about 11, 12 or 13. I did some work experience with a female vet and decided no, this wasn’t what I wanted to do, um, and did medicine as a way to do psychiatry.

EK: Is there a specific incident that you can think of?

Nicola: No, I just was always fascinated by what made people tick.

EK: Right.

Nicola: They were the most interesting things. I always liked biology as well. I remember being quite young and having those books in the library in school that had transparencies that showed you layers of the internal stuff of creatures. You know, all the different organs and things, and wondering what the mind was like, if you could have transparencies of the mind.

EK: Right.

Nicola: So I always, always wanted to understand, both I suppose brain function and human behaviour. Um, and psychiatry’s only fairly limited in actually what it can offer. It teaches you a lot about individuals and small systems, perhaps the dynamic of couples and to some extent families, but it, it really doesn’t have a strong sociological perspective um, at all. So it doesn’t tell you a lot about groups and about large social groupings of cultures. It, it does, but not I think adequately, you can’t be all things, so I suppose you work within the framework you are given, but very aware of the limitations.

EK: Have you been able to transcend some of those limitations in your practice?

Nicola: Um, I suppose the dominant one would be the gender issue, and again, being a female and coming into a medical model and very patriarchal system.
Um, that's probably one area where I suppose the sociological aspects have been very real for me and I hope that's been reflected in my dealings with ah, patients male and female. Um, but the larger issues about, I suppose, provision of health services and um, where the medical institution fits into that as an institution, I haven't transcended that. I keep chipping away at it, but it's difficult to do it, in a sort of isolated sense.

**EK:** What sort of chips are you aiming your blows at?

**Nicola:** Well I've got some very challenging friends, um, who come to it from a very different perspective. I've got a good friend in, um, XX who is the health care complaints commissioner and have a lot of very vigorous debates with her about the self-interest of doctors. Um, yeah, you know, even unconscious and within systems doesn't mean that people are necessarily driven by self interest in terms of their conscious motivations to participate in those groupings, which have at their core both social privilege and a lot of social benefits.

**EK:** That, um, things in the gender imbalance have affected you personally?

**Nicola:** Very little personally, very little.

**EK:** OK

**Nicola:** Um, and I think in that way, I've been extremely fortunate.

**EK:** How do you, that so you see it in your patients, is that what your saying?

**Nicola:** Yeah, and in the way that I think psychiatry has dealt with ah, with women. It has lacked a perspective about, you know, how the power structures in our society have dictated various roles and, and, incorporated attitudes to women very deeply in its processes. Um, and trying to um, assist people to have an understanding about other perspectives, one that gives them more choices, it also makes sense sometimes of their personal difficulties and suffering, in terms of that larger picture, rather than seeing it as some personal pathology all the time.

**EK:** So you get females in here who feel quite persecuted by the social structures that they see themselves –

**Nicola:** Not necessarily persecuted, but see their lack of satisfaction or their unhappiness or their, yeah, their dissatisfaction often with the structures that they participate in as reflecting something wrong with them. And I think psychiatry has often reinforced that, rather than saying well, you know, there may be forces at work here that are bigger than you and this is where you may fit in and if you look at it this way you may see things differently and therefore not see yourself as failing or limited, but rather dealing with something which is difficult and challenging.

**EK:** So being a part of that system, of psychiatry, you have actually been able to step out of it, or you're able to advise them from within the framework of being a psychiatrist?

[long pause]
Nicola: I suppose I'm doing it within the framework of a psychiatrist yeah, yeah. I suppose that depends on how they see me, um [pause]. I'm not sure about that one.

EK: It seems that you, although you could be called a psychiatrist, is perpetuating some of those gender imbalances in society. You not labelling yourself, because you are able to help people with –

Nicola: I suppose to being, um, involved in the college which has been very active in promoting things, um, like part-time training for women. It has had, what four or five of its presidents, have been women, um, and has a large proportion of its practitioners who are women. I mean, it is a speciality that attracts women because it gives you the option of doing part time work when you have family, so it lends itself to, as a career for women who want to combine parental with, ah, with work. So I suppose being in an environment where there's quite a lot of practical attention given to those matters, um, has helped. Maybe it's again a part of medicine which isn't so traditional in that sense.

EK: Right, a bit left of centre.

Nicola: It needs to be.

EK: So what do anticipate for your next 15 years, what are your challenges?

Nicola: Ah, well, um, one of the um, things I've taken on um, and again, this is the first time it's been done by a woman in the college, is the um, the chair of our Committee for Exams. The Committee for Exams is, um, is part of a structure of what's called the Fellowships Board in the College, which looks at training and exams. And um, I've got the chairmanship of, um, the Committee for Exams and that runs um, 3 times a year. The major clinical exams and also the various other components along the way that people go through in their 5 year training, um, and that's a 3 year commitment. And um, and, I'm just through my first year and with the option of another 3 years, so I mean, I took that on again as one of those things that stretches you and challenges you, rather than going along becoming too comfortable in, in a system. And ah, and then perhaps losing your edge to, to, go to these meetings and argue the point about, um, you know, whether somebody's crossed a standard ,in terms of passing or failing an exam, and constantly reviewing those processes with the people who do the marking and overseeing that um, that, that's quite a challenging, um, activity. So that's one of the things for the next 6 years, anyway.

EK: Yeah, how is that stretching you?

Nicola: Um

EK: What are you seeing out there with the new graduates – perhaps relating it back to the training you are doing, or not doing?

Nicola: Yes, as I said the, the umbrella has training on one arm, and um, and exams on the other, so, um, it's very artificial in that sense because you're assessing the outcome of processes that you don't actually control. Um, so there has to be a lot of interplay and feedback between those two processes. Um, what am I seeing?
EK: And how is it stretching you?

Nicola: I, I think they are two separate questions. Um, stretching me personally, in as much as taking on a task like this, not being an academic, all the people who have done it before have been academics and that changes in some way the status of it. So I'm not even a female academic, I'm just a female psychiatrist in private practice. Um, so there's a great deal of scrutiny, I suppose and expectation and that's while it's not tangible. I know it's there, so there's quite a lot of anxiety about the process.

EK: Is that self-inflicted a little bit, because you see yourself as not as a female and not an academic?

Nicola: Oh yes, I don't think it's just self-inflicted, I think that, you know, there is a fairly strong, I suppose, concern about how well it will be done.

EK: You're being watched?

Nicola: Yeah, Yeah. A lot of support though, particularly from women, not just women by any means, a lot of support for it. So I don't feel isolated or particularly under threat, but I'm aware that it's, um, you know, when you go out ahead, you can get your head chopped off. Yeah, so it's quite a challenge.

EK: So most of the professorial positions in medical school in psychiatry are they held by men?

Nicola: There are a couple of um, ah, women who are around in Associate Professorship roles, um, and then there are some notable exceptions like XX, who is um, Professor of Psychiatry at a Newcastle and then in Queensland and is now in the Health Department here in NSW. Um, yeah, she's probably the most outstanding example, there's an Associate Professor XX over at St Vincent's, who's exceptional as well and ah, she stands out. Those are some of the people who come to mind. But no, there's still in the, in the upper echelons, there's still a predominance of men and ah, I think that's because partly because it's very much a career path you know. It's hard to do without ah, someone else running the domestic scene for you.

EK: The academic part is the career path—

Nicola: Yeah, Yeah, it's a tough life.

EK: Um, on that point then, back to the, ah, what are you seeing?

Nicola: In the graduates? Mm, Mm ... very stressed people. I mean the public system is being stretched enormously in terms of funding and ah, the services are um, often inadequate when it comes to matching the demand made on them. So, you see people come through a system, which is very spare, um, in New Zealand and Australia, because it's a bi-national college, um, um, yeah, so people, you, despite that, manage often to form a real capacity for appreciation of the individual and concern for the person they encounter, um, in the exam setting and communicate that effectively, yeah. People who are clinically competent, I suppose, is what we are seeing. Whether that quite prepares them for the world of psychiatry particularly, say in private practice, is a whole different matter. I think there's a large learning curve when they get through. That clinical component, which is essential to
then start developing the more consultant skills, um, but then people have to do it in steps; they can't do it all at once. There's so much demanded of them now in terms of their basic knowledge and their proficiency in a whole range of, um, again basic skills, um, and particularly their clinical skills, that, those later developments, I think, are things that they will attend to in the later years of their training and afterwards.

EK: So they've got the diagnostic-making skills but –

Nicola: Mm, diagnostic and some degree of, ah, management skills.

EK: Rating skills using the DSM-IV?

Nicola: I hope they're more competent than that, it's just a table. Yeah, um, yeah, I mean, one of the things we look for is the ability obviously to think beyond just the various categories, categories and systems and ah, to think about things like the history of how diagnostic systems emerge. In some of the areas of uncertainty, where the cutting edge is, and how very much it's a tool and you can't let the tool govern you. And people, you actually stick rigidly within a D, you know, a diagnostic system, can't think beyond it, fail. You know, they've got to have a capacity for broader thought than that.

EK: So, you mentioned that private practice and the consulting skills that they need to gain, on a learning curve. What is it about private practice that, that you've found that's really different for you, that you haven't been prepared for by university training?

Nicola: Um, I think, it's the multiplicity of human difficulties that you encounter. You, that the, the public system is strapped for cash, that the people who get the services have pretty severe, clearly defined difficulties, um, because there's more choice involved, if you like, on the other side, the private system. You get people who come along, who may in many levels, may appear to be quite well-functioning, but whose private lives, either their personal relationships or their relationships with their children, or their own survival, um, can be quite compromised. And yet, it does not necessarily show up particularly, ah, in terms say of the work place, um, or their, income, or, you know, how they, how they function to the outer, another persons view. Um, and there's such a multiplicity of difficulties that people encounter that finding ways to engage effectively, both to identify what difficulties are and work out some system for addressing them, and then to monitor how well that's going, um, those, those skills require then a lot more time to develop I think. And you have to do things to learn how to do that, you've got to do more training, go along to workshops and trial things and learn things and also what things you're good at, to what you're not good at.

I'm a general psychiatrist; I don't for example deal a lot with younger adolescents, um. I don't deal specifically with sexual problems, um, or drug and alcohol purely. I mean, I look at the interface, people who've got, you know, a range of problems and that would be one of them, um, yeah, and also you go through varying interests as you go along too. I had a great interest initially in forensic psychiatry, fascinated by it. Um, but, I think, at one point when my secretary at the time said: I hope you've not going to do any more of these cases; it makes me vomit when I'm typing them up. I realised that I, too, couldn't face some of the sorts of horrors that you encountered. Yeah.

EK: Like, could you give an example of what you're talking about?
Nicola: Well, um, I didn't, I never had an interest in civil forensic, your sort of back pain and compensation.

EK: Right.

Nicola: Those sorts of things, although you inevitably have to deal with it to an extent, but what interested me was the interface between insanity and crime. And, um, Queensland at the time had a new Mental Health Act, which I still think is one of the better ones. Um, so, that people who at whatever level of the criminal, um, procedures were identified as perhaps being, um, mentally ill, could be diverted out of the legal system into a health system. And, um, this is before I had children. I actually managed long-term, about 3 cases of infanticide, which were terrible cases where women, psychotic women, killed their children. And, ah, I think I was able to handle that because I didn't have children. So, I could be actually not troubled so much by that perspective and was able to be, I think, very helpful to those people and saw them through to recovery and having further children.

After that, yeah, and again, not, not me, just me, but a system. One woman, for example, ended up in goal. The new Mental Act came in and the other didn't, um, and it was interesting looking at what that was like, you know, one person who was basically persecuted for being mad and behaving in a way that she was not responsible and the other who wasn't, who was actually hospitalised and seen through it, without that awful, awful, experience of being in goal for 3 or 4 months.

So, so, that, that's the sort of thing that I was interested in and then I started to do assessments of cases where the lawyers would come to you and say: will you assess this person to see if they've got a mental illness. And, then, um, you know, we'll take that to court. So, it was seeing people who weren't insane, who weren't crazy, they may have been very nasty disturbed people, basically murdered other people, but that, that, was the point at which I discovered that evil was very banal and uninteresting and I didn't want to have to do any more of it. Quite a different group of people from those who were insane when they behaved dreadfully, I mean, because they basically weren't responsible. It was interesting working out all the factors that lead to that. It was very interesting work, because working for the Mental Health Tribunal, in the role, in the sense of assisting the Tribunal, you got everything. There was no, nothing you didn't see. You got all the transcripts, you could go to the goal and interview people, you could talk to their relatives, you got all the past history, talked to their treating psychiatrists, you know, you were someone who had access to all the information. It wasn't an adversarial system in that way, and so, that was fascinating, um, and I liked that. But it was just dealing with the ordinary, nasty murderers, um, and, ah, encountering a complete cold-bloodedness of people who could kill. It was just horrible, mm.

EK: So did they have an underlying mental pathology?

Nicola: Not always, no.

EK: Right, they just –

Nicola: I mean, one could argue that they'd been in some ways so damaged as human beings in their development, they often had awful developmental histories that they had no sense of conscience or rapport, or empathy with others; that they just would kill. It was chilling. And, ah, that was around about the time that I, ah, decided that I didn't want to do that any more.
EK: Would you have been able to help those three ladies who committed infanticide after you'd had children?

Nicola: I think it would have been more difficult.

EK: Why?

Nicola: Because, because, I think the horror of it would have been too overwhelming.

EK: You'd think of yourself and your own children and you can't separate –

Nicola: No. I think it would have been very difficult. I mean, maybe I would. I can't answer that because I haven't had to do it. But, I think, I would find it very difficult to, to deal with their grief.

EK: Right. Because you don't identify too much? Would that be a similar sort of situation if you, um, had yourself or within your family some co-morbidity of, ah, of mental illness and, then you were trying to treat the same thing as it came into your office? Would that present the same sort of difficulty of not being able to, maybe, what would be the right word, detach yourself, or not emote as much?

Nicola: No, I mean, I think there are often situations where you see parallels to your own members of your families' lives and things will affect you, um, often quite deeply. Um, but, ah, but I think, that's your private stuff, and if you have difficulty with that, then you go and talk to someone about it.

EK: A mentor sort of thing –

Nicola: Yes, Yeah.

EK: I wonder if I could ask you about um, the, the ah, government health mental health policy at a federal level, sort of, ah, the second 5-year plan that's been trotted out, and that sort of thing. What are your comments on, on, on that?

Nicola: I'm not very good on policy stuff. I mean, one of the reasons I, I went for this exam job is because it's task-orientated. And, um, you, you, approach things in a certain way, and you can have outcomes that you can see. And I, ah, I deliberately asked, asked to go and join General Council, which is the governing body of the College and, um, which participates a lot more at the level of assessing those sorts of things and responding to them and I just know I'm not very good at it. I get very frustrated at the amount of verbiage you have to plough through and, um, processes which are sometimes mind-numbingly, to me boring, that have to do with the diplomacy of seeing things through. So, I, I'm aware of it, and, um, and I have to know about it, um, because we ask questions of our candidates about it. Um, and, and I can see, you know, that there are very useful things that come out of having a concerted, again overarching sense of how to deliver services and what priorities to make. And, ah, you, that there are some major social problems in our communities, um, that our, a process like that can address. Um, but it's not something that I um, warm to.

Mm, Mm, I got the latest thing that came in the College journal about the most recent, ah, processes that are being looked at, the preventative interventions of
suicide and some of the focus areas that they’re concentrating on, and I can see that there are benefits in that. Doesn’t make a lot of difference when you get down to the: Where’s the bed for the patient? And: How, how much services are eroded at the delivery end. Still, that seems to, um, not, not just in psychiatry, medicine generally. Yeah. Yeah.

**EK:** Um, apart from your dabbling in forensic, your, your general, you went, sort of, then into more general practice?

**Nicola:** I had always done that. Um, always liked, um, a general approach, not a specialist approach. Um, I found being, again a female psychiatrist, this is in Queensland, that came on the crest of the eating disorders, the books just got full of people, of, with eating disorders. So it was actually a relief to transfer down here to Sydney that has a specialist eating disorder unit next door than say I treat people with eating disorders specifically.

**EK:** Right, because, ah, why?

**Nicola:** Um, it just got boring, I mean, really, it did. You know, repetition of the behaviours and the issues and the difficulty of overcoming it, so it was a relief to do more general things.

**EK:** Right.

**Nicola:** And also, I’d developed an interest in cognitive behavioural work and liked working with people, ah, predominantly with anxiety and milder depression and self-esteem issues using that sort of framework, and liked that. I find people can relate to you very comfortably, you give them lots of tasks, they do them, they come back, they can see the benefit of them, um, so that they engage more actively in their own, in their own work.

**EK:** Like task-orientated things?

**Nicola:** Yeah.

**EK:** Would that be because of a desire to, sort of, see outcomes and, um, and performance? I wonder how you judge, how does psychiatry judge its performance? It has been pretty well criticised on and off throughout history for being a poor performer, or not actually being able to show its performance.

**Nicola:** I, I don’t personally. Just coming back to my own practice, um, put all the emphasis on that. I mean, I also do some psychotherapy where I see people once or twice a week for several years, because I can see that they’ve often tried a lot of those more, um, straightforward interventions, or medications or supportive therapy, or some of the other sort of, you know. I’ve done body work and re-birthing and these sorts of things and it doesn’t make any difference, and you really have to engage them long term, in a, in a healing, and preparative relationship, and help them see what they bring to that, that distorts relationships. And that takes a long time, and you can’t do it quickly, um.

**EK:** So you’ve done a psychotherapy extra course on top of your psychiatry?

**Nicola:** Yes, Yes.
EK: That's another 2 years isn't it?

Nicola: Ah, no, that, that's down here. In, in Queensland, it was much more loosely organised. Um, the Psychotherapy Association up there, which interestingly had huge fights with the psychiatrists, there were always, you know, demarcation issues and disputes, who owns what territory, and yes, poor old trainees used to fall down holes between the –

EK: Sorry, psychologists could do that too could they, if they'd done the psychotherapy course?

Nicola: Ah, not just psychologists, um, a whole range of people. I mean, it's not, it doesn't actually require any specific um training, other than to do psychotherapy. If you'd ever read the journals of Anias Nin, you know, she went off and became a psychotherapist, and ah, I mean, she's a very erudite and, ah, complex woman, and probably very good as a therapist. There's a couple of articles in the paper recently one of my patients bought along, um, um, John Cleese's current wife –

EK: Yes, yes, I saw that. She was gorgeous looking.

Nicola: Yes, yes, yes, wasn't she? Very American looking, yeah ... with an accent that could stop a tram. So, I mean, there, you don't actually need a medical degree, or even a psychology degree to do that. And, ah, yes, so I mean, I also, um, had some personal therapy myself, which I think probably helps because, you, you know what it's like to be the patient, then you really get that sense of where the power differential is, and ah, and how much, how important can be, in issues of trust and, um, ah, regard.

EK: You often hear about that, um, whether it's through choice or need, that psychotherapists put themselves through –

Nicola: It's certainly, I mean, the more, um, ah, I suppose stringent psycho um, psycho-dynamic therapists ... It's part of the requirement that they have analysis.

EK: To go through it themselves?

Nicola: Because otherwise, you know, you unconsciously, um, treat your patients in the same way that, ah, um, that you haven't worked out from your own developmental glitches. And, you know, hold-ups, and problems, so you end up using the patients in some way, if you don't actually know what your own vulnerabilities are.

EK: Is it hard to keep on top of your own vulnerabilities so you're not, transferring the wrong word, but sort of biasing your, um, assessments and your treatments?

Nicola: Um, generally no, but I think we all, you know, we run into problems and one of the difficulties is recognising when, when you can't be any more value. And you've, I suppose I'd say failed, you've failed effectively to meet that persons needs and then obviously you have to call on other, um, colleagues to, to assess and assist and hope that you don't damage the patient too much in that process of saying, you know, I, I don't think I can help you any more, um, this has got to do as
much with me as it has with you, um. Inevitably it is damaging, but you hope that that can be assisted and sometimes it actually makes a difference, because it sometimes shakes people up, not that you do it for that reason, but it kind of makes them reassess what, what they're doing, and how there doing it, yeah and –

EK: And then what you're doing, and how you're doing it?

Nicola: Yeah.

EK: Is it hard to um –

Nicola: In those circumstances ... yeah, just a bit yeah. You know, you wonder what your colleagues all think of you, like how you've ballised up with this person. But uh, its not for want of trying, yeah, but I think there are points where, or when patients leave you, that's not so hard, I don't take that personally if someone says, you know, I can't work with you, or haven't got any rapport with you, that's alright, people are different.

EK: Has that happened?

Nicola: Oh yes, that alright. That, that isn't an issue, it's when you can't deliver from your end, that's the hard bit. Um, I was going to say something then. Oh yes, how much personal vulnerabilities might influence; I think like any professional you, you have to take good care of your personal life, I mean, when I've got too many stresses in my own life, I don't function so well. You know, it just, it intrudes, you know, you're not free, um to, um, to be, as ah, I suppose to be, as ah, ah, attentive.

EK: Do you leave part of yourself at the door before you walk in here?

Nicola: The training very much trains you to be a more neutral figure. I mean, I'm very particular about not giving any personal details of my life, of my marital or family situation, or my background, um. Sometimes I will, but it's rare, it's extremely rare. Um, so, yes, I mean, that if you say, leave part of myself at the door, there's very much the presentation of the self that's available, and hopefully warm, but, um, but it's not, it's not a friendship in that sense. There isn't an exchange, I mean, inevitably people think, winkle things out, you know, they find things and, ah, yeah. Mm, mm.

EK: So you, you mentioned you get, you get favourite things to do, like you psychiatrists, they develop a favoured, would you say, you've gone through your forensic stage, you're in general, so now it's, your favourite would be [pause] Treating?

Nicola: A favourite, I don't know, I like, I like the mix.

EK: Anxiety, depression and social problems, that sort of?

Nicola: Yeah, and psychotherapy, and, and I, I have a number of patients who have, you know, what are called severe mental illnesses, um, who have schizophrenia or manic-depressive illness or um, anxiety disorder which are well beyond being able to be managed with cognitive behavioural interventions. Um, who require medication and, ah, need to have it, um, I have quite a few patients with
significant physical illnesses and the psychological impact of that is, is, um, you know, an important component of their lives, and how they handle it.

EK: Is it because of pain, chronic pain?

Nicola: No, I don’t actually deal with pain.

EK: Oh, OK.

Nicola: Mm, I haven’t, I haven’t sought out the training, and I don’t feel I’ve got enough expertise in that area. Maybe I’m not very good at it either, I don’t know.

EK: You, you go towards what you’re good at, do you feel that’s what most psychiatrists would do? And you, you yourself, gravitate towards those things you feel more competent in?

Nicola: More competent in, certainly, yeah. And some of it is opportunity, you know, if you’re in an area and there’s a need, and you respond to it, then you develop an expertise.

EK: So beyond you’re, um, academic aspirations, um, for the training and the exams sort of thing, you’re next 15 years: More of the same, or diversifying a bit?

Nicola: I’m not sure about that. I mean, the fact that the practice is, is closing, I’ve um, um, for the first time ventured outside its supportive environs, and ah, going over to start, ah, one session a week at St Vincent’s. And um, in a private clinic there. I was invited by a colleague who, who’s over there, um, he’s the only psychiatrist who’s in that group, and they need more psychiatric services. So I mean, that’s a, a new world. Yes, so that, that will offer a different range of, of people I think. One of the curious things about Sydney is how tribal it is. Ah, you know, coming from another environment and, ah, apparently there’s a sort of different tribe over there. So I’ll encounter a different expectation, outlooks and attitudes and social strata.

EK: Is that what you mean by new? Is that what you meant by new environment?

Nicola: I don’t imagine that I’ll necessarily get all that different problems in terms of what people bring through the door, um, no, not necessarily.

EK: Eastern Suburbs?

Nicola: Yes, yeah. Whatever that, whatever that’s going to mean. But, ah, in terms of the psychiatry itself, um, yes, it is a bit of a watershed time, when, when things are changing, to think about what you do, and how you do it. Um.

EK: And why do it? And why do it, yeah, um?

Nicola: I mean obviously it’s to make a difference to peoples’ lives. Um, um, yes, I mean, um, make a difference to peoples’ lives. One of the curious things we are doing at the moment, we are going through all the old files of the practice and divvying them up to the doctors who own the files, that is, who’ve treated the patients. You look back on files of people, I mean, I haven’t been here that long.
I've got another group of them at home, locked in storage, but, um, when you look back at people and, ah, wonder what's going on in their lives now, you know, because, you know, you see them for limited periods and they drift off, or they, you finish with them. That's an agreed time to move off, you wonder what's happening yeah. Very occasionally, you get a call out of the blue, from someone you saw many years ago, and, to either touch base, or say hello, or ask some advice at that point about seeing someone again if they've hit another problem. Yes, so, make difference to peoples' lives, I'm not sure. I mean, how do you know? You may deal with them, they're very grateful at the time, if that makes a difference in the long run. Um, yeah, I suppose unless you actually follow people up, and that's intrusive.

EK: Right, so what are the satisfactions then?

Nicola: Oh, I think, yes, in a large number of cases you do get a sense that it's positive. That the intervention is useful, or people tell you it's not, and you accept that. Um, one of the satisfactions of being in private practice is that you do get the opportunity to work long-term with people with chronic illnesses, with severe illnesses, and you, you just build up such a knowledge base with them, about their condition, um, that you, you, you just know. Know when you encounter people, you know, haphazardly, how, how much that makes a difference to people with chronic illness, that, that continuity, the knowledge base, the shared trust, um, the engagement with their family members, just provides them with a really stable um support. Um, and it's, it's a knowledge support, and it's a personal support, um, and ah, that's, that's rewarding. I, I know that from having, um, worked long term. It's also obviously very sad, because, you know, we see people we can't cure these illnesses, um, so it's very much a preventative, secondary and tertiary approach rather than primary, um, but that's, that's rewarding, and you build up a regard with those people, it's a good relationship. They, ah, they know they can rely on you and you do your best by them when they need you, ah, there's also the psychotherapy. I suppose that it's interesting, it's the long-term therapeutic relationships that offer the most satisfaction. Perhaps you see the most profound, you know, either sustaining health as best people can, or the most profound shifts in function over years, um, and um, that's very, very satisfying. Again, you know people really well, and they, um, build a regard and trust for you which is, um –

EK: The idea that you are making, making a difference?

Nicola: Yes, yeah. You can see a process going on, a maturation. Often people who have been handicapped by that, you know, most of their lives up to that point, so to see those barriers start to crumble if they make advances in that way in their lives, that's very satisfying.

EK: You mentioned people who are out there, not really being able to cope and superficially looking like they are coping with life; there must be plenty of people who don't come across the door to psychiatrists?

Nicola: I think there's a lot of unmet need. And again, it's one of those problem interfaces, you know, the notion of treating the worried well. If people are functioning, what, ah, justification is there for putting resources into their care? And, I suppose, I see a lot of trans-generational pathology, and I think, if you can make a difference, I'll often work with people that, you know, I don't necessarily know I'm making a lot of difference to them, but I'm pretty sure I'm making a lot of difference to their parenting. And I think, in that way, you, you can actually reduce the burden
of, um, of dysfunction across generations and I think, in that sense, it's worthwhile, mm.

**EK:** What sort of pathology are you talking about there?

**Nicola:** Oh, some case, oh, I mean, often it's um, um, it's the results of early, early, poor parenting, um. So that if people have major difficulties, in terms of dependency, needs, or issues of control. Um, an example is, a woman who's mother suicided when she was 5 and who's depressed most of the time and regularly contemplates taking her own life. And, you know, we talk about helping her through those periods, because, you know, she's got children, including a daughter, you know, and the notion, that, that, will inflict a similar wound on that child is very important to help her. And she's a very, very troubled person, um, but you know, she, we, also make use of other resources for her. She's gone to the anxiety disorders for kids across the road here and done some work with them, in terms of managing her child, um, that's one example, a particular case example, um.

Depressed mothers is another important thing, that if you can really treat people well, and get them well, in the post-partum period, then again, the impact of a depressed mother on a baby, there's a lot of evidence for that. The other problems are people who have been sexually abused, um, who often have enormous difficulties with intimacy and trust and fears and conflicts surrounding their own children's sexuality, and their own, um, capacity to mother and care. So helping them regain their own sense of well-being and self-esteem, and, um, be able to separate themselves from the self that, that happened to, and see themselves as more than that, I think brings a lot of different qualities into their nurturing.

**EK:** One final question. Is there anything else that you could tell me to help me understand what it is to be a psychiatrist practicing at the end of the 20th century in Australia, any other issues that are important to you?

**Nicola:** Relevance!

**EK:** Relevance

**Nicola:** Mm, mm, to, to, maintain an input that's actually useful to the community, rather than sitting in a room doing things which are personally satisfying, but not necessarily making a considerable difference to the wellbeing of the community as a whole. Yeah, so I think the scrutiny of what psychiatrists do is well founded.

**EK:** Terrific

**Nicola:** I'm exhausted, my husband's a journalist. I just [tape turned off].
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Medicine, Money and Madness:
Conversations with Psychiatrists –
A Postmodern Perspective

by

Elizabeth Carole Keirnan

A thesis presented to the School of Management,
College of Law and Business
University of Western Sydney
for the degree of

Doctor of Philosophy

January 2004
CANDIDATES CERTIFICATION

I certify that the thesis entitled Medicine, Money and Madness: Conversations with Psychiatrists – A Postmodern Perspective and submitted for the degree of Doctor of Philosophy, is the result of my own work, except where otherwise acknowledged and that this thesis (or any part of it) has not been submitted for a higher degree at any other university or institution.

Elizabeth Carole Keirnan

Date  30 June 2004
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
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Abstract

The main interest in life is to become someone else that you were not at the beginning ... The game is worthwhile insofar as we don't know what will be the end (Foucault, 1988: 9; cited in Sawicki, 1994: 286).

Foucault speaks of the formation of an individual's identity, or the process of becoming someone else, as a worthy game. For postmodernists, it is considered a life-long process of reconstruction and re-evaluation (Wilska, 2002: 196). The identities that are the focus of this research are psychiatrists, but also the self. The choice of psychiatry and psychiatrists as the subject of this research is regarded as both accidental and fortuitous, but may also contain a degree of inevitability. This research follows previous post-graduate research that reflected on knowledge, power, space, surveillance, the body and organisational control. The major question of this earlier research was: What constituted “normality” in the work place and who were the arbiters of this normality? Because of this work, some theoretical influences were persuasive at the commencement of this present research and persisted throughout. In particular, these were Foucault’s writings on knowledge, subjegated knowledge(s) and “genealogies”, which are 'critical analyses tracing the making of identities, selves, social norms, and institutions' (Seldman, 1994: 6). In this research, these same theoretical influences informed the interpretation of the interview material.

Chapter One, entitled Psychiatrists in Postmodernity, introduces the research project through the research questions, motivation for the project and the challenges to be met. Chapter One also introduces the influential people, circumstances and events. In stating the challenges and influences, this first chapter also introduces the researcher with dual roles. One role is that of a Clinical Research Associate (CRA), monitoring clinical trials, which requires a review of patient's medical records and their doctor's correspondence, for verification with transcribed data collected for specific clinical trial objectives. The medication being tested in these trials, the transcribed assessment data produced, and the professional CRA, all “belonged” to the same pharmaceutical company. The second role is that of a social researcher doing this doctoral research, a role which emerged from the first. Consequently, this text describes my becoming someone that I was not at the beginning.

Chapter Two is a theoretical chapter that presents a Postmodern Philosophical Perspective. Chapter Two discusses the history of development of postmodern thought in social research.

The postmodern perspective maintained aims to:

- Consider the possibilities beyond our usual frame of reference;
- Agree that any interpretation or explanation may simply be different descriptions of the same underlying phenomenon or theory;
- Recognise the struggle or tension between gaining "knowledge" through the unifying interpretation demanded by modernist, scientific "understanding", and a postmodern acceptance of the unknowable.

1 At the time of enrolment for the doctoral research, I had just commenced employment with a pharmaceutical company as a Clinical Research Associate (CRA) and was given the responsibility for managing and monitoring the conduct of a number of clinical trials with the company's new anti-depressant medication. I was working with psychiatrists throughout Australia on these clinical trials.
Chapter Three, entitled History, Myth and Reality, places today’s psychiatry in Australia, in historical context. It describes the development and inheritance of the profession of psychiatry. This history includes the development of the discourse of psychiatry – the knowledge and the practices associated with that knowledge – that locates the psychiatrist in a space, and creates the popular image-making of the psychiatrist. It reviews the definition, diagnosis and control of mental disorder and mental health within the evolving discourse of psychiatry. It also identifies how and why some personal and public images of psychiatrists, mythological or not, have been constructed and accepted, and how they can change to become something else.

Chapter Four, entitled People, Politics and Purpose, considers the current state of mental health policy in Australia. It explains how psychiatrists are concurrently included and excluded by the current policy objectives that focus of “mainstreaming” and “integration”. It also raises concerns about the underlying economic motivations and potential success of the Australian Federal government’s National Mental Health Strategy for Promotion, Prevention and Early Intervention. This strategy’s objectives are to communicate and promote the government’s concept of mental health to all the community, identify at-risk population groups and individuals and propose strategies to prevent illness in at-risk groups. The strategy also aims to maintain mental health through early identification and adoption of preventative strategies within primary practice, general hospitals or the community, rather than institutions specific to mental health care.

Chapter Five, Methodology and Methods, considers the methodological debate in the social sciences between qualitative and quantitative research methods. Chapter Five explains the methods chosen as being consistent with the postmodern theoretical perspective. This chapter also describes the choices made of interview and reflexive interpretation as a means of "analysis" of the conversations, interviews and experiences reported. Eighteen interviews were conducted for this research with fourteen of Australia’s practicing psychiatrists.

Chapter Six, Outcomes and Interpretation, presents an interpretation of the research interviews and discusses the connections and possible meanings of the stories told by psychiatrists, within the context of the postmodern philosophical perspective. The interpretation also draws on opinions expressed in the published literature by psychiatrists on psychiatry. The interview material\(^2\) sheds new light on the realities and myths associated with psychiatry. The story of psychiatry presented is one of Medicine, Money and Madness. This chapter also, concurrently, provides an interpretation of the research experience, the interviews and conversations – the multiple places and spaces in which we find ourselves and seek meaning. ‘We do not live in a kind of void within which individuals and things might be located ... we live inside an ensemble of relations that define emplacements’ (Foucault 1984; cited in Faubion 1994: 178). The interpretation raises a common concern for psychiatry that arose in a multiplicity of forms. Will the deinstitutionalisation for the twenty-first century be the removal of the psychiatrists from psychiatry? What will be the place and where will be the space for psychiatrists in the evolving discourse of psychiatry?

\(^2\) A number of informal conversations were conducted with many more psychiatrists than were formally interviewed due to the nature of my work as a CRA. Conversations were also had with some interviewees both pre- and post-interview for the same reason. The content and potential influence of these conversations is recognised. However, as these conversations were not formally documented as part of the approved research proposal, they have not been formally incorporated into the research.
The final chapter, Chapter Seven, is entitled Postmodern Psychiatry. It considers the question: Is there or can there be a postmodern psychiatry? In doing this, it takes the interpretations, connections and meanings from Chapter Six and locates them in the wider social context of the Australian National Mental Health Strategy. It is a discussion of the research interpretations and the implications for the existing place of psychiatrists within the mental health care policy agenda. Finally, this concluding chapter provides a commentary on if, and how well, the research challenges were met and discusses some options for future research.