

READMISSION AND THE SOCIAL CONSTRUCTION OF MENTAL DISTURBANCE

by

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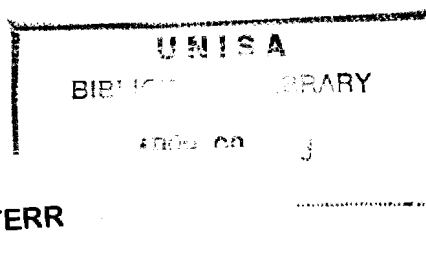
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Summary

This dissertation examines recurrent patterns in the interaction between psychiatric patients and the systems of knowledge and power that constitute them as patients. These patterns are traced both in the historical migration of patients into and out of the asylum, and in the language used by doctors and patients to account for such migration. Transcripts of interviews with patients and case notes written by doctors are subjected to new forms of quantitative analysis and this is used together with qualitative interpretation to reveal the ways in which disciplinary power operates through confession and surveillance to constitute psychiatric subjects in the tension between freedom and incarceration.

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Preface

A visit to the aquarium

I should have been a pair of ragged claws

Scuttling across the floors of silent seas.

- T.S. Eliot

In an article in the *British Journal of Medical Psychology*, Thomas Szasz (1993a), doyen of the antipsychiatry movement, writes: "It seems to me that no amount of reasoning or research can bridge the gap between tissue and talk, between cellular pathology and language pathology" (p. 65). Szasz's assertion is remarkable for two reasons. The first is that he should once again (cf., Szasz, 1967, 1978, 1993b) choose to build his critique on the use of language in schizophrenia, when schizophrenic speech, or crazy talk as Szasz would call it, is in fact rare. Leff (1993), for example, reports having encountered no more than 50 cases in over 1000 patients diagnosed as schizophrenic. The second is that, unlike what happened when he made similar claims in the 1960s, Szasz's article is almost certain to have no impact on psychiatric practice.

Szasz's own explanation for his choice of crazy talk as key to the argument is that in the absence of real biological markers disordered language continues to be used by psychiatrists as a kind of pseudo-biological marker of thought disorder, which is then equated

with brain disorder¹. Thus by removing 'disordered speech' as a legitimate part of the system, Szasz hopes to bring down the whole house of cards. To the extent that he theorises the puzzling ineffectiveness of this strategy, Szasz's reasoning can be summed up in two words: Medical hegemony.

Mainstream psychiatrists themselves, if they could be bothered to take note of Szasz's work, would most probably find other explanations for his continued obsession with the issue of language and for the negligible impact of his critique. Szasz, they might say, does not conduct proper scientific research on mental illness, and is therefore reduced to philosophising about language. He is no longer taken seriously both because of the disastrous consequences when his ideas *were* implemented in the 1960s, and because biological research on mental illness has progressed to the point where his brand of linguistic nitpicking has become irrelevant.

In this dissertation I attempt to study the tension between language and biology from a position somewhere between the antipsychiatric (as exemplified by Szasz) and the mainstream psychiatric approach. Like Szasz I take language to be a key site of resistance, but unlike him I focus on the ordinary daily language of patients and physicians, rather than on crazy talk, as that which maintains the system of psychiatric illness. Like mainstream psychiatrists, I assume that patients are to a large extent not free agents, but constrained in what they can say and do, but unlike them I view the constraints as discursive as much as biological, and as affecting the sane as much as the insane.

The substantive problem to which I apply this approach is that of psychiatric

¹ An undated booklet (*A member of your family suffers from schizophrenia*) published by the Department of Health and Population Development neatly illustrates the process by which crazy talk is turned into disordered thinking: "Such a person may say things you do not expect or understand. He may talk a great deal or loose [sic] the trend of what he is saying. Sometimes it looks as though there are too many thoughts for him to cope with." (p. 3)

chronicity, which translates as *readmission* in modern hospital psychiatry. My purpose is to demonstrate that chronicity has its own lexicon, syntax and semantics; that the walls of the asylum are fashioned in language, and are therefore susceptible to being linguistically breached, scaled, subverted and deconstructed. In the course of the dissertation I take two steps away from readmission as a problem of overt individual behaviour. First, I trace how chronicity can be viewed as a social construction with a particular contingent history, a history marked by oscillations between confinement and liberation, but more particularly by the increasing influence of 'moral', rather than physical confinement. Second, I trace how this moral confinement becomes real not only in the movement of bodies in and out of the psychiatric hospital, but in the minutiae of the everyday language used by psychiatrists and their patients.

I start with a review of empirical research on readmission (Chapter 1) and suggest instead a possible historical structure (involving an oscillation between pessimistic somatic and optimistic psychosocial views) within which to understand the phenomenon (Chapters 2 and 3). I elaborate this in an attempt to account for the somatic orthodoxy which currently holds sway in psychiatry (Chapter 4), evaluate criticisms of such accounts as being insufficiently data-driven (Chapter 5), and review the possible utility of techniques from corpus-based linguistics in responding to these criticisms (Chapter 6). I then apply newly developed techniques to transcripts of interviews with psychiatric patients (Chapter 7) and to psychiatric case notes (Chapter 8). Finally, I reconsider (Chapter 9) the implications of a discourse-based approach to mental illness.

Methodologically, the dissertation attempts to draw on both quantitative and qualitative empirical enquiry, and to speak simultaneously in the idiom of objectivity and of constructionism. Of all academic disciplines, psychology is perhaps the most difficult to

assign to one or the other of what C.P. Snow (1959, 1964) called the "two cultures" of learning: Is it Mr Eliot the banker, the dull but reliable calculator of behavioural interest rates and cognitive amortization values, or Mr Eliot the poet, inventor and exposé of a more forbidding reality below the surface of our routine existence? Thus I am concerned with the cold surfaces of numbers in psychology and with the colder depths of words - and with deconstructing the distance which separates them.

The materials I have used in putting together this dissertation are academic and other publications on topics such as the postmodern ferment in the social sciences, the history of psychiatry, the 'causes' of psychiatric readmission, and qualitative versus quantitative research; transcripts of interviews with patients at a mental hospital; case notes from the psychiatric ward of a general hospital; and ethnographic observation over a number of years in and around South African psychiatry. I have tended to treat published texts with different degrees of piety, taking seriously both the rather bland (Potter & Wetherell, 1987) and the more radical (Parker, 1989a, b) versions of discourse analysis practised by social psychologists interested in language; both mainstream (Kleinman, 1988) and critical (Singer, Baer & Lazarus, 1990) medical anthropology; as well as various other cultural, sociological, and political critiques of medicine and madness. However, texts of the sort that are published in psychiatric and clinical psychology journals I have not engaged on their own terms, using them instead as data for analysis.

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Soviale kont.*

According to Gergen (1985), accounts of social constructionism, as this dissertation attempts to be, cannot be empirically warranted. Their success depends on the author's capacity to "invite, compel, stimulate, or delight the audience, and not on criteria of veracity" (p. 272). However, while these are standards by which I would wish this dissertation to be judged, the empirical warrants offered (especially in Chapters 7 and 8) are not included

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entirely for their entertainment value. At best the dissertation should evoke the same kind of response as would a casual visit to an aquarium, namely mild pleasure upon viewing each new exotic creature - Marble Hatchet, Bleeding Heart Tetra, Kissing Gourami, Green Hi Fin Molly, or, Pair of Ragged Claws - together with a slight stimulation of interest in precise scientific nomenclature and muted scepticism about the degree to which each underwater display approximates imagined real aquatic ecologies.

Chapter 1

Readmission: An overview of empirical research

Myself when young did eagerly frequent
Doctor and Saint, and heard great argument
About it and about: but evermore
Came out by the same Door as in I went.
- Edward Fitzgerald 1809-1883

Psychiatry does not have a distinguished research tradition in South Africa, qualifying for little more than a cursory mention in both Brink's (1988) and Malan's (1988) histories of medical research. Although it could be argued that these histories are biased against psychiatry as one of the less glamorous medical specialties, empirical evidence on publication impact and frequency confirms South African psychiatry's relatively low research profile. While other branches of South African medical research are highly regarded internationally - local work in 'General and Internal Medicine' ranks seventh in the world according to bibliometric and citation indices (Pouris, 1989) - psychiatry is listed among those scientific disciplines "in which South Africa does not make any international contributions" (p. 625). Thus when the Medical Research Council (MRC) established its Clinical Psychiatry Research Unit in 1980 there was a considerable backlog of research and a need to identify the most urgent priorities. Gillis (1987), who was appointed as first head of the unit, summarised the unit's research agenda as follows: "The areas which were selected as being of greatest concern were mental illness in the aged, the high readmission rate to South

African psychiatric hospitals (approaching 50% overall and rising), and substance abuse, particularly marijuana, as a concomitant or cause of mental illness" (p. 797). The importance of the readmission question was later endorsed in an official statement by the Society of Psychiatrists of South Africa (Ben-Arie & Nash, 1986).

It is disturbing that in the face of issues such as the lack of recreation areas and poor sanitation in many South African psychiatric facilities (highlighted in a survey by Visser, Haasbroek and Bodemer, 1989), the mental health effects of poverty and apartheid, the generally appalling conditions in psychiatric institutions for blacks and the extreme racial disparities in outpatient facilities (all of which were highlighted in papers by amongst others Dommissie, 1987, and Jewkes, 1984), the MRC and the Society of Psychiatrists should have opted for a relatively safe topic such as readmission.

Nevertheless, from the point of view of emulating a certain international research tradition, they chose well (as will be shown) in fixing on readmission as a priority area, and within five years of its founding the Clinical Psychiatry Research Unit was able to report (Gillis, Sandler, Jakoet & Dickman, 1985) on what it construed as an alarming rise in readmissions to South African psychiatric hospitals, with 45% of 1984 admissions nationwide being readmissions. In one study of patients in a mental hospital in Cape Town (Gillis, Sandler, Jakoet & Elk, 1986) it was found that 26.5% of white, 41% of coloured and 42% of black patients were readmitted within a year.

What causes South African psychiatric patients to be readmitted so frequently? The answers thus far suggested by Gillis and his colleagues (Gillis *et al.*, 1985; Gillis *et al.*, 1986; Gillis, 1987, 1988; Sandler & Jakoet, 1985) invoke both general historical factors (which account for the overall rise in readmissions) and specific causal variables (which account for individual differences in readmission frequency).

The historical factors are explained as follows by Gillis (1988): "Major changes in the pattern of admissions, readmissions and community and outpatient attendances have occurred in the last 10-15 years. Inpatient admissions have decreased to a remarkable extent and outpatient and community services have increased about 400%" (p. 303). The result of this shift is that there are now upwards of half a million community and outpatient attendances per year as compared to around 30 000 inpatient admissions and, given this change of emphasis to community (as opposed to custodial) care, cases of relapse are now less likely to occur in the hospital setting and are therefore more likely to require (temporary) rehospitalisation.

The process of deinstitutionalisation has been uneven in South Africa, with many facilities (particularly for Black patients) remaining essentially custodial in nature (Dommissie, 1987; Freeman, 1991). George (1988) reports that, despite continued population growth, there was a decrease in the number of patients resident in institutions financed by the state from 25 881 in 1975 to 19 576 in 1985. In the then exclusively white psychiatric hospital where the empirical study reported on in this dissertation was conducted, the number of hospital beds were reduced from 200 (Moross, 1969) to around 100 over a 25 year period. The Oranje Hospital in Bloemfontein, on the other hand, which caters mainly for Black patients, achieved a similar reduction (from 235 to 100 beds) over a three year period from 1985 to 1987 (Fourie & Gagiano, 1987)¹. Taken overall, psychiatric inpatient numbers in South Africa appear to have started declining sharply from the second half of the 1960s. Between 1964 and 1976, inpatient admissions declined by 27%, while outpatient visits went up by 834%; altogether 8800 psychiatric inpatient beds were done away with between 1961

¹ According to Gagiano (1990) the reduction was from 415 to 100 inpatients between 1985 and 1989, with a concomitant increase from 20 000 to 50 000 in patients being cared for in the community.

and 1989 (Visser, Haasbroek & Bodemer, 1989). However, by the late 1980s South Africa was still lagging in terms of deinstitutionalisation with around one bed in a psychiatric institution for every 1000 population, compared to the WHO recommendation for Europe of 1 per 2000 population (Freeman, 1991).

In terms of specific causal variables, Gillis and his colleagues (1986) were able in one study to isolate as significant readmission predictors (for white patients): Living alone, mixed substance abuse and having no supportive relationship, and (for coloured patients) being male and being diagnosed as schizophrenic. The only variable which was predictive across racial groups was having more than one previous admission in the past five years. Other factors which have been blamed for readmission in local research include 'job-related difficulties', lack of social contact, dependency on others, the effects of stigma, non-compliance with medication (Strong, 1987; Gillis, Trollip, Jakoet & Holden, 1987; Gillis, Koch & Joyi, 1989), and high levels of 'expressed emotion' (Ben-Arie, 1988) or a lack of understanding in patients' families (Moross, 1969).

Although the MRC team suggested various steps which may be taken to limit readmission (more careful surveillance of outpatient compliance with medication, bolstering social support systems and so on), none of these interventions have been shown to have a major impact on readmission (Ben-Arie, Koch, Welman, & Teggin, 1990). However, as Gillis *et al.* (1986) are quick to point out, the failure of any intervention to prevent readmission should not necessarily be interpreted as an index of the inefficacy of psychiatric treatment, but may simply be due to the chronic and recurrent nature of mental illness itself.

The main themes characteristic of South African academic literature on readmission outlined above - contextualising the problem within an historical trend towards outpatient care for the mentally ill, a (usually unsuccessful) search for specific causal variables and

preventative interventions, and an attempt to normalise readmission as an inevitable part of mental illness - closely resemble similar trends in the international psychiatric literature, which is reviewed below.

Deinstitutionalisation

Although the term 'deinstitutionalisation' only came into use in the mid-1970s (Morrisey, 1982), the ideal of phasing out mental hospitals started in the early 1950s and was already well under way during the 1960s. As in South Africa, the readmission problem is internationally ascribed to this process (Dorwart & Hoover, 1994). Lehman, Possidente and Hawker (1986) report that "since deinstitutionalization began more than two decades ago, the inpatient census of public mental hospitals has been reduced by more than 70 percent." (p. 901) According to Levine and Perkins (1987) there was a drop in the mental hospital population in the United States in this period from 600 000 to 200 000, with a concomitant growth in community mental health centres from nil to around 750. Expressed in terms of 'market share' (counted as care episodes), state mental hospitals in the United States have seen their share drop from nearly 50% in 1955 to only 9% in 1975, with resident patients accounting for 75% of episodes in 1955, but only 29% in 1980 (Morrisey, 1982). The process of deinstitutionalisation, although a global phenomenon, varied considerably in precipitating factors and chronology.

Krauss and Slavinsky (1982) attribute deinstitutionalisation to the discovery of more effective psychiatric medications in the 1950s: "The widespread use of chlorpromazine and related neuroleptics was the single greatest contributor to a reduction in the number of patients residing in mental hospitals, to the shortened length of stay, and to a shift to

community-based care." (p. 74). Chien (1981) also endorses this view, pointing out that by the early 1980s more than 10 000 scientific papers had been published on psychotropic medication, and that the pharmaceuticals industry which had arisen around psychiatry was already worth billions of dollars per year.

Mechanic (1986) disputes this view, arguing that economic, rather than scientific, factors were mainly responsible for deinstitutionalisation in the United States:

Superficial historical overviews link the reduction of public mental health populations to the introduction of the phenothiazines in the middle 1950s, but in reality individual states varied significantly in the timing and rates of deinstitutionalization. Large scale relocation of chronic mental patients began only ten years later with the introduction of Medicaid and improvements in the social welfare system (p. 892).

Mechanic (1986) argues that expectations that outpatient care would be either cheaper or a less direct tax burden were the main driving force behind deinstitutionalisation, with American states shifting costs to federal programs by transferring patients from mental hospitals to alternate facilities such as nursing homes.

A third precipitating factor, and one which is often invoked when discussing the undesirable consequences of deinstitutionalisation, is the ideological critique of institutional psychiatry developed by the anti-psychiatry movement (reviewed in Dain, 1989).

Finally, explicit political initiatives, such as John F. Kennedy's 1963 address to Congress in which he called for a 'bold new approach' to mental illness and which resulted in the Mental Retardation facilities and Community Mental Health Centers Act of 1963 (Krauss & Slavinsky, 1982), also contributed to deinstitutionalisation. In Italy, which had perhaps the most radical approach to deinstitutionalisation (Basaglia, 1981; Crepet, 1990), Law 180 of 1978 brought in sweeping changes aimed at the dismantling of mental hospitals, to be

replaced by mental wards in general hospitals and community care. According to Law 180 there were to be no first admissions after May of 1978 and no new admissions after December 1981. Surprisingly, this has been largely complied with (although patients have sometimes been disguised as 'guests') and the mental hospital census in Italy is still dropping (Tansella & Williams, 1987).

It appears that internationally the readmission crisis, which followed on deinstitutionalisation, set in almost immediately. Already in 1968 Crumpton could complain:

Most admissions to psychiatric hospitals are discharged within six weeks. However, our problems now are not so much new admissions, but of readmissions (p. 15).

In 1964 for every new schizophrenic patient admitted to a British mental hospital, two more were readmitted, and by 1968 patients who had been readmitted ten or more times were by no means rare (Crumpton, 1968). This state of affairs has been termed the 'revolving door' of psychiatric admissions and readmissions.

Of course not all patients released from mental hospitals become part of the 'revolving door' pattern. Lerner, Popper and Zilber (1989) followed a 10% nationwide random sample (n=832) of all psychiatric patients hospitalised in Israel in 1980 over a four year period and found three main hospitalisation patterns: 50% were admitted for a single, short hospitalisation; 22% accumulated a year or more of hospitalisation over several rehospitalisations during the period; and 8% were admitted for one long hospitalisation of at least a year. The mean number of hospitalisations during the four and a half years of follow-up was 2.62. Some studies have reported a readmission rate as high as 64% (Schnur, Friedman, Dorman, Redford & Kesselman, 1986).

Psychiatry is not the only branch of medicine to have had to contend with high readmission rates. According to Soeken, Prescott, Herron and Creasia (1991), reported one-

year readmission rates range from 3% for surgical patients to 66% for patients with chronic congestive heart failure. As in other fields of medicine, however, it appears that there is a group of patients who are particularly prone to rehospitalisation, and the challenge becomes to empirically identify the distinguishing features of these revolving door patients, also known as 'new chronics' (Casper, Romo & Fasnacht, 1991) and heavy or frequent users (Casper & Pastva, 1990), in order to predict and possibly prevent future readmission.

Predicting and preventing readmission

A typical example of the kind of research conducted with this purpose in mind is a study by Zeff, Armstrong, Crandell and Folen (1990). They set out, in a sample of 246 psychiatric patients in a military psychiatric facility (mainly first admissions and mainly young males), to isolate those factors predictive of rehospitalisation within 90 days. Not having any particular theoretical perspective, and since a host of factors had been implicated in previous readmission research, they used no fewer than twenty independent variables (including age, sex, branch of service, rank, marital status, number of children, diagnosis, number of days hospitalised, past psychiatric admissions and medication). Of these, four proved to be statistically significant in predicting rehospitalisation; however, together these variables accounted for only about 10% of the variance in readmission outcomes.

While these sorts of results are disappointing, it is through the accumulation of findings from such studies, so it is hoped, that a solid scientific understanding of the causes and cures for readmission will arise. Empirically-minded researchers will readily acknowledge that there may be technical difficulties in rendering findings from different studies comparable, for instance due to wide variation in sample composition and the ways in

which readmission is measured, but the specific facts yielded by each study are believed to add to the growing body of knowledge on readmission. The facts thus far accumulated are surveyed below.

Demographic factors

Anecdotally, revolving door patients tend to be young males (Bender, 1986), and demographic variables are therefore often seen as potential risk factors for readmission. Hughes, Joyce and Staley (1987) compared 110 readmitted psychiatric patients (of whom 19 were multiple readmissions within one year) to 100 non-readmissions and found that there were no demographic differences between the two groups. In a much smaller sample (n=38) of depressed and non-depressed patients Hirschfeld, Klerman, Andreasen, Clayton and Keller (1986) similarly found that none of a range of demographic variables predicted readmission over a two-year period. However, in some studies particular demographic variables have been found to be statistically significant in predicting readmission.

Gender, although not a significant predictor in Zeff, Armstrong, Crandell and Folen's (1990) study (which used a largely male sample), may have some predictive value. Both Colenda and Hamer (1989) and Zilber, Potkin and Lerner (1990) found that male gender was predictive of low probability of readmission for first-time patients, although not for non first-time patients, with first-time non-white females being at greatest risk in Colenda and Hamer's study. It is not clear how these findings relate to the stereotype of 'new chronic' patients as consisting mostly of young males.

There is some evidence that age may play a role (e.g., Kastrup, 1987; Hadley, McGurrin, Pulice & Holohean, 1990) with patients who over-utilise services tending to be

relatively young. However, in other studies (e.g., Zeff, Armstrong, Crandell and Folen, 1990) age was non-significant. As with gender, age may be differentially related to readmission for first-time and non-first-time patients. Zilber, Popper and Lerner (1990) found that for patients hospitalised for the first time in their life, age was negatively correlated with probability of readmission (but not cumulative hospitalisation), but for patients who were not first-timers, age was positively correlated with cumulative length of stay.

Similarly, Zilber, Popper and Lerner (1990) found that marital status was conditionally related to readmission in that being single was predictive of long cumulative stay for non-first-time patients, but not for first time patients. Zeff, Armstrong, Crandell and Folen (1990) found marital status to be non-significant as a predictor of rehospitalisation.

Race may play a role in that Colenda and Hamer (1989) found that for first-time patients nonwhite females are at greatest risk. However for non-first-time patients race was not significant. Zilber, Popper and Lerner (1990) also found 'ethnic origin' to be unrelated to readmission for non first-time patients.

Number of children has been investigated in a single study (Zeff, Armstrong, Crandell and Folen, 1990) and found to be non-significant.

Diagnosis

A considerable amount of work has been done relating psychiatric diagnosis to probability of readmission and to the related variable of length of hospital stay (reviewed in Parks and Josef, 1997). Several studies have suggested that being diagnosed as suffering from a major mental illness (Colenda & Hamer, 1989; Hadley, McGurrin, Pulice & Holohean, 1990;

Kastrup, 1987) or the severity of the diagnosis (Zeff, Armstrong, Crandell & Folen, 1990) may be predictive of readmission.

However, some authors have found no differences in diagnostic category (e.g., Hughes, Joyce & Staley, 1987), while others (e.g., Bender, 1986; Paris, 1988; Zeff, Armstrong, Crandell and Folen, 1990) have suggested that a diagnosis of personality disorder is most predictive of readmission. Somewhat by contrast Zilber, Popper and Lerner (1990) found that (for first-time admissions) personality disorder patients have significantly shorter hospital stays than schizophrenics. Studies by both Grossman, Harrow and Goldberg (1991) and Mojtabai, Nicholson and Neesmith (1997) found that patients with a diagnosis of schizophrenia had much higher relapse rates, particular when compared to patients diagnosed with depression. Mojtabai, Nicholson and Neesmith (1997) also found differential readmission rates for patients diagnosed with personality disorder, with those diagnosed as schizoaffective most at risk and those diagnosed as suffering from adjustment disorder least at risk.

A major problem with this research is the notorious variability of psychiatric diagnosis. Commenting on their chart review study of 99 readmitted psychiatric patients in San Francisco, Surber, Winkler, Monteleone, Havassy, Goldfinger and Hopkin (1987) write: "Even though the patients were almost always diagnosed as having a major mental illness, 40 percent were difficult to diagnose definitively from the records because they received multiple diagnoses or no consistent diagnosis over time" (p. 1113). In Kastrup's (1987) study which tracked all Danish psychiatric patients over a period of 10 years, only 43.5% kept their original diagnosis. Fennig, Craig and Tanenberg-Karant (1994) have shown that clinical diagnoses of psychiatric disorders frequently differ sharply from psychiatric disorders diagnosed by means of structured research interviews.

Length of hospitalisation

The major characteristic of psychiatric hospitalisation in the post-deinstitutionalisation era is of course that it no longer consists of lengthy and continuous incarceration, but rather of one or more much shorter stays. Perhaps, so the argument goes, patients are discharged before they are quite ready for life outside the hospital, or before the hospital treatment has had an opportunity to exercise its beneficial effect.

In their review of studies relating readmission to length of hospital stay, Caton and Gralnick (1987) differentiate between uncontrolled and controlled studies. Uncontrolled studies have mostly found no differences in outcome between long and short stays, except that short stays appear to be indicated for nonchronic, nonpsychotic patients. There have been six major controlled studies; five found no differences, while one found that short stays lead to more re-hospitalisation.

De Francisco, Anderson, Pantano and Kline (1980), who in their study did find shorter stays to be related to more readmissions, explain the effect in terms of greater family involvement in the patient's treatment (since there is more time to involve the family), more family involvement in discharge planning, and better discharge planning generally for longer-stay patients. Axelrod and Wetzler (1989) explain the possible beneficial effects of longer hospital stays as follows: "It appears that as patients remain in the hospital, they become better stabilized, develop greater insight into the need for aftercare, and become more willing to comply with recommendations for aftercare" (p. 400-401). Appleby, Desai and Luchins (1993) and Mojtabai, Nicholson and Neesmith (1997) suggest similar reasons for their findings that shorter stays are related to increased risk of readmission.

Taken to its extreme, the contention that longer hospital stays lead to fewer readmissions can of course not be other than true, in that those who are permanently incarcerated are at zero risk of readmission.

Quality of aftercare

As early as 1968 Crumpton blamed the high readmission rate on uncoordinated aftercare, and this continues to be a prominent theme in the literature on readmission. Mechanic (1986) argues that greater co-operation between various agencies and better case management would help substantially in reducing the readmission rate. Empirically, almost any kind of aftercare seems to be effective in reducing relapse (Axelrod & Wetzler, 1989). In one study Bond, Witheridge, Wasner, Dincin, McRae, Mayes and Ward (1989) found that although there were no dramatic differences in the effectiveness of different forms of aftercare, hospitalisation could be 'deflected' in 68% of cases. It is now generally accepted that at least some of the blame for the rise in readmission rates can be attributed to inadequate aftercare (Hadley, Turk, Vasko & McGurrin, 1997). This situation is similar to that obtaining for criminal recidivism where interventions aimed at altering prisoners' life circumstances outside the prison have met with some success (Bedell, Challis, Cilliers, Cole, Carty, Nieuwoudt, Phayane & Zachariades, 1998).

As with length of stay, there is an inherent contradiction in using quality of aftercare as predictor of readmission. The nursing care residences into which many 'deinstitutionalised' patients were 'transinstitutionalised' (Morrisey, 1982) in the 1960s and 1970s, were no doubt very effective in preventing readmission, but were as confining and dehumanising as the mental hospitals from which they were supposed to protect patients.

This point is further elaborated in Chapter 3.

Medication

Although patients in mental hospitals are notoriously unreliable at taking the medication prescribed for them (as many as 20% of inpatient schizophrenics avoid taking their medication), outpatients are even more unreliable, with up to 45% defaulting (Crumpton, 1968). Axelrod and Wetzler (1989) found that greater compliance was related to continuity of treatment (particularly having the first outpatient appointment soon after discharge), more incidents of hospitalisation, longer hospital stays, less denial of the need for treatment, and greater perceived need for medication.

Unfortunately, findings on the relapse-preventing properties of psychotropic medication are equivocal. With regard to antidepressant medication, Baldessarini (1989) contends that:

Evidence for true prophylaxis against subsequent recurrences of major depression is still meagre. Although a few controlled, prospective follow-up studies of 1 to 3 years' duration indicate the TCAs and perhaps lithium may have a moderate preventive (or recurrence-aborting) effect in the treatment of recurrent depression, little is known about the optimal choice of drug or of dose or about safety or efficacy after several years of such treatment. Moreover, the average degree of benefit of TCA and lithium treatment over a placebo is not impressive after the first 6 to 12 months (p. 124).

Neuroleptic medication is not entirely unproblematic as a form of rehospitalisation prevention either. Commenting on the results of a study in which a group of schizophrenic patients had their dosage cut by half, Faraone, Cirelli, Curran and Brown (1988) write:

It is striking that 45% of our original 29 patients remained stable for three years on 50 percent of their previous neuroleptic dose considering that they had been treated for a mean of 23 years, that none were being treated with megadoses before the dose reduction, and that their current doses are in most instances below the usual therapeutic range. Clearly, a substantial subgroup of schizophrenic patients can be maintained on neuroleptic doses far below the current standard (p. 1208).

Previous admissions

In a much-cited paper, Rosenblatt and Mayer (1974) concluded that the number of previous admissions was the only variable consistently predictive of rehospitalisation in the studies they reviewed, and this appears still to be the case for more recent studies (e.g., Bond, Witheridge, Wasner, Dincin, McRae, Mayes & Ward, 1989; Buel & Anthony, 1973; Casper, Romo & Fasnacht, 1991; Casper & Pastva, 1990; Colenda & Hamer, 1989; Hughes, Joyce & Staley, 1987; and Zilber, Popper & Lerner, 1990).

However, a single study (Zeff, Armstrong, Crandell & Folen, 1990) found number of previous admissions to be statistically unrelated to readmission frequency.

The Family

A patient's family inevitably plays a large role in the course of her illness, and is often the base to which she returns after hospitalisation. Even where a patient lives away from family, they may continue to exert a strong influence. In a study of 73 chronic patients living away from home, Wilk (1988) found that only 26% had not seen their families in the past two

weeks.

Writing relatively soon after the initial wave of deinstitutionalisation, and at a time when antipsychiatric ideas still held some sway, Simmons and Freeman (1967) claimed that the clearest indicator of a return to hospital is a lack of family tolerance for deviance. More recently the literature has tended to emphasise not so much family members' acceptance of the patient's 'eccentric' behaviour, but rather their understanding of and cooperation with the official psychiatric constructions and management of the problem.

Grunebaum and Friedman (1988) identify four key areas for mental health professionals wishing to build 'collaborative relationships' with families of the mentally ill:

1. Give the family a chance to be heard.
2. Impart information on the rules and structures of the mental hospital and the nature of the patient's illness (e.g., its prognosis and treatment).
3. Help families deal with feelings arising from hospitalisation (e.g., guilt, fear, anger, and depression).
4. Identify the family's coping pattern (e.g., denial, hypercontrol/intrusiveness, lack of distance/separateness).
5. Assist with the ethical dilemma of the family's versus the patient's needs.

In a similar vein Jacob, Frank, Kupfer, Cornes and Carpenter (1987) describe a day-long workshop for unipolar depressed patients and their families, the objectives of which were, inter alia, "to validate unequivocally that major depression is a legitimate medical illness over which the patient cannot exercise voluntary control" (p. 969) and to inform patients and family "of the high likelihood (50 percent) of having a recurrence of depression within one's lifetime and of the exceptionally high recurrence rates (up to 80 percent) among patients who already had three episodes" (p. 970).

There is some empirical evidence that such efforts to recruit families into psychiatric ideologies and treatment plans help to reduce the probability of rehospitalisation (Hughes, Joyce & Staley, 1987; De Francisco, Anderson, Pantano, & Kline, 1980).

Expressed emotion

Antipsychiatrists such as Laing and Cooper have long maintained that madness - when it is not "some sort of lost truth" (Cooper, 1967, p. viii) - must be the result of the duplicitous and disempowering ways in which society and the family communicate with those who become mad. This idea survives, in a reified and insipid form, in research on Expressed Emotion (EE) in families. Invented in the early 1970s by the group of British psychiatrists around Vaughn and Leff (1976a, b), the degree of Expressed Emotion in families, and in particular the number of critical comments aimed at the schizophrenic family member, has repeatedly been found to be predictive of relapse and readmission (reviewed in Leff, Berkowitz, Shavit, Strachan, Glass & Vaughn, 1989). What makes the EE concept particularly attractive for mainstream psychiatrists is that it may be useful in identifying that group of patients who are readmitted despite adequate medication and compliance (Herz, 1984; Miklowitz, Goldstein & Nuechterlein, 1988; Schnur, Friedman, Dorman, Redford & Kesselman, 1986).

However, the EE literature has also been strongly criticised. In their review Kanter, Lamb and Loeper (1987) point out that EE is only related to florid positive symptoms in schizophrenics (i.e., the kinds of symptoms which are likely to lead to rehospitalisation), not the more lasting negative symptoms such as apathy, passivity, and withdrawal. The direction of causality in EE is also unclear - is it patients' impossible behaviour which causes families to become hyper-critical or are patients driven mad by hyper-critical families? Finally, EE may

actually be harmful because it tends to place the blame on families who may be innocent.

EE has also been criticised for the unnecessary complexity of the construct and of the instrument (the Camberwell Family Interview) used to measure it. Hooley and Teasdale (1989) found that the single best predictor of relapse was not Camberwell Family Interview scores, but a patient's response to the simple question "How critical is your spouse of you?"

Integrating empirical findings

There are at least two mainstream psychiatric responses to the kinds of piecemeal findings relating to gender, age, marital status, race, number of children, diagnosis, length of hospital stay, medication, previous admissions, quality of aftercare, family involvement and expressed emotion presented above.

The first is to pretend that, although as yet inconclusive, the findings will eventually - and probably sooner rather than later - add up to something more substantial and coherent. Thus despite the rather dismal results of their review of studies relating to length of hospital stay and readmission (discussed above), Caton and Gralnick (1987) remained confident that "an empirically based policy on length of stay is within reach" (p. 862). Similarly, when all the variables (age, marital status, diagnosis, previous hospitalisations, etcetera) in Zilber, Popper and Lerner's (1990) study accounted for only 14.7% of the variance in the mean duration of hospitalisation (in non-first-time patients) they did not conclude that the enterprise is hopeless, but suggested that "adding variables related to personality characteristics and availability of services would probably explain part of the residual variance" (p. 148). Such visions of an imminent (but somehow always deferred) resolution to empirical problems is typical of psychiatric research (and most probably of positivist research

generally) and is reviewed at greater length in Chapter 4.

Steps may even be taken to hasten the hoped-for breakthrough, for instance by advocating the use of larger sample sizes (Mojtabia, Nicholson & Neesmith, 1997) or quantitative meta-analyses of previous research. However, Kastrup's (1987) work with a very large sample (the entire population of Danish psychiatric patients) suggests that increasing the sample size is in itself not likely to be a solution. Due to the large sample size virtually all variables (diagnosis, sex, age group, proximity to hospital, size of municipality, referring agency, discharge destination, marital status) were statistically significantly related to readmission. However, the amount of variance accounted for remained negligible.

Although no quantitative meta-analyses of the psychiatric readmission literature appear to have been done, Soeken, Prescott, Herron and Creasia's (1991) meta-analysis of 44 non-psychiatric readmission studies is suggestive of what sorts of results may be expected. They found that (among a host of other potential variables) medical readmissions were statistically significantly related only to diagnosis, age, length of initial hospital stay, and prior admissions. All relations were trivial in absolute terms. A meta-analysis of twelve intervention studies showed a non-significant overall treatment effect. Once again, despite these discouraging results, Soeken *et al.* (1991) are upbeat in their conclusions: "If risk factors for readmission can be identified, then providers can focus on developing interventions aimed at reducing unnecessary and preventable readmissions" (p. 264).

From readmission to chronicity

A less charitable view would be that as findings accumulate, readmission research will become ever more fragmented (readmission is statistically related to factor x, but only for

young black male first-time patients diagnosed as schizophrenic) and ever more prone to circular restatements of the problem: The longer patients stay in hospital, the smaller the probability that they will be readmitted; the more a patient has been readmitted, the more likely she is to be readmitted; the more community care comes to resemble hospital care, the more effective it will be in deflecting readmission.

Although piecemeal empirical readmission research as such is not usually criticised in this fashion, there is an admission among psychiatric researchers that the problem itself needs to be retheorised. Not only is a theoretical model necessary if readmission research is to get anywhere (Hughes, Joyce & Staley, 1987), but it is argued that readmission should be accepted as an inevitable consequence of the nature of mental illness. Where readmission has in the past often been taken as sign of failure and used to compare different institutions (Kastrup, 1987; Chambers & Clarke, 1990), it should now be realised that chronicity is part and parcel of mental illness (Mechanic, 1986). Mental health professionals should not blame themselves for failing to prevent readmission, but rather ask if deinstitutionalisation was a good idea in the first place (Gralnick, 1985).

This movement, from considering readmission as an unfortunate and essentially preventable side-effect of deinstitutionalisation to being an indicator of an inherent psychiatric chronicity, and thus of the need for large scale reinstitutionalisation, is described in greater detail in the next two chapters and contextualised within longer-term historical oscillations in psychiatric orthodoxy.

Chapter 2

An archaeology of psychiatric readmission I:

The 18th and 19th centuries

"I am not a professional historian; nobody is perfect." - Michel Foucault (Cited in Gutting, 1994)

An article in the Johannesburg *Star*, by health writer David Robbins (1994) features the work of South African psychiatric reformer Carlo Gagiano¹. Gagiano has been credited with reducing the inpatient census at the Oranje Hospital in Bloemfontein by more than a thousand percent in ten years - from 1250 in 1984 to 108 in 1994. When Gagiano first arrived at the hospital as chief of psychiatry, he found patients crowding at the bars, pleading to be released; his response was to order the bars cut away. This is how Robbins (1994) has him describe what happened:

As the hacksaws were busy at the main entrance to one of the wards the patients began to scream and rave inside. I told the warden to unlock the outer door. He demurred. I told him that I would take the consequences. When the door was flung open, most patients in the ward surged out and disappeared. The staff wanted to give chase. I said let them go.

"Amazingly," Robbins (1994) continues the story, "Gagiano's gamble paid off. Within 30

¹ Another version of these events, as presented for scientific consumption, can be found in Fourie and Gagiano (1987).

minutes all the patients had returned" (p. 11).

Without detracting from the authenticity of this account it is easy to recognise in it a reenactment of countless similar dramas performed over the past 300 years, in which the mad are set free so that they may present themselves voluntarily for readmission. In this and the following chapter I review such tales of madness rendered tractable through the paradox of liberation, and attempt to place these endlessly repeated readmission rituals in their historical context.

In claiming to detect broad patterns from a jumble of chronological facts this kind of re-telling of psychiatric history inevitably classes itself with the numerous arbitrary forms of periodisation imposed on the development of the profession by psychiatric historians². What distinguishes the present account from such psychiatric histories is, firstly, its more modest scope. Relying in the main on secondary sources, I set out to tell not the story of madness or mad-doctoring, but one aspect of that story - the evolution of the discourse and practice of readmission. Secondly, unlike traditional psychiatric histories, which almost uniformly assume that psychiatry has benefitted from scientific progress, my account is inspired by the critique of scientific and human progress in medicine and psychiatry set out by Foucault (1967³, 1973), and elaborated by the new generation of critical historians of psychiatry.

Foucault divides the story of madness into three parts - the middle ages and early Renaissance when lunatics wandered freely from town to town (or later were set adrift on

² For example Howells' (1975a) assertion that "viewing the development of world psychiatry, it is possible to discern a series of eras, each dominated by a theme. There is a world wide movement through the eras in a predictable direction" (p. ix). Howells divides psychiatric history into six periods: Primitive, rational, religious, somatic, and holistic. In the next chapter other, equally self-serving, forms of periodization are reviewed.

³ I consulted the English translation by Richard Howard, which is of a greatly abridged French edition of *Histoire de la folie à l'âge classique*. An English translation of the full text is said to be imminent (Gutting, 1994).

'ships of fools'), the Great Confinement of the 17th century, and thirdly the Moral Confinement of the 19th. Foucault's system represents a thorough-going reversal of the standard medico-psychiatric idea of a progression from cruelty to humanity and from incarceration to liberation, and it is at this level - as a manoeuvre in the battle for the status of the present - that his work should be understood, rather than as a dispassionate historical exposition⁴. The essence of Foucault's strategy consists of showing how the ostensible liberation of the insane has resulted in ever more aggressive forms of incarceration, or, put differently, to show how discharge has invariably been followed by readmission.

In what follows I draw on Foucault's ideas to describe how physical release has resulted in a form of moral readmission (e.g., submission to the authority of reason, self-normalisation, the silencing of madness), but also by actual readmission (either openly or covertly in the form of revolving door admissions and through transcarceration from one institution to another) and how this has been justified, either as a form of cure or as the inevitable consequence of chronic illness. My account is roughly chronological, trying to describe in sequence the journey of the mad as they were in turn admitted to and expelled from a variety of physical and mental structures.

⁴ A useful distinction here is between 'histories of the past' which in medicine almost invariably speak of continuity and progress versus 'histories of the present' which do not treat their subject as a given (Butchart, 1998). In the case of psychiatry, histories of the past typically show how increased scientific understanding and humane management of mental illness lead up to the present, while histories of the present would show how mental illness is inconsistently and differently fabricated at different historical moments.

Free at first: Madness before the Enlightenment

Foucault's ideas about the care-free and nomadic existence the insane enjoyed until the middle of the 17th century are often quoted as historical fact (e.g., Harland, 1987), and it may well be so. That the first Bridewell or house of correction (in which the insane were kept together with the indigent and criminal) was built in London long before the Enlightenment, as early as 1555, followed by numerous similar institutions throughout Europe during the next century (Scull, 1984), does not necessarily disprove Foucault's chronology and may be seen as a gradual erosion of freedom which culminated in the Great Confinement. Porter (1987b), while critical of the overly-romanticised presentation of the insane during the middle ages, concedes that during the 17th century their existence did become less free:

We need not go all the way with [Foucault's] ... romantic primitivism. But we can accept his further contention that from the seventeenth century onwards movements were activated which led for the next three centuries to mad people increasingly being segregated from sane society, both categorically and physically. In particular, the institutionalization of the insane inexorably gathered momentum (p. 14).

Foucault (1967) himself does not present the change from freedom to incarceration as being sudden, but rather as proceeding in a series of steps from the image of the ship of fools, to the image of the madhouse, to the reality of the Hôspitaux Généraux in Paris, 1656. Once again, however, the historical detail is perhaps less important than the rhetorical intent of Foucault's argument. Traditional psychiatric histories paint the middle ages as a period of superstition and cruelty to the insane, against which is offset the various acts of psychiatric liberation: Johann Weyer's publication in 1563 of *The Deception of Demons*, with which he supposedly rescued witches from their non-scientific tormentors (e.g., Colp, 1989); Tuke and Pinel's

dramatic gestures (which are discussed in greater detail below); and the various more humble attempts since at emulating these examples. Contrary to this, Foucault draws the middle ages as a time of relative tranquillity for the mad from which they had no need to be liberated.

Irrespective of whether Foucault's idyllic picture corresponds to any kind of objective fact, the concept of readmission (which, as will be shown, is central to both critical and mainstream constructions of psychiatry) clearly requires a primeval state of freedom which each readmission prevents the mad from returning to, and which has to be ruptured by some original act of incarceration.

The Great Confinement

Madness and civilization, in which Foucault (1967) sets out his contrasting scheme for an early history of psychiatry, is in the English translation subtitled *A history of insanity in the age of reason*. It is in this period of Enlightenment thought and scientific discovery⁵ (from about 1600 to 1815) that conventional histories of psychiatry also typically place the origin of the discipline. However, the difficulty for such histories is, as Porter (1987b) puts it:

There was no Newton of insanity, no Copernican revolution in psychiatry discovering the secrets within the skull. The real watershed in attitudes towards, and the treatment of, the mad came rather from a long-term shift in policy towards those displaying delinquent and dangerous traits: the rise of exclusion (p. 13).

⁵ To give some idea of the intellectual and scientific flavour of the time: Plater's *Practice of Medicine, Observations of Diseases Injurious to Body and Mind* (the first natural science-style medical text) appeared in 1602, Harvey's *Motion of the Heart* (describing the circulatory system) in 1628, Descartes' *Discourse on method* in 1637, Newton's *Mathematical principles of natural philosophy* in 1687, and Locke's *Treatise on Civil Government* in 1690.

This is what Foucault (1967) calls the Great Confinement, when all over Europe the poor, mad and criminal - all those who were perceived as a menace to the new age of reason - were cast into prisons, hospitals, converted leper colonies, madhouses, houses of correction, poor houses, workhouses and houses of industry. At the height of the Great Confinement, according to Foucault, 1 in 100 inhabitants of Paris were confined. Thus what Foucault shows is that it was not prejudice and superstition which imprisoned the insane in the Dark Ages, but science and rationality in the Age of Reason.

In England the Poor Law Act was passed in 1601 compelling parishes to act against vagrancy and begging, and to put the poor (including lunatics) to work (Allderidge, 1990). The same Act enabled parishes to levy special taxes to pay for the inevitable cost of such an enterprise (Scull, 1984). The Act was followed in 1691 by the Bristol Poor Act, which allowed for the joining together (as the Corporation of the Poor) of several parishes, an example which was followed elsewhere in England, and which led to the creation of numerous workhouses so that by the 1760s few of the larger British towns were without their own workhouse. For the next 100 years, "wherever workhouses, poor-houses, or houses of industry were set up, these were the most usual places to be used for the accommodation of pauper lunatics" (Allderidge, 1990, p. 38). Despite these developments, however, there is little evidence from this period for anything like a Great Confinement in England comparable in scale to what Foucault describes for France (Porter, 1987a). For England, at least, Foucault's chronology appears to be out by between one and two hundred years, and the Great Confinement did not get fully underway until the 19th century.

Nevertheless, the period from 1650 to 1800 clearly did see some significant

expansion in the technology⁶ and bureaucracy of physical incarceration in England and its colonies: Numerous new prisons were built - 27 public and 125 private prisons in London (Scull, 1984) in the early 1700s - and workhouses and almshouses spread rapidly (Scull, 1984), with the first lunatic admitted to the original Bristol workhouse in 1707 (Allderidge, 1990). A rash of American almshouses were constructed (Scull, 1984) - in Boston, Philadelphia (1731), New Orleans (1734) and New York (1736). Although large-scale centralised incarceration of the insane did not occur in Great Britain and its colonies, as Foucault describes it in France, many insane were accommodated in these decentralised and often privately run institutions, a situation allowed for in common law for several centuries before being taken up in a 1714 Act (Porter, 1987a).

Some provision was also being made specifically for the mad, such as the hospital for the insane built at Norwich in 1713, the oldest outside London (Allderidge, 1990), and the special ward for Lunatics established at Guy's hospital in 1728. There was a multiplication of private madhouses - 15 in London alone (Howells & Osborn, 1975) - and such local enterprise has been described as "the hallmark of hospital development in the 18th century" (Allderidge, 1990). In South Africa (then still a Dutch colony) a separate apartment was built for lunatics at the Cape Hospital in 1711 (Kruger, 1980; Moyle, 1987; Vitus, 1987) and the first lunatic was confined to Robben Island as far back as 1718 (Kruger, 1980).

The picture that emerges for the English speaking world is therefore not of a totalising Great Confinement, but perhaps rather of a heterogenous 'little confinement'. As Porter (1987a) describes it:

Many possibilities were tried including domiciliary care, boarding out in the

⁶ It is also perhaps worth noting that the straight-waistcoat was introduced, as a more humane alternative to chains, in the early 1700s (Ingram, 1991).

community, sending the insane to stay with a clergyman or physician, placing them in private asylums, applying to Bethlem⁷, or, particularly if violent, securing them in houses of correction. Better-off patients often lived with their own personal attendant (p. 278).

Although it would probably be incorrect to assume that the mad were permanently and continuously incarcerated in these various general and specialised structures, the question of cure and readmission, as it exists today, apparently did not at first arise.

Curing the insane I: The eighteenth century

However, according to Porter (1987b), "increasingly, from perhaps the mid-eighteenth century, the case for segregating the insane was reinforced by a new faith in therapy and the dream of curing" (p. 17). This change is well illustrated in the difference between the 1714 *Act for the More Effectual Punishing such Rogues, Vagabonds, Sturdy Beggars, and Vagrants, and Sending them Whither They Ought to be Sent*, among whom were included the 'furiously mad or dangerous', (Porter, 1987a) and the 1774 *Act for Regulating Private Madhouses*, "which stressed that inmates of asylums were to be 'cured'; they were no longer regarded as hopeless incurables to be incarcerated for the protection of society" (Howells & Osborn, 1975, p. 192). Although it could be argued that i) this latter act licensed abuses, rather than prevented them (Porter, 1987a); ii) it applied only to madhouses within a seven-mile radius of London (Ingram, 1991); and iii) it excluded pauper lunatics sent to madhouses by their parishes (Allderidge, 1990), it clearly signalled a change in the management of the

⁷ The small but notorious public madhouse in London that had been in operation since the middle ages.

insane - in Foucaultian terms a move from sovereign power (which operates through punishment and exclusion) to disciplinary power (which operates through knowledge dissemination).

The Act came in the wake of a long period of increased public concern about the conditions in which the insane were kept, and about callous assumptions regarding their incurability. In 1763, under public pressure, a parliamentary Select Committee was appointed to investigate the affairs of public asylums (Howells & Osborn, 1975) and it is from the deliberations of this committee that the 1774 act followed. Accordingly, in the face of public suspicion and exposure of cases of illegal confinement in the 1760s (Porter, 1987a), the more astute madhouse keepers took pains to present an image of humane treatment and efficacy in bringing about cures. The following pamphlet, published in 1779 (quoted in Porter, 1987a, p. 143), is a case in point:

Cure LUNATICS

WILLIAM FINCH of MILFORD, near Salisbury, [has] for many years had great success in curing people disordered in their senses ... the many cures he has performed on Lunatics ... can be attested by the greatest satisfaction he can say, that every person he has had charge of, has, with the blessing of God, been cured and discharged from his house perfectly well. The friends of such unfortunate persons who are committed to his care, may depend on their being treated with the greatest tenderness and humanity, by their faithful humble servant,

WILLIAM FINCH, Milford

Nor was the enthusiasm for cure limited to small private asylums. Already in 1851 William Battie had founded St Luke's Hospital for Lunatics in reaction to what had come to be seen as the scandalous treatment meted out to the mad at Bethlem (Allderidge, 1990; Crammer, 1994; Howells & Osborn, 1975). Unlike Bethlem, where it was more or less assumed that nothing could be done about madness, St Luke's claimed two cures in three (Porter, 1987a). Similar results were achieved at other hospitals modelled after St Luke's, such as the Manchester Lunatic Hospital, opened in 1766, and the York Asylum opened in 1777 (Porter, 1987a). Meanwhile madness was touted as a curable condition in Battie's *Treatise on Madness* of 1758, Benjamin Faulkner's *Observations on the General and Improper Treatment of Insanity* of 1785 and (in France) Joseph Daquin's *Treatise* (Warner, 1994).

Although Monro, superintendent at Bethlem, tried in his *Remarks on Dr Battie's Treatise on Madness* (1758), to justify his harsher treatment of the insane and more pessimistic view of their prognosis (Ingram, 1991), public viewing at Bethlem was stopped in 1770 (Porter, 1987b); in 1815 there was a Commons enquiry into the institution (revealing amongst other atrocities the case of one James Norris, "confined for eighteen years in a grotesque custom-built harness made of chains and rods, preventing virtually all movement"; Porter, 1987a, p. 124); and in the same year it was closed down and moved to a new location. Elsewhere in Europe, custodialism was also being replaced by reform and a belief in the curability of insanity, some examples being the reforms instituted in 1787 by Joseph Daquin at the Chambery Hospital in Italy (Mora, 1975) and at the Bonifazio hospital in 1789 by Vincenzo Chiarugi⁸ (Mora, 1975; Warner, 1994).

What were the reasons for this newfound enthusiasm for curing the insane, this 'little liberation' after the 'little confinement'? Warner (1994), who interprets the various

⁸ Vincente Chiarugi according to Fleck (1990)

oscillations between incarceration and decarceration in the care of the insane in economic terms, ascribes it to the increased need for labour sparked by the American Revolution of 1776 to 1783 and the British Industrial Revolution of the 1780s. Foucault (1980) would ascribe it to the rise of disciplinary power.

Whatever the reasons, the events of the second half of the 18th century in many ways prefigured the larger scale movements of the insane which were to follow in the 19th and 20th. One similarity is that some of the cures turned out to be temporary, and as a consequence periodic readmission was common (Allderidge, 1990). Another pattern established as early as the 1750s was that readmission (with its implication of failed cure) was disguised by means of transcarceration. In particular, discharges from St Luke's (Battie's show-piece public asylum) often landed up in his private asylum, "the public asylum providing a 'feeder' to the private" (Porter, 1987a, p. 131).

Turning the subject: George III and the mad-doctors

In November of 1788, only months before the start of the French revolution, George III of England lost his senses. As Ingram (1991) describes it:

In the early hours of the morning of Friday, 7 November 1788, after two days of delirium, George III arose from his bed and walked into the next room to find a conference of his sons, his physicians, his equerries and his pages. He expressed amazement and consternation. He demanded to know the meaning of the gathering. He grew angry, and publicly berated his personal physician, Sir George Baker, penning him into a corner and calling him an old woman whose advice he never should have followed. No one had the temerity to intervene until at last one of those

present, a Mr Fairly, took him by the arm and got him back to bed (p. 1).

Despite the king's protestations of sanity ("I am not ill, but I am nervous: if you would know what is the matter with me, I am nervous"; Ingram, 1991, p. 3), it soon became evident that his delirium was ongoing and beyond the control of the royal doctors. In desperation Francis Willis, a flamboyant mad-doctor who, bettering Battie's two in three recovery rate, claimed nine in ten (Porter, 1987a), was summonsed. Unlike the king's own doctors, Willis had no hesitation in applying the strait-waistcoat and other harsh measures to establish his dominion over the king, while at the same time making it quite plain that these were contingent on the king's behaviour, so that "when George rattled on, Willis would warn the obstreperous King that he was talking himself into restraint"⁹ (Porter, 1987b, p. 48). When the king behaved in an acceptable manner, however, Willis "equally boldly - most thought rashly - allowed the King a razor to shave himself, as a way of demonstrating confidence in his royal charge" (Porter, 1987a, p. 209). Whether the king was cured is equivocal (he had relapses in 1801, 1804 and 1810, from which last bout he never recovered¹⁰), but he was back to normal by 1789, in time to learn of the revolution in France and to forestall the Regency Bill in England (Porter, 1987b).

George's case neatly illustrates the moral subjugation of the mad, set free to negotiate an implacably reasonable (but not to be reasoned about) system of rewards and punishments. When Willis spoke to the king it was to lecture, and when he tried to speak back he was gagged, so that "mad language, if it has any sense, goes into retreat in the face of sane

⁹ As a consequence, when the doctor was out of the room George "rambled wildly on various subjects, but when the doctor returned he turned the subject, played his cards better and talked more cautiously" (Greville, quoted in Porter, 1987b).

¹⁰ It has been suggested that the cause of George's erratic behaviour was actually porphyria.

treatment" (Ingram, 1991, p. 43). Willis's speciality was "fixing patients with the eye" (Porter, 1987a, p. 209; Ingram, 1991), and there are countless descriptions of raving lunatics rendered manageable by this method. Dr William Pargeter, a close associate of Willis', describes one incident where he used the technique (quoted in Porter, 1987a, p. 210):

When I was a pupil at St Bartholomew's Hospital employed on the subject of Insanity, I was requested ... to visit a poor man ... disordered in his mind ... The maniac was locked in a room, raving and exceedingly turbulent. I took two men with me, and learning that he had no offensive weapons, I planted them at the door, with directions to be silent, and to keep out of sight, unless I should want their assistance. I then suddenly unlocked the door - rushed into the room and caught his *eye* in an instant. The *business was then done* - he became peaceable in a moment - trembled with fear, and was as governable as it was possible for a furious madman to be.

It was in 1791, three years after George III's first brush with insanity, that Jeremy Bentham published his *Panopticon; or, the Inspection-House: Containing the Idea of a New Principle of Construction Applicable to Any Sort of Establishment, in which Persons of Any Description Are To Be Kept under Inspection*, a device used by Foucault (1980) to symbolise the transition from sovereign to disciplinary power, from power as the exercise of the will of the powerful over the powerless, to power as "the invitation that modern discourse makes to us to assume full responsibility for our acts and intentions" (Parker, 1989a, p. 62). By subjecting the king to the kind of surveillance needed for this form of power to work, by fixing him with the eye, Willis was able to remove him from the straight-waistcoat, even allow him a razor, confident that he would exercise his sovereignty in a reasonable manner.

Breaking their will: Pinel and the liberation of the insane

On 21 February 1793 Philippe Pinel¹¹, as a member of the National Guard, witnessed the execution of another king (Birley, 1990). In the same year he was appointed as physician at the Bicêtre, the men's hospice near Paris, and struck the chains from the madmen kept there (Moyle, 1987; Pelicier, 1975); in 1795 he was put in charge of the Salpêtrière (Allen & Postel, 1992), the women's prison, "and here too he adopted the same generous attitude" (Pelicier, 1975, p. 125). Or at least so the official version goes.

If not 'wholly fictitious' (Scull, 1991a), these events are no longer believed to have occurred in quite such a straight-forward manner. Although Pinel was appointed to the Bicêtre in 1793, and took a special interest in the several hundred madmen in Ward 7, he 'kept a low profile' (Allen & Postel, 1992) during the 19 months he stayed there, busying himself with work on the classification of mania (Weiner, 1992). Amongst other similar cases, in Ward 7 were three patients shackled for 15, 25 and 45 years respectively. Pinel made no attempt to remove the shackles or even to replace them with strait-waistcoats. It was in fact the non-medical director of the Bicêtre, Pussin, who initiated such reforms in 1797, followed three years later, in 1800, by Pinel at the Salpêtrière (Weiner, 1992).

Despite the inaccuracies in the account of Pinel's actions at the Bicêtre, he served as a prototype for numerous strong, male, medically-qualified reformers during the succeeding two centuries, who are ritualistically described as being outraged at the condition of the insane at some institution to which they had been newly appointed, and as instituting far-reaching reforms almost immediately. I have already mentioned the case of Gagiano in 1984. Other examples are Langermann, who is said to have freed the insane in Germany shortly

¹¹ Emile Pinel according to Fleck (1990)

after Pinel (Fischer-Homberger, 1975); Baron Pisani who took charge of the Real Casa de Matti in Palermo in 1824 and "in less than three years ... abolished the systems of restraint then in use" (Mora, 1975, p. 66); Dr James Barry¹² who exposed the filthy conditions in which lunatics were kept in the Old Somerset Hospital at the Cape (Hurst & Lucas, 1975; Moyle, 1987); the Belgian psychiatrist Guislain who in 1826 "denounced the abuses perpetrated in psychiatric institutions" (Pierloot, 1975, p. 144); Dr Sabler who in 1828 in the Moscow hospital saw to it that "chains were abolished, occupational and recreational activity introduced, case histories utilized. and annual reports published" (Howells, 1975b); Mihály Viszánik, the Hungarian-born chief physician of the Narrenturm ('Tower of the insane') in Vienna who "had to remove a considerable number of chains still binding the patients there as late as 1839" (Horánszky, 1975); John Conolly, who became resident physician at Hanwell Asylum in the same year and promptly set about instituting a system of non-restraint¹³ (Colp, 1989; Crammer, 1994; Howells & Osborn, 1975); and H Campbell Hyed who exposed conditions at the Pak Klong Sarn mental hospital in Thailand where as late as 1910 patients were "chained to the floor like fierce animals" (Sangsingkeo, 1975, p. 652).

Another famous example of this genre is Henry Cotton who in 1907 became superintendent at Trenton State Hospital in New Jersey, where patients were kept in deplorable conditions, many being restrained for years without anyone knowing why. "Within two months, he had eliminated all mechanical restraint, freeing 96 patients from their

¹² Ironically, Barry was later the subject of scandal when it was discovered, post mortem, that she was a woman.

¹³ Connolly also published a book *The treatment of the insane without the use of mechanical restraints* in 1856. Instead of mechanical restraint he used whirling chairs, spinning beds, purging, emetics, bleeding, the douche and so on (Wing, 1990).

shackles, and tossing aside more than 700 restraining devices"¹⁴ (Scull, 1990, p. 147).

Despite the flaws in the original historical account of Pinel's activities, he is not totally unworthy of being regarded as the model upon which these men patterned their lives. This is particularly so with regard to his invention of *traitement moral*¹⁵, which he described in his *Memoir on Madness*, presented in 1794 to the Society for Natural History in Paris. The society, rather appropriately, voted to forward the memoir to the revolutionary Committee for Public Safety (Weiner, 1992). Pinel's methods of taming madness are remarkably similar to Willis', including a belief in its curability, an unwillingness to listen to mad-talk, and reliance on a mixture of kindness and intimidation - and the doctor's all-seeing eye.

As regards cure, Pinel (1794¹⁶) was pleased to report that "I had the satisfaction of seeing 25 of 200 - that is 1/8 of them - recover" (p. 728). Although an even larger number (28) died in the time Pinel was at the Bicêtre, and these figures are paltry compared to the two in three or nine in ten claimed by Battie and Willis, they represent a considerable achievement given the kind of long-term inmates Pinel was dealing with. Along with the need to bring about cure, there is, as in Willis, an impatience with the ravings of the insane: "The exalted imagination of poets also leads sometimes to madness, and I am often importuned by a confabulator who urges me to read his productions, while I see only the urgent need to subject him to treatment for madness" (p. 728).

And what does moral treatment actually consist of? In essence, it is the careful titration of confinement and liberty in the quantities demanded by the particular case: "I mean

¹⁴ The alternate regime to which Cotton subjected these patients is discussed later.

¹⁵ Usually translated as moral treatment in English, although more accurately translated as psychological treatment.

¹⁶ All extracts are from Weiner's (1992) reprinting of Pinel's *Memoir*.

a kind of supervision adapted to the nature of their madness, the prevention of dangerous consequences of their impetuous outbursts without any mistreatment, a timely deprivation of liberty, or permission to move about freely within the hospice" (p. 731).

Pinel's (1794) description of what to do should things go wrong bears a close resemblance to the Willis method of 'catching the eye', backed up by physical force:

If a madman suddenly experiences an unexpected attack and arms himself with a log, a stick, or a rock, the director [Pussin] - always mindful of his maxim to control the insane without ever permitting that they be hurt - would present himself in the most determined and threatening manner but without carrying any kind of weapon, so as to avoid additional vexation. He speaks with a thundering voice and walks closer toward the maniac in order to catch his eye. At the same time the servants converge on him at a given signal, from behind or sideways, each seizing one of the madman's limbs, an arm, a thigh, or a leg. Thus they carry him to his cell while thwarting his efforts and chain him if he is very dangerous or merely lock him up. That is how one dominates agitated madmen while respecting human rights (p. 731).

Here, in its earliest (and therefore most easily recognisable) form, is the dual nature of modern subjectivity, which has "allowed a system of right to be superimposed upon the mechanisms of discipline in such a way as to conceal its actual procedures, the element of domination inherent in its techniques, and to guarantee to everyone, by virtue of the sovereignty of the State, the exercise of his proper sovereign rights" (Foucault, 1980, p. 105).

Or, in Pinel's words:

One of the fundamental principles of the conduct one must adopt toward the insane is an intelligent mixture of affability and firmness. When they are obstinate one must sound totally superior and unshakable so as to convince them to bow to the will of the

directors. But one must avoid any unnecessary constraints and use only enough force to restrain them (Pinel, 1794, p. 731).

Sometimes, in the interests of the patient, it may of course be necessary to extend intimidation into the realms of terror:

Thus one of the major principles of the psychologic management of the insane is to break their will in a skilfully timed manner without causing wounds or imposing hard labor. Rather, a formidable show of terror should convince them that they are not free to pursue their impetuous willfulness and that their only choice is to submit (Pinel, 1794, p. 732).

Having been freed of their chains, the mad are thus subjected to "the lucid firmness of Pinel, who masters in a word and a gesture the two animal frenzies that roar against him" (Foucault, 1967, p. 242). Expelled from a state of pure brutish insanity, they are reinducted into a form of psychological imprisonment.

Madness reduced to silence: The York Retreat

In 1790 a Quaker woman, Hannah Mills, died under suspicious circumstances at the York Asylum - one of the model asylums constructed some twelve years earlier under Battie's influence. When the church elders investigated, they were appalled at the conditions. In 1796¹⁷ William Tuke¹⁸, a prominent Quaker, founded, at the age of 64, a competing institution - the York Retreat (Howells & Osborn, 1975; Moyle, 1987; Porter, 1987a; Kaplan

¹⁷ The date is often given as 1792 (e.g., Bebbington, 1987; Warner, 1994; Wing, 1990), but it appears that this is the year that planning for the Retreat started (Birley, 1990).

¹⁸ James Tuke according to Fleck (1990).

& Sadock, 1981). Designed for no more than 30 patients, the Retreat was everything the Asylum was not: Spacious grounds, comfortable rooms, individual attention and a general air of tranquillity, described by Foucault (1967) as "the patriarchal calm of Tuke's home, where the heart's passions and the mind's disorders slowly subside" (p. 242). Every effort was made to remove any impression of incarceration or restraint, and even "the iron sashes of the windows were disguised to look like wood" (Warner, 1994, p. 103). Patients were treated like children in a family. "They would be resocialized into the ways of Quaker fellowship through walking, talking, and taking tea with the superintendent and his family" (Porter, 1987a, p. 223).

The Foucaultian interpretation of the Retreat is the same as for Pinel's reforms: "The Retreat could do away with manacles of iron, because it was enclosing patients in manacles of mind; internalized control of patients' consciences through creating guilt was so much more thorough, silent, and far less scandalous" (Porter, 1987a, p. 225). As with Willis and Pinel, the Tukes were not interested in the nature of their patients' delusions, or in talking to them about the details of their madness (which they dismissed as 'dialogues of delusion'); rather, the intention was to distract with exercise, walks, conversation, reading and other recreation - "the business of the Retreat was not analysing insanity but restoring normality" (Porter, 1987a, p. 232). This is a sentiment which would continue to echo through the history of psychiatry, leading Benjamin Rush (the 'father of American psychiatry'), for instance, to comment that for the sake of good manners "it will be necessary for a physician to listen with attention to [the patient's] tedious and uninteresting details of his symptoms," but that these could in no way influence the treatment (Alexander & Sheldon, 1966, p. 163). Foucault (1967) formulates it thus: "Madness is responsible only for that part of itself which is visible. All the rest is reduced to silence. Madness no longer exists except as *seen*" (p. 250).

Foucault (1967) closes his account of madness at this point, with the insane everywhere silenced and in psychic chains. Unfortunately, however, this is not where it ended. Given the apparent efficacy of releasing the insane from one method of control while readmitting them into another, what more could possibly be required to make a perfect world? The answer explicitly stated at the end of Pinel's *Memoir*, and implicit in the success of the Retreat, was: More, and better asylums.

Asylum-building in the nineteenth century

Foucault's main argument is that in the late 18th and early 19th century the mad progressed from physical to mental imprisonment. He also points out that physical incarceration continued: "It is within the walls of confinement that Pinel and nineteenth-century psychiatry would come upon madmen; it is there - let us remember - that they would leave them, not without boasting of having 'delivered' them" (Foucault, 1967, p. 39). In this section I will show that it is not only that the mad were left in a state of incarceration, but that many, many more were recruited to join their ranks and that the nineteenth century in many ways came closer to Foucault's idea of a Great Confinement than did the eighteenth. Where asylum building in the 18th century was tentative and sporadic, in the 19th it was unbridled.

According to an 1807 Commons Committee enquiry there were 45 registered madhouses then operating in England and Wales, mostly small private institutions (Crammer, 1994). These were however thought to be insufficient, especially in terms of caring for pauper lunatics. Accordingly, the 1808 County Asylums Act (also known as "Wynn's Act"; Smith, 1994) was framed, authorising (although not yet compelling) justices of the peace in every county to borrow money over a 14 year period to build an asylum for the lunatic poor

(Crammer, 1994; Howells & Osborn, 1975, p. 193). By 1827, 27¹⁹ of the 52 counties had done so (Porter, 1987a). Maintenance money for these asylums came from local taxes, while food and personal requirements were paid for by each lunatic's parish (Crammer, 1994). The Act was partly aimed at desegregating the poor and the insane, and the first madhouses to open "were in rural districts where pauperism was severe and subsistence farming declining" (Warner, 1994, p. 108).

Although most of these institutions started out on a small scale, by the mid 1840s their average size had grown from 115 to 300 (Barham, 1992). This growth, which often led to overcrowding, may have been the impetus for the 1845 Lunacy Act, which established the 'Commissioners in Lunacy' with jurisdiction over the whole of England and Wales - no longer London only (Crammer, 1994; Howells & Osborn, 1975) - and "made compulsory the provision of asylums by counties and boroughs" (Howells & Osborn, 1975, p. 194). As it was markedly more expensive to house lunatics in such asylums than in workhouses, the Act was seen as a philanthropic move, but "the reality almost immediately betrayed the hope" (Bebbington, 1987, p. 12). Despite the large-scale building programme which resulted from the Act, rather than relieve the pressure on asylums and workhouses, after 1845 overcrowding and understaffing simply built up even further (Crammer, 1994), so that by 1877 each asylum contained on average 542 lunatics, and 961 by 1900 (Barham, 1992). By 1854, the dream of small, curative asylums was dead, and Thomas Kirkbride's *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* became a blueprint for building large, centralised asylums (Morrisey & Goldman, 1980).

In France the equivalent of the 1845 Act was an 1838 law creating a lunatic asylum in every *département*. According to Colp (1989) Germany built even more asylums than

¹⁹ 18 according to Allderidge (1990).

France. Elsewhere in Europe numerous asylums were opened. A 300 bed mental hospital was built in Portugal in 1848, with two more in 1893 and 1895 (Lopez Ibor, 1975). The first private mental hospital was founded in Hungary in 1850, followed in 1868 by a state mental hospital, which soon proved too small for the demands made upon it, so that another, larger, hospital had to be founded in 1883 at Angyalföld. However, even this proved insufficient, and in 1896 an old public building was adapted to provide another even larger mental institution (Horánszky, 1975). In Italy, the number of mental hospitals grew from 21 in 1840 to 35 in the 1870s, to 50 in the 1880s (Mora, 1975).

In America asylum building also surged ahead. Starting with the Friends' Asylum in Pennsylvania in 1817 (Warner, 1994), the second oldest in the USA and the first where chains were not used (Zilboorg & Henry, 1941), innumerable asylums, penitentiaries, workhouses, orphan asylums and juvenile reformatories were founded in the course of the century (Scull, 1984; Warner, 1994) - six private asylums between 1820 and 1870 in New York alone (Johnson, 1990). Originally small and based on principles of non-restraint - such as Bloomingdale Asylum in 1821 and the Retreat at Hartford in 1824 (Warner, 1994) - these asylums soon grew to massive proportions and frankly custodial intentions, for example the Willard Asylum for the Chronic Insane established in New York in 1865 for 1500 patients (Morrissey & Goldman, 1980). By 1890 there were 120 public and 40 private asylums in the United States, containing a total of 91,152 patients (Scull, 1984).

In South Africa asylum building also progressed inexorably, although at a more modest pace. The first civilian hospital at the Cape, known as the Hospital and Lunatic Asylum, or Baily's Hospital (later Somerset Hospital) was built in 1818 (Hurst & Lucas, 1975; Kruger, 1980; Moyle, 1987) and accommodated an increasing number of lunatics. In 1834 this hospital started serving the interior as well, with 10 lunatics transported overland

from Grahamstown (Moyle, 1987). In the same year slavery was abolished in the Cape, and the Slave Lodge was turned into an alms house for paupers, including lunatic paupers (Moyle, 1987).

In 1843 the rather ingenious 'Montagu Plan' was accepted for turning Robben Island into an asylum for lunatics, lepers, paupers, and the chronically sick, while at the same time making the convicts until then kept on the island available for an ambitious programme of road construction. In this way Bain's Kloof Pass, Mitchell's Pass, and Sir Lowry's Pass, amongst others, were built, while the pressure on the Somerset hospital was relieved by moving the lunatics to the former convict station on Robben Island - where they were kept until 1863 when Somerset hospital was reopened (Moyle, 1987; Visser, Haasbroek & Bodemer, 1989). By 1868²⁰ it was clear that the Somerset hospital had become too overcrowded to serve the interior and the Town Hill asylum was founded in Pietermaritzburg (Vitus, 1987), followed in 1875 by the Grahamstown Lunatic Asylum and Sick Hospital, located at the Fort England barracks (Hurst & Lucas, 1975). In 1889 another mental asylum was founded at Port Alfred (Hurst & Lucas, 1975; Moyle, 1987). These Eastern Cape asylums were all for whites only, so that in 1894 it became necessary to build an asylum for blacks in Fort Beaufort (Hurst & Lucas, 1975; Moyle, 1987; Swartz, 1994a)

Despite these asylum-building efforts in the interior the demand for accommodation for the insane in Cape Town continued to grow, resulting first in plans to extend the asylum on Robben Island (Cape of Good Hope, 1863), and later in the appointment of a parliamentary commission on the best means of closing the asylum and establishing a larger facility on the mainland (Cape of Good Hope, 1880a, 1880b). The recommendations of this commission were finally given effect in 1891 when Valkenberg Asylum was founded (Hurst

²⁰ 1875 according to Moyle (1987)

& Lucas, 1975; Vitus, 1987). Initially for whites only, it was only in 1916 that a 'black side' was added to the asylum (Swartz, 1994a). By the end of its first year of operation, Valkenberg was filled to capacity (Moyle, 1987) so that in 1898 a new building was added with facilities for 310 patients (Moyle, 1987).

The Boer republics were also facing an increasing accommodation crisis for the insane. In 1875 the Orange Free State Volksraad gave the president powers to have lunatics taken to Bloemfontein, where provision had been made for them to be kept in a government building (Moyle, 1987; Vitus, 1987). By 1881 the building was overcrowded and the Bloemfontein Kranksinnigengesticht was opened in 1883 (Moyle, 1987), later to be known as the Oranje Hospital²¹ (Hurst & Lucas, 1975). In 1890 a section for black inmates was added (Moyle, 1987).

In the Transvaal Republic lunatics were at first held in the Pretoria jail (Moyle, 1987), until the Weskoppies asylum, officially known as De Kranksinnigengesticht te Pretoria, was founded in 1892 (Hurst & Lucas, 1975; Vitus, 1987). Before the asylum opened, there had been 25 mental cases in various jails in the Transvaal; by the end of the year the asylum held 29 patients, of whom 15 were white (Minde, 1975). By 1897 Weskoppies had become very crowded, and by 1898 it was so crowded that no further male admissions were accepted and some patients were again being confined in jails (Minde, 1975).

This catalogue of asylum building is of course scarcely different from what one would expect for any other kind of institution - whether hospitals, schools or prisons. The growth in institutional provision for the insane could thus be explained simply in terms of population growth and urbanisation. The English population, for example, doubled in the second half of the nineteenth century (Barham, 1992) and, as Bebbington (1987) puts it: "The most salient

²¹ The same hospital from which Gagliano freed the insane a hundred years later in 1984.

demographic feature of 19th century Britain was the speed of urbanization²²" (p. 12).

Alternately, the increase in the number and size of asylums could be taken to support Foucault's (1967; 1980) ideas about the rise of a 'carceral principle' not limited to insanity. One example of this kind of process is the case of habitual alcoholic inebriation, which in terms of two British Acts in 1878 and 1879 became grounds for compulsory detention (Berridge, 1990).

However, the case of insanity does appear to be special. In 1807 a Commons Committee found that there were 1765 pauper lunatics in Poor Houses and Houses of Industry in England and Wales (Allderidge, 1990), but by 1844 the number of certified lunatics had increased to 20 809²³ and to 117 200 by 1904, representing a fivefold increase over the second half of the century alone (Barham, 1992). Thus, where "around 1800, no more than a few thousand 'lunatics' were confined in England in all kinds of institutions; by 1900 the total had skyrocketed to about 100 000" (Porter, 1987a, p. 2).

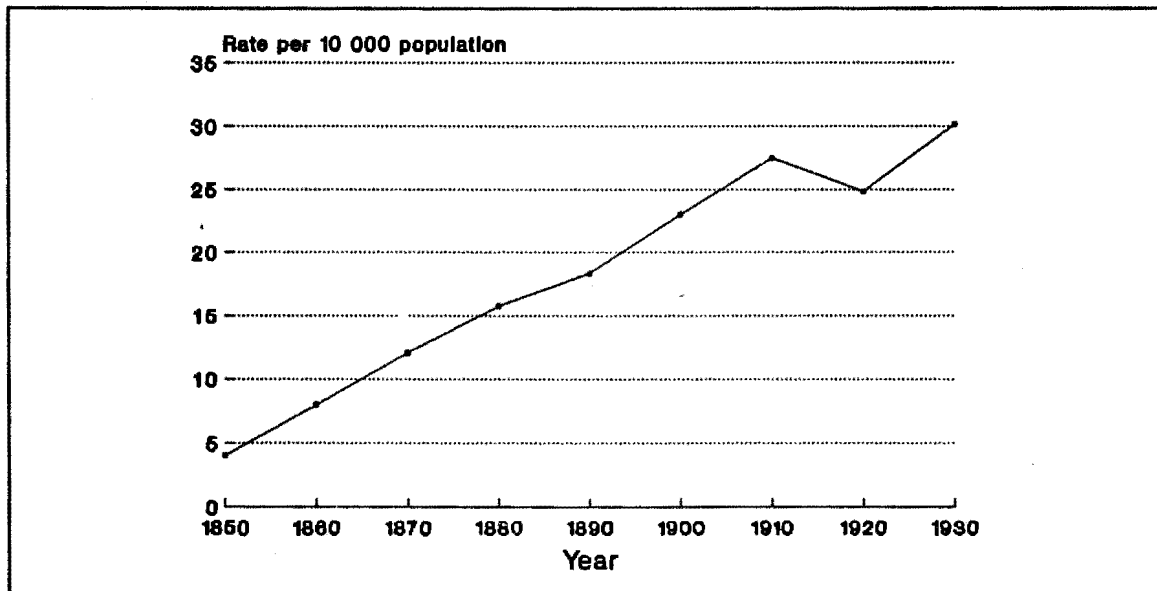
Even when expressed as a proportion of the population (see Figure 2.1), the number of insane in public asylums in England and Wales increased sevenfold between 1850 and 1930 - from 4.03 per 10 000 to 30.14 per 10 000 - dipping only briefly during the first world war (Scull, 1984).

²² In 1891 for first time the majority (53.6%) of the population in England and Wales lived in cities of 20 000 or more (Scull, 1984).

²³ Crammer (1994), quotes the following figures from the 1844 Commissioners in Lunacy reports: 3 579 lunatics in public asylums, 2 559 in licensed houses, 4 080 in workhouses and 3 940 at home or with friends.

Figure 2.1. Patients in public asylums in England and Wales, 1850-1930

(source: Scull, 1984)



Some Victorian doctors argued that the increasing numbers of institutionalised insane was due to a real increase in the incidence of insanity (Porter, 1987a). This is a theme which has recently been resurrected by Hare (1982, 1990), who believes that there was a 'slow epidemic' of schizophrenia. Tuke (1878) had a different explanation, which is however equally favourable to the profession of psychiatry:

The same number of persons may have annually become deranged fifty years ago as in 1877, and yet if of the former a larger proportion were neglected and died, the existing number of lunatics would vary greatly in the two periods. This is what has actually happened. The insane succumbed in large numbers from neglect or cruelty half a century ago; now they live on to a fair age, some of them to very advanced life (p. 49).

Tuke's (1878) argument rests on two implicit and by then relatively uncontroversial claims:

That the mad received more humane physical treatment than they had in the past, and (as will be shown in the next section) that their madness was itself not amenable to treatment.

Foucault's inversion of the former claim has already been discussed, but the latter is more puzzling. As has been shown, the asylum-building spree of the nineteenth century received its initial impetus from the belief that moral treatment cured insanity and that what was therefore needed was more and better asylums. How did the belief in curability become transformed into its opposite, and how did it affect the programme of asylum-building? Both these questions, I will try to show, can be addressed with reference to the concept and practice of readmission.

Curing the insane II: The nineteenth century

It is generally agreed that the nineteenth century started with a firm belief in the curability of madness, specifically through moral treatment in asylums. Thus asylums, according to Barham (1992) "were not intended as repositories for the excommunicated. Far from it; in their original purpose and design they were seen as reformatories through which the wayward and unproductive could be brought into more promising and acceptable lines of communication" (p. 72).

This optimism was particularly prevalent in the United States, where enthusiasm for the new technology of mental treatment was combined with the general spirit of evangelical reform which preceded the Civil War (reflected, for instance, in the various movements for temperance, women's rights, public education, the rights of the poor, the abolition of slavery) to produce greatly expanded facilities for the insane (Grob, 1980; Luchins, 1992).

The spirit prevalent in the mad-business in the early years of the century has been

called a 'cult of curability' (Luchins, 1992; Schneck, 1975), and examples are often quoted of the apparently inflated cure-rates claimed by asylum supervisors. Schneck (1975), for instance, mentions the case of William Maclay Awl whose claims were so extravagant that he came to be known as Dr Cure-all Awl. Other examples include the Hartford Retreat where "within four years of establishment, its report for 1828 made the remarkable announcement that about ninety per cent of the patients admitted that year had been cured" (Shryock, 1940, p. 17); the Worcester State Hospital, where Woodward in 1840 published recovery rates since 1833 of between 82% and 91% (Grob, 1980; Schneck, 1975; Warner, 1994); and the Eastern Virginia asylum, where John Galt in 1842 claimed cure rates of between 53% and 92% (Warner, 1994). Typical of the times is the opinion expressed by Amariah Brigham of the Utica State Hospital that "no fact relating to insanity appears better established than the general certainty of curing it in its early state" (Warner, 1994, p. 122).

In England the 1845 Lunacy Act, which was intended as "a mechanism for providing the mentally ill with the early treatment thought necessary for cure" (Bebbington, 1987, p. 12), reflected the continuing prevalence of similar sentiments.

Statistics compiled under the influence of the cult of curability were used to great effect by the American reformer Dorothea Dix in her campaign to establish more public mental hospitals, which resulted in the founding of more than 30 such institutions (Morrissey & Goldman, 1980; Warner, 1994). In South Africa most asylum building occurred in the second half of the century, by which time the American and English 'cult of curability' had already subsided. Nevertheless Greenlees (1895) presents, with evident satisfaction, a 28% recovery rate for 'native' patients (plus 16% 'relieved')²⁴ at the Grahamstown Asylum, compared to the 10% then being achieved at the Somerset hospital and the 3% at Robben

²⁴ The figure for 'European' patients was even better.

Island (Moyle, 1987). It was partly in response to such figures that the Valkenberg asylum was founded in Cape Town in 1891, as an institution specifically for curable cases of insanity. (As it turned out, however, only 3 of the original 36 patients ever recovered, compared to 24 who died in the asylum after an average stay of 14.4 years; Swartz, 1994a).

How real were the high cure rates at first reported, especially at American asylums? Warner (1994) has argued that cures were indeed being achieved due to the special nature of the early asylums which were small enough and sufficiently well staffed to facilitate recovery. It is only as asylums became larger and more overcrowded that the cure rate started dropping off. A very careful follow-up study conducted late in the 19th century by Park suggested that 58% of those discharged as recovered from Worcester never had a relapse (Grob, 1980).

However, it has also long been claimed that the figures were skewed because first admissions and readmissions were not distinguished (Shryock, 1940) and thus cure rates were "artificially exaggerated by repeated recovery of readmissions" (Schneck, 1975, p. 445). Morrissey and Goldman (1980) quote Park's 1879 observation about cure rates at Worcester as follows:

It is a sad and almost cruel blow to the worth of the earlier tables of this Hospital, which gave 70, 80, and even 90 per cent of recoveries, to know ... that many a patient who helped to swell the tables of recoveries to the large per cent mentioned, returned again and again to this Hospital, and finally died here; the many more, after repeated admissions to this and other hospitals, died in the town or city almshouse (p. 60).

Psychiatric recidivism, like its criminal equivalent, thus almost immediately started eroding the new institutions' claims to efficacy. As Foucault (1980) describes it:

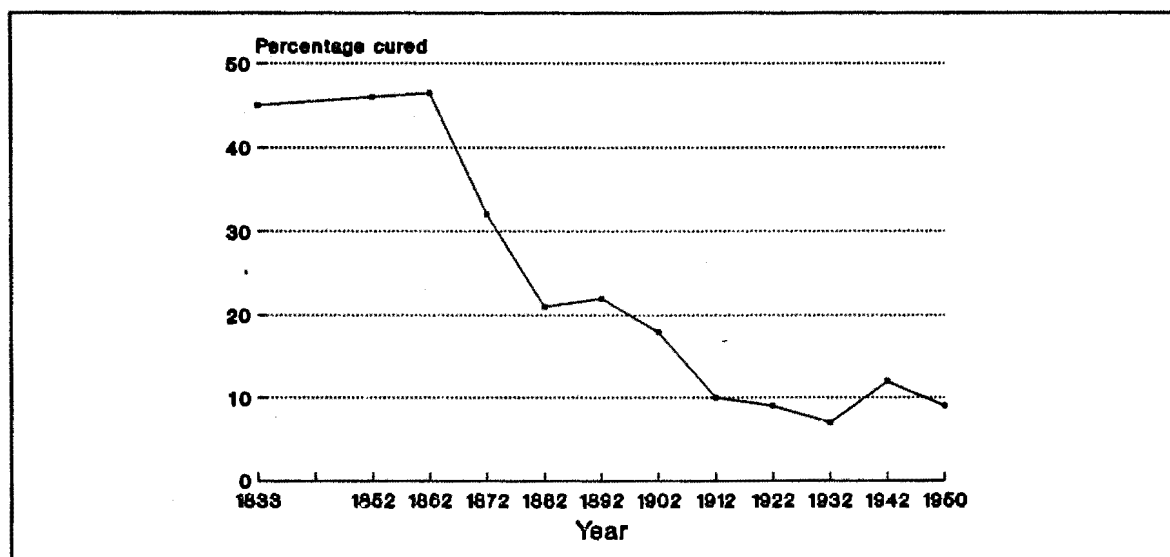
The prison was meant to be an instrument ... acting with precision upon its individual

subjects ... The failure of the project was immediate and was realised virtually from the start. In 1820 it was already understood that the prisons, far from transforming criminals into honest citizens, served only to manufacture new criminals and to drive existing criminals even deeper into criminality (p. 40).

In the psychiatric context readmission soon became evident even at the two original sites where moral treatment was practised. Prichard (1837) claims that 105 of the 334 patients admitted to the York Retreat between 1812 and 1833 relapsed and were readmitted, while 68 of the 546 admissions to the Bicêtre and Salpêtrière up to 1834 were readmissions. One person was admitted as many as 14 times.

The high point in using readmission figures to debunk the 'cult of curability' came in 1876 with the publication of Pliny Earle's *The Curability of Insanity* (Overholser, 1940), in which, with reference to the Worcester figures, he "made much of the fact that the same patient may be counted as "recovered" after every relapse and that percentages of recoveries were calculated on the basis of those discharged, not on the numbers admitted" (Warner, 1994, p. 124). It has since been shown that counting the readmissions properly would have made a difference of less than a quarter percent to the Worcester cure rate, and follow-up studies in the 1890s and 1950s have tended to confirm the genuineness of the cures (Warner, 1994). However, irrespective of the statistical accuracy of the reported cure rates, it is evident that readmission was rhetorically very effectively deployed to counter the idea of curability. Whether as a self-fulfilling prophecy or for one or more of a host of other possible reasons, it is in any case true that cure rates did start declining from the 1830s onwards, dropping particularly sharply in the second half of the century (Figure 2.2).

Figure 2.2. Percentage of admissions discharged as "recovered" from the Worcester State Hospital (source: Warner, 1994)



Readmission in the nineteenth century is therefore in the first place a symbol of the ineffectiveness of treatment, and thus of the incurability of insanity. However, just as in the eighteenth and twentieth centuries, readmission should be seen not purely as an oscillation between freedom and incarceration, but as part of a larger pattern of trans-carceration. In both England and America the insane were continually on the move between families, private and public asylums, and institutions for the indigent poor.

Scull (1991a) describes the tensions which developed between asylum and workhouse superintendents in America as the former transferred some of the insane to workhouses and the latter some of the poor to asylums. A favourite ploy was to move 'incurables' out of asylums and into almshouses: "If a patient had not improved enough to live with his own family, it was thought that perhaps he could get along in the almshouse" (Hamilton, 1940, p. 88). By 1856 superintendents of almshouses had had enough of the situation and asked to be

relieved of the insane, with the result that in 1869 the Willard Asylum was built for 1500 patients, followed by numerous similar institutions for the incurable (Hamilton, 1940). New York State passed an Act in 1890 formally transferring the mentally ill from county almshouses to state hospitals, and in the decade following the state hospital census rose from 5402 to 21 815. The New York model made it possible for counties to shift costs to the state level and was copied throughout the United States, eventually leading to the end of almshouses by 1920 (Johnson, 1990). Apart from almshouses and asylums, around 30% of mental patients were still being cared for at home or in private institutions towards the end of the century (Howells & Osborn, 1975).

Thus what distinguished a reformer such as Dorothea Dix is not so much that she either freed or incarcerated the insane, but that she imposed coherence on an otherwise chaotic pattern of admissions, readmissions and transfers. Under Dix's influence the insane were shifted "from the small, inadequate quarters of the almshouses and jails ... to small local institutions, then to county hospitals newly constructed, and finally to the larger state hospitals that replaced them" (Schneck, 1975, p. 446).

In England, too, the insane were shunted from pillar to post, and there was an 'element of rivalry and contempt' between the Poor Law Commission and the Commissioners in Lunacy (Crammer, 1994). In South Africa it has already been shown how lunatics migrated back and forth between the Somerset Hospital and Robben Island. The same happened with the new asylum at Valkenberg. Of the 36 'curables' initially admitted, 8 were transferred to other institutions, of which 3 were sent back to Robben Island (Swartz, 1994b). In the interior, Greenlees (1895) accounted for many of the non-recoveries at the Grahamstown Asylum by noting that they had been discharged to "other institutions" (Greenlees, 1895, p. 73).

The terrifying system

What characterised the system of care from which the insane were continually being discharged and readmitted in the course of the 19th century, was its growing rationalisation and efficiency. A person who indulged in insane behaviour around 1800 was inducted into a legal and professional structure far less sophisticated and consolidated than would her equivalent around 1900. Along with the endless list of asylums built in the 19th century goes a series of legal reforms. In England we have, amongst others, the Criminal Lunatics Act or "Act for the Safe Keeping of Insane Persons charged with Offences" of 1800 (Porter, 1987a); the Act to Regulate the Care and Treatment of Insane Persons of 1828 which established the Metropolitan Commissioners in Lunacy and made it compulsory for private madhouses to appoint doctors for weekly visits (Crammer, 1994; Porter, 1987a); the New Poor Law Act of 1834 (Bebbington, 1987; Porter, 1987a); and the Lunacy Act of 1890 which provided for a rigid system of certification and required asylum superintendents to be medically qualified (Allderidge, 1990; Crammer, 1994; Walk, 1990).

In South Africa an equivalent set of reforms was enacted, for example the instructions promulgated by the Burger Senate in 1825 which prohibited the flogging of lunatics (Moyle, 1987) and various ordinances of 1833, 1837, 1879, 1891 and 1897 which culminated in the Mental Disorders Act of 1916 (Hurst & Lucas, 1975; Swartz, 1994b; Vitus, 1987).

These legal structures were designed to guard against human rights violations in terms of both unjust incarceration and inhumane treatment. Thus there are a series of legally-instigated scandals in the course of the century, such as the report of the British committee of enquiry into private and public madhouses of 1815 (Howells & Osborn, 1975); the 1844 and

1847 reports of the British Commissioners in Lunacy (Crammer, 1994); and the 1859 parliamentary Select Committee report (Walk, 1990). In South Africa there is the official report of 1826 revealing that patients were being tied up and flogged at Somerset Hospital (Hurst & Lucas, 1975; Moyle, 1987); the parliamentary Select Committee report of 1855 which found Somerset Hospital to be beyond repair (Moyle, 1987); and the 1861 commission of enquiry into conditions on Robben Island (Moyle, 1987).

Even as these legal measures helped to prevent the abuse of power, they facilitated the deployment of a different form of (disciplinary) power which further entrenched madness as a condition defined by the tension between freedom and incarceration. Hand in hand with this went the emergence of the profession of psychiatry, which "could flourish once, but not before, large numbers of inmates were crowded into asylums" (Porter, 1987b, p. 17). Thus in the course of the century "insanity was transformed from a vague, culturally defined phenomenon afflicting an unknown, but probably small proportion of the population into a condition which could only be authoritatively diagnosed, certified, and treated by a group of legally recognised experts" (Scull, 1991b, p. 149). Apart from asylums, psychiatry set up for itself an entire professional infrastructure. Professional journals started appearing such as the *Magazin für psychische Heilkunde* in 1805 (Colp, 1989); the *American Journal of Insanity* (forerunner of the *American Journal of Psychiatry*) in 1844 (Schneck, 1975); the *Allgemeine Zeitschrift für Psychiatrie* in the same year and the *Annales Médico-Psychologiques* a year later (Colp, 1989; Schneck, 1975); the *British Journal of Psychological Medicine and Mental Pathology* in 1848 (Rollin, 1991); and the *Asylum Journal* of 1853, which became the *Asylum Journal of Mental Science* in 1855 and the *Journal of Mental Science* in 1858 (Rollin, 1991).

Professional associations were founded, such as the British Association of Medical Officers of Asylums and Hospitals for the Insane formed in 1841, reactivated in 1845 (Walk,

1990), and later to become the Royal College of Psychiatrists (Howels & Osborn; Walk, 1990); the German association of Directors of Lunatic Asylums founded in 1844 (Rollin, 1991); and the Association of Medical Superintendents of American Institutions for the Insane (renamed the American Medico-Psychological Association in 1892 and the American Psychiatric Association in 1921) founded in the same year (Grob, 1980; Johnson, 1990; Schneck, 1975).

Specialist courses in psychiatry were started for medical students, for example in 1843 at the University of Vienna (Horánszky, 1975) and in 1870 in England and Wales (Crammer, 1994); as well as courses for psychiatric attendants, for example in 1891 in Britain (Nolan, 1991). Textbooks were published, such as Bucknill and Tuke's 1858 *Manual of Psychological Medicine* (Colp, 1989; Crammer, 1994); and Kraepelin's 1883 *Lehrbuch* which went through nine editions until 1927 (Alexander & Selesnick, 1966). Pelicier's (1975) remarks about Kraepelin's text can equally be applied to all these moves towards professionalisation:

Within the first edition of his handbook of psychiatry in 1883 and the edition of 1896, Kraepelin enclosed European psychiatry in a terrifying system: every clinical picture had its place, every patient's destiny was predetermined. The psychiatric hospital was like the firmament of Kepler in which the position and movement of the stars and planets are determined (p. 132).

What was this 'terrifying system' which had closed over the insane even as it promised to restore their human rights? The 19th century started of course with moral treatment, that careful mix of paternal charisma and individual accountability which replaced physical restraint, and this is the system at first used by Woodward and his contemporaries - together with a considerable reliance on narcotics such as morphine and opium "to quiet the patient

and thus make him amenable to moral treatment" (Grob, 1980, p. 26). What psychiatry, as Foucault leaves it at the start of the 19th century, thus at first represents is the triumph of modernity in which social order is guaranteed not through the exercise of repressive power, but through classification, surveillance and the doctrine of free will. Early 19th century psychiatry demonstrates that even raving lunatics can be tamed by the doctor's eye, and even those who have lost their senses can have their individual accountability restored to them.

Hill (1839; quoted in Bebbington, 1987, p. 12) explains the system as follows:

But it may be demanded, What mode of treatment do you adopt in place of restraint? How do you guard against accidents? How do you provide for the safety of attendants? In short what is the substitute for coercion? The answer may be summed up in a few words, viz - classification - watchfulness - vigilant and unceasing attendance by day and night (p. 12).

Connolly describes the essential conditions needed for this form of power to work in similar terms:

One of the first of these is, a properly constructed building, in which the patients enjoy the advantages of light and air, and a cheerful prospect, and ample space for exercise, and for classification, and means of occupation and recreation. The next is the constant and watchful superintendence of humane and intelligent officers, exercising full but considerate and just control over an efficient body of attendants (Connolly, 1846, p. 9).

Connolly's system still held some currency in South Africa in 1864 when the new superintendent of Robben Island expressed his opposition to mechanical restraint (Moyle, 1987), and this was the case even as late as 1894. In this year the medical director of Weskoppies, a Dr Smeenk, especially imported from Holland, wrote in his first report under

'dwangmiddelen': "Deze zyn door my niet toegepast, aangezien ik het 'no restraint' stelsel volg" (Minde, 1975, p. 368). [Coercive measures: These are not permitted by me as I follow the 'no restraint' system.] Ironic proof that Smeenk must indeed have used moral treatment comes from an 1899 pamphlet by a former Weskoppies inmate, F.B. Higginson, in which "Dr Smeenk is accused of personally ill-treating Higginson. He glared at him through thick spectacles and threatened to lock him in his cell 'day and night', and to feed him on bread and water" (Minde, 1975, p. 368).

The Quarterly Reports of the official visitors to Grahamstown Lunatic Asylum for 1892/93 (Cape of Good Hope, 1893) indicate that there too every effort was still being made to ensure humane treatment for patients (including good heating, ventilation and so forth), together with careful observation and classification, albeit with a South African racial inflection:

A subject which we desire to bring very strongly to the notice of Government is the classification, or rather want of proper classification, of patients. In this Asylum are patients of all classes and colours; there are ladies and gentlemen who pay for their accommodation and care, and there are patients of the very lowest class of Native and European. At night and at meals these people are separated, but during the daytime they mix together in the airing yards. This is not a state of matters to be continued, and we would ask that something should be done to ensure an entire separation of Europeans from Natives as a first measure, with a view to having, in the near future, classification according to condition of life and mental state (Cape of Good Hope, 1893, p. 5-6).

In America, however, moral treatment was by the mid-1840s already an anachronism. In his reports Connolly (1845, 1846) makes repeated reference to sceptical visitors from America

and when Henry Tuke visited America in 1845 he "was troubled by much that he saw" (Hamilton, 1940, p. 109). Far from practising moral treatment, American psychiatrists such as Benjamin Rush (the 'father of American psychiatry') had become convinced of the inaccuracy of the original cure rates and had turned to advocating the healing value of restraint instead. Even in England, moral treatment had started to lose its meaning before mid-century. Prichard (1837), who was one of the Commissioners in Lunacy, discusses moral treatment under four heads:

1. seclusion and confinement (almost invariably depicted as a good thing);
2. "other means of abstracting them from the morbid impressions and associations" (p. 205) - such as travel, exercise, walking, gardening and embroidery;
3. moral discipline and personal control, which is described as "a union of firmness in determination with the greatest gentleness of manner" (p. 216), although "it is often necessary to confine violent patients with the strait-waistcoat" (p. 216) while "occasionally it is better to confine them by straps round the legs, fastened down in an arm-chair, or shut up in their rooms, according to circumstances" (p. 218); and
4. "treatment of their understandings in relation to their illusions" (p. 205), which involves playing tricks of deception.

Similarly in Belgium Leuret published in 1840 *Du Traitement moral de la folie* in which he described an evolved version of Pinel's method, involving coercion, pain and terror (Vandermeersch, 1991).

By 1884, when Daniel Hack Tuke visited America, the mood had shifted sufficiently in England that he was much less displeased with the various paraphernalia for restraint - straitwaistcoats, cupboard showers, covered hot baths to tranquillise excited patients - than his grandfather had been forty years earlier (Hamilton, 1940). In his 1885 book *The Insane*

in the United States he even went so far as to defend these various forms of mechanical restraint, secure in the knowledge that many British mad-doctors in any case saw Connolly's views about non-restraint as 'pious opinion' (Schneck, 1975).

It is not, however, that restraint came to be seen as a better form of cure than moral treatment, but that the idea of cure was, especially from 1850 onwards, abandoned. Released from the obligations of moral treatment, patients were recruited back into an ideology of prognostic pessimism (Digby, 1987; Porter, 1987b; Scull, 1991a), so that by the mid-1850s almost all American asylum superintendents had come to believe in the incurability of insanity (Cockerham, 1981) and even in Britain by 1877, after Connolly's death, "the pretensions of the asylum to curing inmates had gone" (Bebbington, 1987, p.12) and "the idea that insanity was largely incurable was divested of its controversial or contestable aspect and taken very much for granted" (Barham, 1992, p. 75).

This pessimism was related to a growing belief, especially in the second half of the century, that insanity was a physical rather than a mental affliction. Griesinger published his *Mental Pathology and Therapeutics* in 1845, which proclaimed psychiatry as a medical specialty focused on the brain and which "became the authoritative text for a generation of psychiatrists" (Colp, 1989, p. 2138). From 1857 onwards Morel propagated a similar somatic line, suggesting that insanity is a form of hereditary degeneracy (Scull, 1991a): "Inheritance, incurability, physical types; these were the dominant notes of his findings, confirmed in his travels and through contacts with the directors of the most prestigious European hospitals" (Huertas, 1992, p. 393). Morel's theory of degeneration was further popularised in Germany by Krafft-Ebing, in France by Magnan and Esquirol, in Italy by Lombroso, and in England by Maudsley (Alexander & Selesnick, 1966; Huertas, 1992; Mora, 1975; Pelicier, 1975). Even where environmental factors were admitted, these were always in interaction with genetic

predisposition, and the outcome remained inevitable. In Maudsley's (1899) words:

Were all the circumstances, internal and external, scanned closely and weighed accurately it would be seen that there is no accident in madness; the disease, whatever form it had, and however many the concurrent conditions or successive links of its causation, would be traced as the inevitable consequence of its antecedents, just as the explosion of a train of gunpowder may be traced to its causes, whether the train of events of which it is the issue be long or short. The germs of insanity are most often latent in the foundations of the character, and the final outbreak is the explosion of a long train of antecedent preparations (Maudsley, 1899, p. 140).

This move towards somatic aetiology occurred not only in response to the apparent failure of moral treatment, but also in the context of rapid scientific progress in biology, medicine and neurology. To name but a few: Darwin published his *Origin of Species by Means of Natural Selection* in 1859; Lister introduced the practice of antisepsis in the 1860s; Broca discovered cerebral localisation in 1861; Dax demonstrated the left lateralization of language in 1863; Lombroso published his 'discoveries' on the hereditary nature of genius and insanity in 1864; Wernicke published his work on aphasia and brain dominance in 1874; Koch discovered the causative micro-organism of cholera in 1883; Korsakov described alcohol-induced psychosis in 1890.

Given this intellectual climate, it is therefore scarcely surprising that in 1893 Dr Smeenk, the medical officer of Weskoppies, should report: "Ik het waargenomen dat erfelykepredispositie *prima facie*, de grootste bron van geesteskrankheid in de Z.A. Republiek is"²⁵ (Minde, 1975, p. 369). Greenlees of the Grahamstown asylum also found

²⁵ "I have observed that hereditary predisposition is *prima facie* the greatest source of mental illness in the South African Republic."

heredity to be a leading cause of insanity, although "the statistics for white and black patients differ strikingly, with many more white than black patients being said to have inherited their predisposition to insanity" (Swartz, 1994a, p. 10).

In the course of the nineteenth century asylums therefore lost their curative function and became "a convenient apparatus allowing for the collection of dead souls in a network of cemeteries for the still-breathing" (Scull, 1991a, p. 161). Hamilton (1940) provides a poignant description of what had become of the insane liberated by Pinel a hundred years earlier:

Utica had a one-story ward for disturbed men who were kept in restraint all day.

They were seated in large and fairly comfortable chairs and fastened there. The hands were confined to the chair arms and the knees could not be raised very high, leaving an opportunity merely to swing the feet back and forth; on the floor of this ward are slight depressions worn by swinging feet prior to 1890 (p. 107).

Where at the start of the century the practice of mad-doctoring was in the vanguard of modernity, helping to demonstrate the practicability of the new forms of social control, by the end of the century it had come to represent the dark, more overtly coercive, side of power. Thus the 'terrifying system' into which the institutionalised mad had been readmitted in the course of the century consisted in the first place of somaticism in aetiology, pessimism in prognosis and custodialism in therapy. However, at the same time psychiatry was starting to venture beyond the walls of the asylum:

The rigid and pessimistic somaticism which increasingly pervaded psychiatric discourse provided a powerful rationalization for the profession's dismal therapeutic performance ... But psychiatry simultaneously sought to transform the failure to redeem its therapeutic promises into the basis for obtaining a wholly new importance

in the battle to contain social pathology and to defend the social order. The march it now undertook into the 'borderlands of insanity', its embrace of the 'demifous', the neurasthenic and the hysteric marked the opening shots of a campaign to secure an 'awesome extension of the medical role' in policing the boundaries of society, and in the regulation of asocial behaviours (Scull, 1991a, p. 159).

Now comes the era of neurasthenia, invented by Beard in 1868, and hysteria, invented by Charcot in 1871, and of the various cures for these afflictions - the rest cure, the talking cure, animal magnetism. These patients, of whom there were potentially many more than those until then incarcerated, were far more likely to prove amenable to treatment. It has been suggested that it is for this reason rather than any other that Freud's ideas became popular. Forrest (1973), for example, claims that "it seems to us that his theories began to gain acceptance because his therapy offered hope rather than because they were effective" (p. 8), while Hays (1964) suggests that "his work by promising some hope of a cure in a field where no successful treatment was possible or in sight, produced some much-needed optimism" (p. 27).

However, Foucault (1967) as usual has a more sinister interpretation of what psychoanalysis was really up to:

It would be fairer to say that psychoanalysis doubled the absolute observation of the watcher with the endless monologue of the person watched - thus preserving the old asylum structure of non-reciprocal observation but balancing it, in a non-symmetrical reciprocity, by the new structure of language without response (p. 250-251).

In psychiatry the nineteenth century therefore starts and ends with cure. Between these two poles the insane, whose ranks are continually swelled by new recruits, are admitted, discharged, readmitted, transferred within an ever-more sophisticated system of professional

care.

Chapter 3

An archaeology of psychiatric readmission II:

The 20th century

Scull (1990) describes psychiatry at the start of the twentieth century as being in desperate straits: "Presiding over a ramshackle and decaying empire of ever-more over-crowded and run-down institutions, and swamped by legions of the poor, the aged, and the chronically disabled, institutional psychiatrists could do little more for their charges save to provide a dubious haven from a heartless world" (p. 144). In Europe Sigmund Freud's psychoanalytic and in America Adolf Meyer's 'psychobiological' approach pointed the way to an alternate practice which, while continuing to pay lip service to the primacy of the biological component of mental illness, made possible a psychological technology for dealing with non-incarcerated patients.

Those who followed Freud and Meyer did not attempt to reform the asylum, but set up parallel structures in private consultation rooms, outpatient departments and child guidance clinics to deal with and forestall the growing assembly of neurotic disorders. At the same time the numbers of those incarcerated in asylums continued (until the mid-50s) to grow steadily, even exponentially, although (at least until the mid-30s) institutional psychiatry continued to be characterised by neglect and apathy (Cunningham Dax, 1975).

Outside of the asylum, Kovel (1981) has depicted 1905-10 as a 'critical period' in the psychologisation of society, in which people "are no longer undesirable, bad, mad or possessed: they are sick" (p. 82). Particularly significant in this period is the founding, under

Meyer's direction, of the Mental Hygiene Movement in 1908, which on a practical level helped set up sites for psychiatric practice outside the asylum, and on the level of ideology served to objectify the notion of mentality, linking mental health to the removal of psychic dirt.

Scull (1990) tells the horrifying tale of Henry Cotton, a protégé of Meyer's, who, as superintendent of the Trenton State Hospital, took these ideas quite literally and waged a decades long battle against 'focal infection' - localised infections which supposedly spread to the brain and cause mental illness. Like so many before and after him, Cotton was concerned to bridge the gap between psychiatry and mainstream medicine, hankering like the rest of the medical profession to have illness spread out before the clinical gaze (Foucault, 1973), and visible in the depths of the physical body. From 1916 to the late 1950s thousands upon thousands of infected teeth and tonsils were removed at Trenton and elsewhere, together with massive colonic irrigations and 'reconstructive surgery' of the stomach, duodenum, small intestine, gall bladder, sinuses, womb, appendix, colon, and the genito-urinary tract. For some of these operations the mortality rate was as high as 25%, while independent studies (which Meyer helped to suppress) showed their worth in curing or preventing madness to be nil.

It is however another protégé of Meyer's, Clifford Beers, who became the official hero of the Mental Hygiene movement. Beers had been a mental patient at, amongst others, the Hartford Retreat, one of the asylums famed for its high cure rates in the 1820s. There he was subjected to the alternate regime which had long since replaced moral treatment: The straitjacket, force-feeding and forced medication. On his recovery, Beers started writing a book to expose these malpractices, but under Meyer's influence he gradually abandoned this project and when *A mind that found itself* appeared in 1908 it was more a testimony of the

power of positive thinking than an exposé of institutional psychiatry. In the same year Beers helped found the National Committee for Mental Hygiene, with Meyer as one of the charter members, followed by an International Committee in 1919 (Alexander & Selesnick, 1966). Working with luminaries such as Meyer, William James and Weir Mitchell (the inventor of the rest cure for neurasthenia), Beers' committee was little concerned with patients' rights²⁶, and responded in a lukewarm manner to appeals for intervention from incarcerated individuals (Porter, 1987b). Rather, Mental Hygiene "was a creed for psychological success. Under its umbrella, books were published with titles like *Understanding Yourself*, a self-help of the psyche advocating a sort of mental keep-fit, jogging for the mind" (Porter, 1987b, p. 197). Mental Hygiene was about personalising health, about recruiting individuals into taking responsibility for their own personal sanitation. Not surprisingly, therefore, the committee hosted, in 1909, a visit by Sigmund Freud and (despite Freud's radically less optimistic view of the psyche) helped to popularise a version of his ideas in America. The American Psychoanalytic Society was founded two years later in 1911 (Davies, 1990).

Mental Hygiene societies were subsequently also founded in several other countries, such as the Social Hygiene Council in England (Porter, 1987b); the National League for Mental Hygiene in 1924 in Italy (Mora, 1975) and the Hungarian League for the Protection of the Mentally Ill in the same year (Horánszky, 1975). Mental Hygiene committees were also formed in Canada, Australia, France and Belgium (Vitus, 1987). In South Africa the Mental Disorders Act was passed in 1916, in terms of which a Commissioner for Mental Hygiene was appointed (Minde, 1975), and in 1920 the National Council for Mental Hygiene

²⁶ Ironically Beers himself died in an asylum, in 1943, all the while protesting that the doctors assigned to his care were 'impersonators' (Porter, 1987b).

and for the Care of the Feeble-minded was formed (Hurst & Lucas, 1975; Vitus, 1987)²⁷.

Meyer's intention with Mental Hygiene was both preventive, and to ensure that where psychiatric hospitalisation did occur it would be followed by adequate aftercare - thus forestalling the need for further readmissions. "Originally envisioned as a kind of friendly visiting, the aftercare model was soon defined as an important adjunct to a psychiatrist's treatment, in which the social worker not only helped the patient adjust after discharge but also modified the home environment that had provoked his symptoms in the first place" (Johnson, 1990, p. 13). Meyer's wife, a social worker, was active in instituting aftercare, and several Child Guidance Clinics (mostly funded by private philanthropies) were founded, as was also the case in South Africa (Vitus, 1987), but the envisaged ties to state mental hospitals never fully materialised, so that these for the most part continued to exist as purely custodial institutions parallel to, but largely uninfluenced by, psychiatric social work and the activities of the Child Guidance Clinics (Johnson, 1990).

One hospital, the Worcester state hospital, is reported as having introduced reforms such as liberalised discharge and visiting policies, and the use of social workers, as early as 1912 (Morrisey & Goldman, 1980), but this appears to have been the exception rather than the rule. The following description of Worcester hospital in the 1930s illustrates the extent to which asylums had remained worlds unto themselves:

The hospital was located on a 350-acre tract of land on the eastern edge of the city, removed from the major residential areas. It had its own radio station; 200 acres of farm land with facilities for processing and canning the produce; prize herds of cattle and swine; a security force; staff dormitories and recreational facilities; medical-

²⁷ In this country mental hygiene often translated into racial hygiene (Swartz, 1994a), as also at times in the United States where Congress instituted immigration quotas in the 1920s (Johnson, 1990).

surgical services for staff as well as patients; a chapel; and libraries for staff and for patients (Morrisey & Goldman, 1980, p. 82).

In the Soviet Union an integrated system similar to what Meyer had in mind, involving supported home care, outpatient clinics, day hospitals, and custodial hospitals, is reported actually to have been instituted shortly after the 1917 revolution (Howells, 1975). Although the Mental Hygiene movement never achieved this kind of success, there was a gradual progression in Western countries between the two wars towards the boundary between mental hospital and society becoming more permeable. Of those discharged as disabled from the U.S. Army in the first world war, 20% were for reasons of mental illness (Johnson, 1990), although most of these were not candidates for long-term confinement, often suffering from the newly-invented and more-or-less transient syndrome of 'shell shock' (Howells & Osborn, 1975). In the United Kingdom the Mental Treatment Act of 1930 for the first time allowed for voluntary admissions (Howells & Osborn, 1975) and provided for the creation of outpatient clinics (Barham, 1992). Thus from the mid-1930s British mental hospitals began to be inhabited by a new population which both came and went more freely, leading to a steady rise in first admissions and readmissions (Barham, 1992).

Contemporaneously, the growth of non-institutional psychiatry led to "a paroxysm of experimentation among institutional psychiatrists with various forms of physical therapy" (Scull, 1991a, p. 165): Metrazol and insulin shock treatment in 1933-35 (Alexander & Selesnick, 1966; Colp, 1989); leucotomy in 1936 (Schneck, 1975); electric shock in 1938 (Mora, 1975). These developments are discussed more fully in the next chapter.

With the advent of the Second World War there was again an influx of new psychiatric cases, this time suffering from 'battle fatigue', 'combat neurosis' and 'demoralisation' in addition to 'shell shock'. Of the 15 million men examined by the US army,

856 000 were judged to be mentally ill, and 700 000 mentally retarded. What these men often seemed to require was brief hospitalisation (Johnson, 1990), thus further eroding the custodialism of the mental hospital. In South Africa a military hospital with a psychiatric section was built at Potchefstroom in 1942 to deal with World War II psychiatric casualties. After the war the officer commanding, H.J. Moross, founded Tara hospital in Johannesburg - the first in South Africa for non-certified patients (Minde, 1975; Reid, 1986).

In the United States, the Veterans Administration began in 1945 "the largest hospital program in American history: the construction of 69 general hospitals, each with a psychiatric unit, and 16 mental hospitals" (Colp, 1989, p. 2141). These psychiatric wards and hospitals differed significantly from the custodial institutions which preceded them and although some of their inmates received the dreaded diagnosis of schizophrenia, "the proportion of schizophrenic people out of hospital at follow-up increased significantly from around 50 or 55 per cent before 1940 to more than 70 per cent in the immediate postwar period" (Warner, 1994, p. 74).

In Europe there occurred at this time a "social psychiatry revolution" (Fleck, 1990; Warner, 1994), also contributing to the softening of the stark boundaries between mental hospital and community, with hospitals set up as miniature 'therapeutic communities' (Arthur, 1971; Jones, 1968; Warner, 1994) in order to ease the transition from community to hospital and from hospital to community.

In 1949, at Dingleton Hospital in Scotland, George Bell, like so many psychiatrists before and after, unlocked (or perhaps more accurately gave orders to unlock) the doors of all the wards, heralding an Open Door Movement which gained numerous adherents throughout the West (Warner, 1994, p. 86), with at least seven British hospitals reinstating an open-door policy between 1949 and 1956 (Colp, 1989).

It is during the war years and in the immediate post-war period that Mental Hygiene was rechristened Mental Health, which could be interpreted as a further move from repressive sovereign power (as is still partially implicit in the idea of policing the public's mental hygiene) to constructive discipline. In the United States in 1946 Congress passed the National Mental Health Act, establishing the National Institute of Mental Health, which opened in 1949 (Colp, 1989; Morrisey & Goldman, 1980). In South Africa the National Council for Mental Hygiene became the National Council for Mental Health in 1943 (Vitus, 1987), spawning a number of local mental health societies. The World Federation for Mental Health was formed in 1948, with the South African council as an affiliate (Vitus, 1987).

In the United Kingdom the National Health Service Act of 1946 laid the foundations for the National Health Service which came into operation in 1948. In terms of this Act mental hospitals received equal benefits to general hospitals, and psychiatrists were for the first time put on a par with specialists in other fields (Howells & Osborn, 1975). The National Health Service epitomises the rise of the welfare state in the post-war West, characterised by social pensions, unemployment and sick benefits, and free compulsory education (Wing, 1990). Warner (1994) argues that it is this safety net of social services which made it possible to start releasing the insane, who would otherwise often not have been able to fend for themselves. The era of the psychiatric social worker, foreshadowed by Meyer, had thus finally arrived. In 1953 the California health department took the innovative step of employing 120 social workers to serve 10 000 psychiatric patients on 'convalescent home leave' and in 1954 the first major conference of American psychiatric social workers was held, allowing for the discussion of topics such as job placements for patients, family involvement, community residences, and recreation programmes (Kanter, 1991).

The process of decarceration thus set in motion can be illustrated with reference to

Worcester hospital, described earlier as the epitome of a self-sufficient asylum cut off from the broader social world. In 1949 psychiatrists (several of whom were ex-military) started re-assessing each chronic patient at Worcester with a view to reducing the census. Between 1950 and 1955 a 6% decline in the hospital population was achieved, while annual admissions went up by 13%. "Whereas the number of first admissions remained relatively constant during this period (at about 618 per year), the annual number of readmissions had more than doubled (from 241 to 568)" (Morrisey & Goldman, 1980, p. 87).

However, despite the example of a few hospitals like Dingleton and Worcester, the emptying-out of the asylum was at first a slow process, and world-wide the number of psychiatric patients continued to rise. The high point in the mental hospital population in England and Wales - 148 100 patients or 33.45 per 10 000 (Scull, 1984) - was reached in 1954, with the high point in the USA - 558 900 patients - following a year later (Barham, 1992). In South Africa the mental hospital population is said to have peaked at about 35 000 in the late 1960s (Gillis, 1970; Vitus, 1987). After this the mental hospital population dropped sharply, both in absolute terms (Figure 3.1) and relative to the population (Figure 3.2). The long process of incarcerating the insane had finally come to an end.

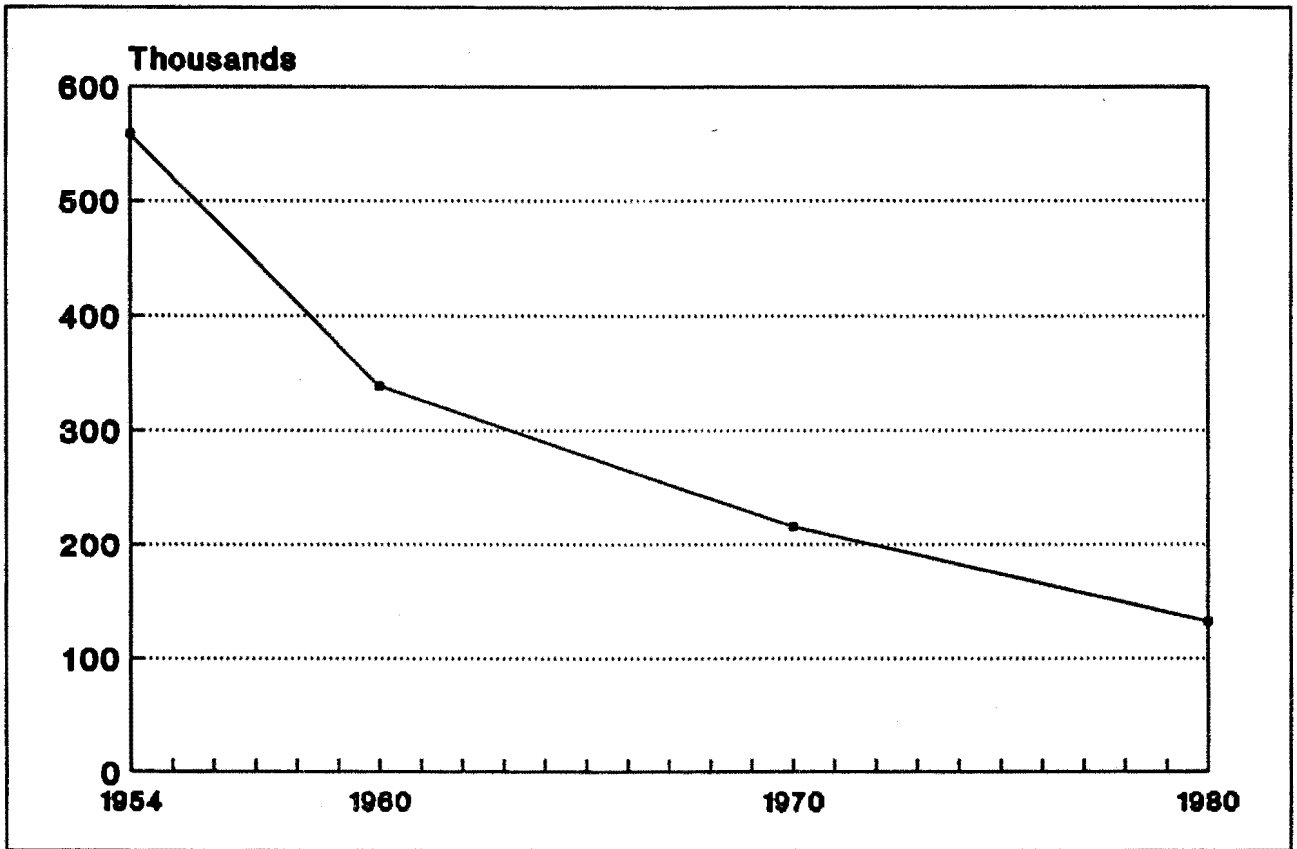
Deinstitutionalisation

The probable reasons for the sudden decline in psychiatric inpatient numbers after 1954 have already been briefly mentioned in Chapter 1. They are:

Ideological. Starting with Mary Ward's *The Snake Pit* in 1946 and Albert Deutsch's *The Shame of the States* in 1948 (Johnson, 1990) and reaching a peak in the 60s with the publications of Szasz (1967), Cooper (1967) and Goffman (1961), the decades after the war

were marked by a strong resurgence of critiques of institutional psychiatry.

Figure 3.1 State mental hospital census in the United States of America (source: Barham, 1992; Scull, 1984)



Economic. Warner (1994) is a strong advocate of the notion that psychiatric patients could only be released once the National Health Service (in the UK) and Medicaid (in the US) were in place. Using historical data he shows how before this, admission rates to mental hospitals had regularly increased during periods of economic decline since the mid-18th century. In Warner's (1994) view, "rather than psychiatric treatment having a big impact on schizophrenia, both the course of the illness and the development of psychiatry are governed

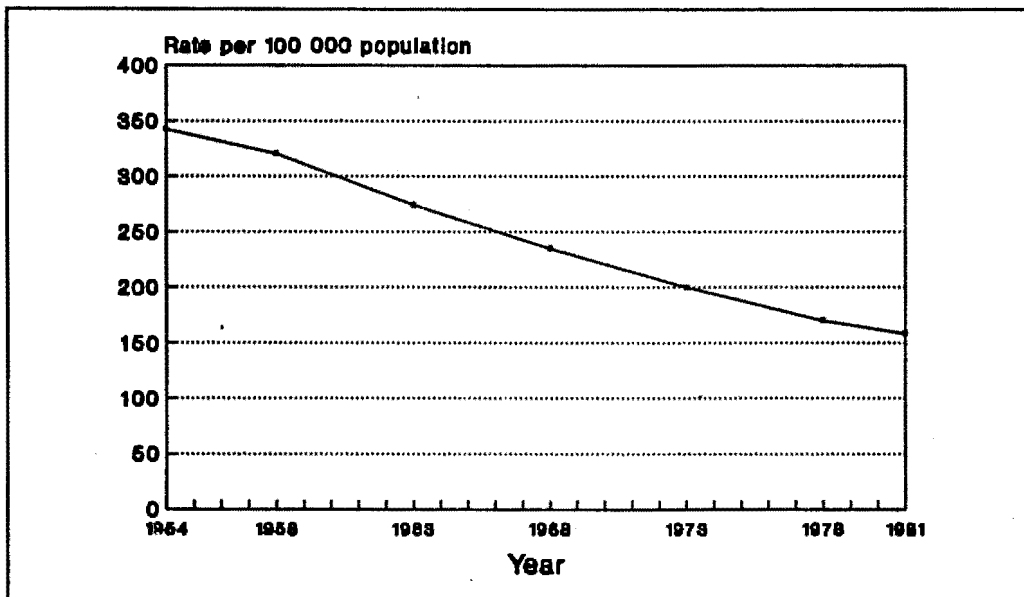
by political economy" (Warner, 1994, p. 75).

Technological. Chlorpromazine, the first of the antipsychotic drugs, was experimentally used by Delay and Deniker in the University Clinic of Paris in 1952 (Alexander & Selesnick, 1966; Colp, 1989; Pelicier, 1975) and introduced to the United States (as Thorazine) in 1954. It was at first seen primarily as a medical and surgical drug, with only 39 of the 563 journal articles published about Thorazine until 1956 concerned with its role in psychiatry (Johnson, 1990). However, within eight months of the initial three uncontrolled²⁸ psychiatric studies (involving a total of 243 patients) in 1957, it had been given to two million patients (Johnson, 1990). Although this is well after the trend towards deinstitutionalisation had begun, Fleck (1990) is no doubt correct in arguing that "with the impact of psychopharmacological treatments and the ensuing accessibility of many patients for therapeutic and rehabilitative work, or at least the docilization through these agents, a more optimistic and therefore also more therapeutic atmosphere began to prevail in many hospitals" (p. 51).

Explicit political initiatives. In the United Kingdom the 1959 Mental Health Act allowed for "more diversified community service embracing a range of agencies" (Barham, 1992, p. 11). A year later the then Minister of Health, Enoch Powell delivered his famous 'water-tower' speech to the National Association of Mental Health: "There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity" (quoted in Barham, 1992, p. xi). Inspired by this the Ministry of Health in 1962 published its 'Hospital Plan' setting out a programme for the deinstitutionalisation of the mentally ill (Ekdawi & Conning, 1994).

²⁸ The first double-blind study of chlorpromazine occurred only in 1964 (Colp, 1989).

Figure 3.2. Mental hospital population in England and Wales as a proportion of the total population (source: Barham, 1992)



In the United States the Joint Commission on Mental Illness and Health in a 1961 report titled "Action for Mental Health" recommended that state hospitals should convert from custodial to treatment centres (Morrisey & Goldman, 1980). The year after, Kennedy made his "bold new approach" speech condemning "cold custodialism" and calling for comprehensive community care. In the same year he signed the Community Mental Health Centers Act (Colp, 1989; Morrisey & Goldman, 1980) which, as was the case with child guidance clinics at the start of the century, set up parallel institutional structures, largely unconnected to the mental hospital system, but radiating the disciplinary power of psychiatry into increasingly intimate and decentered spaces.

In South Africa, the revised Mental Health Act of 1973 resulted in a greatly increased focus on voluntary admissions (Vitus, 1987).

As significant as the drop in the inpatient census brought about by deinstitutionalisation was the steep rise in admission rates, for example from 78 586 per annum in 1955 to 170 527 per annum in 1968 in England and Wales and from 185 000 per

annum in 1956 to 393 000 per annum in 1970 in the United States (Scull, 1984). In South Africa, admissions rose by 40% between 1964 and 1989, while the number of mental hospital beds declined by 8 800 (Visser, Haasbroek & Bodemer, 1989). As was the case in the 1750s and the early 1800s, this rise in admissions was in large measure due to readmissions rather than first admissions. According to Warner (1994) "about half the patients released from U. S. psychiatric hospitals in the early 1970s were readmitted within a year of discharge" (Warner, 1994, p. 90). Where patients were not readmitted to a mental hospital, some other institution often served the same purpose so that, again as before, deinstitutionalisation often turned out to be little more than transinstitutionalisation. Despite the sharp decline in mental hospital patients in the United States in the early 60s, the number in nursing homes increased to such an extent that the total institutionalised population was actually higher in 1969 than in 1963 (Warner, 1994). Not only were nursing homes cheaper²⁹, but where state governments had to pay for those in state mental hospitals, the costs of private nursing home care could be billed to Medicaid or Medicare, which are mostly funded by the federal government (Warner, 1994).

Nursing homes, board-and-care residences and the like have been severely criticised - Scull (1984) describes them as "a poor alternative to living" (p. 165) - although it is a common finding that residents view them more positively than they do the supposedly better equipped mental hospitals (Lehman, Possidente & Hawker, 1986; Lehman, Slaughter & Myers, 1991).

Together with this by now familiar pattern of an increase in admissions, readmissions

²⁹ In 1973, with the United Kingdom's inpatient population shrunk to a fraction of its former size, 300 million pounds were still being spent annually on inpatient care, compared to only 6.5 million on residential and day care (Scull, 1984). In South Africa in the late 80s, 82% of the mental health budget still went on hospital care, and only 7% on outpatients (Visser, Haasbroek & Bodemer, 1989).

and transfers, there has also been an enormous increase in psychiatric 'care episodes' at sites other than the traditional mental hospital. In the United Kingdom, day hospitals have become common (Warner, 1994), and even where full hospital admission occurs, 33% of these were, already by 1977, to psychiatric units in district general hospitals rather than to mental hospitals (Barham, 1992). At the same time the archetypal form of psychiatric incarceration, compulsory admission, has steadily declined. In the United Kingdom one in four admissions in 1955 was compulsory, dropping to one in five in 1964 and one in eight in 1974 (Kruger, 1980). In South Africa many of the worst aspects of incarceration are still in place, for instance at the privately run and notoriously under-resourced Smith-Mitchell institutions, which in 1986 housed 9 500 involuntary patients (Haysom, Strous & Vogelman, 1990)³⁰. However, since the 1960s there has been a large increase in voluntary admissions and outpatient treatments (Vitus, 1987), with psychiatric outpatient attendances increasing by 834% between 1961 and 1989 (Visser, Haasbroek & Bodemer, 1989).

Again, as in the previous century, changes in psychiatric incarceration mirrored changes in the criminal justice system, where "from the late 1960s onwards, probation began to be used in an historically unprecedented way" (Scull, 1984, p. 47) as part of a move to a community-based correction system.

The fact that deinstitutionalisation occurred on such a large scale suggests that yet again the belief had arisen that the insane could be cured and released into the community. As Barham (1992) puts it: "The 'community' came to possess a null value - it was not seen as

³⁰ Several exposes during the 1970s and 1980s revealed abuses at these centres, including excessive drug use and patients being admitted for not carrying pass books or for arguing in public. Connie Mulder, minister of information in the apartheid government was a director of several of the institutions (Theil, 1997). The institutions were later renamed 'Life Care' centres and are, ironically, now part-owned by the black empowerment group, Real Africa Investments (Hess, 1997).

a therapeutic site or as the arena for an interrogation of the moral crisis in the relations between people with mental illness and the larger society, but just as the place to which people were to be sent back after medicine had cured them" (Barham, 1992, p. 14).

The end of deinstitutionalisation I: Lost to aftercare

As happened to the previous 'cult of curability' in the 1800s, dissenting voices soon arose. Bachrach (1987) produces evidence that warnings of the possible adverse effects of deinstitutionalisation and the too-easy glorification of the community concept were published from 1964 onwards. An example of such early critiques is a paper by Dunham (1967) who lampooned the community approach and argued that there was no reliable information on its enabling the prevention of psychiatric disorders nor on how psychiatric disorders could be treated through community interventions. This kind of critique has gathered momentum over the past three decades so that the term 'deinstitutionalisation' is now used almost exclusively in a pejorative sense; and there is general agreement that since the mid-80s we have been in a post-deinstitutionalisation era (Shadish, Lurigio & Lewis, 1989).

The backlash against deinstitutionalisation has taken two forms. In this section I review more extreme reactions, which essentially advocate a return, in one form or another, to the asylum. The more 'humane' (and therefore probably more lasting) option is reviewed in the next section.

By the early 70s resistance to the community approach had started to create 'moral panics' with exemplary tales told in the media of violence committed by ex-patients and of the bad conditions in which the deinstitutionalised were accommodated (reviewed in Scull,

1984)³¹. "Often," so the story went, "they [hospital administrators] do not even know where those they have dumped back on the rest of us are to be found" (Scull, 1984, p. 1). The idea of madness being indiscriminately dumped, in a flagrant reversal of mental hygiene, occurs again and again (e.g., "many severely and chronically disabled patients have been 'dumped' in the rooming houses and decaying hotels of innercity areas": Morrissey, Goldman, & Klerman, 1980b, p. 3) as does the alarmist notion that the mad may have escaped beyond the reach even of surveillance:

In November 1986 the National Institute of Mental Health admitted that the whereabouts of 58 per cent of people with a history of schizophrenia was unknown.

As many as 937 000 had been lost to aftercare, and only 17 per cent were in receipt of outpatient care (Barham, 1992 p. 107).

In South Africa accusations of dumping the mentally ill on society have also gone hand in hand with tales of their spectacular violence. Health Department plans to start a programme of community care in accordance with the White Paper on Health (1997), have been described as a scheme "to shunt thousands of mental patients out of state- run institutions and into the care of their families and friends" (Hess, 1997), and lurid accounts have been published of patients released from Valkenberg hospital killing seven people, including two children (Duffy, 1998). The head of Valkenberg's forensic unit explains the situation as follows (Duffy, 1998):

Either we've got to watch them closely, or someone else must, but we have great

³¹ Monahan and Shah (1989) review the voluminous literature which has since arisen around the perceived dangerousness of psychiatric patients. Two of the highlights of this research are that psychiatrists habitually over-predict dangerousness and that patients are far more likely to be dangerous to themselves than to others. Monahan (1992) nevertheless cautions against completely denying the modest empirical relationship between madness and violence.

difficulty keeping an eye on everyone. The only way we can keep control of them is to keep them in our walls.

Coupled with these concerns and fears is a strong resurgence of official sympathy for the 'plight of the mentally ill': "Thousands of 'deinstitutionalized' patients", wrote Morrissey, Goldman and Klerman (1980b), "have been returned to communities only to encounter hostility and rejection by citizens and the new community centers alike" (p. 3). The 'homeless mentally ill' are endlessly dissected (cf. Bachrach, 1988; Cohen & Thompson, 1992; Morrison, 1989; Mulkern & Manderscheid, 1989; Santiago, Bachrach, Berren & Hannah, 1988; Torrey, 1988) - how many of them are there, what should be done with them, how should homelessness be defined?

One implication of this combination of loathing and sympathy is that the mad should be humanely disposed of. When in October 1939 Hitler decreed that patients with incurable diseases should be done away with, medical personnel arranged for 270 000³² mental patients to be killed (Colp, 1989). Displaying an attitude which has been described as *tödliches Mitleid* (deadly compassion), psychiatrists saw to it that patients were discreetly collected for this purpose in grey vans purporting to be from the Community Patients' Transport Service (Barham, 1992). While, thankfully, the likelihood of such events being repeated in the modern world seem remote, there is a recognition that perhaps a more permanent solution than community care may now be required. As Minkoff (1987) argues, "some patients are simply too sick or dangerous to ever leave the hospital" (p. 948), and even where this is not the case "a longer initial hospitalization can serve as a watershed experience that facilitates a more stable lifelong adaptation to illness" (p. 948).

Thus we see patients being collected from their 'rooming houses and decaying

³² 'Upwards of 100 000' according to Barham (1992).

innercity hotels', if not by grey vans then by ideologies of dangerousness, inability to cope, and chronicity, and returned safely to the asylum. There they find that the 'therapeutic community' has long since closed down and in its stead have come aggressive new somatic therapies (reviewed in the next chapter), consisting chiefly in the various forms of medication, but not excluding old favourites such as restraint and seclusion.

Way and Banks (1990) in a survey of 23 adult psychiatric hospitals in New York state found that between 0.4% and 9.4% of patients were secluded or restrained at some point during their stay. Norris and Kennedy (1992), sensitive to psychiatry's long-fostered tradition of liberating the insane, point out that although "empirical evidence has supported the use of seclusion for managing out-of-control psychiatric patients ... the act of forcibly locking a patient in a room generally leaves the staff with unsettled, uncomfortable feelings" (p. 7). One of the ways of dealing with these unsettled and uncomfortable feelings is to ensure that the patients are at least settled and comfortable, even to the extent of gathering patient 'input' on the preferred temperature, colour of the walls and attitudes of the nurses whilst in seclusion (Norris & Kennedy, 1992). Thus one should 'plan carefully' for seclusion (Kendrick & Wilber, 1986), giving due consideration to difficult questions such as whether seclusion rooms should be visible to other patients or not (Wise, Mann, Leibenluft, Goldberg & McElvain, 1989).

The argument, in summary, is therefore that deinstitutionalisation has perhaps gone too far (in Krauss and Slavinsky's, 1982, words: "an overreaction to bad care in bad hospitals", p. 84) and that many patients may in fact need to be more-or-less permanently readmitted to protect them from the cruelty, exploitation, stress, pauperism, isolation, self-harm and harm to others which only the mental hospital can provide (Wing, 1990). However, the opposite argument, that deinstitutionalisation has not gone far enough, is heard

even more frequently - a view which (as will be shown) does not differ as fundamentally as might be imagined from that calling for reincarceration.

The end of deinstitutionalisation II: The timeless trajectory

Deinstitutionalisation was never simply an effort to do away with the mental hospital, but rather to reposition it in a larger network of psychiatric services. In South Africa, Moross (1969) was already emphasising the importance of involving the patient's family in aftercare and of getting former patients to visit out-patient clinics. Reid (1986) quotes a 1963 promotional movie, *This is Tara*, about the hospital where Moross was superintendent as follows:

... And so today there is a new way of thinking ... not the patient coming to Tara, but Tara going to the patient. This is the forward trend (p. 14).

Thus the patient need no longer experience the inconvenience and stigma of spending time in hospital, but can receive psychiatric services 'in the community', while the ex-patient can continue to enjoy the care and sense of belonging which the mental hospital provides without the need for an actual readmission:

There is also a Tara Social Club to which ex-patients belong, and which preserves the link between patient and hospital after active treatment has ended. Ex-patients have regular meetings in Johannesburg, organise excursions together, and come to Tara at the weekend for sport and social activities (Minde, 1975, p. 373).

A clear-cut distinction can no longer be made between hospitalisation and ordinary life: One is no longer either ill and in hospital or well and out of hospital. Or such, at least, is the ideal. The majority of critiques of the present era of community care do not call for whole-sale

rehospitalisation, but simply complain that not enough is being done to create a properly integrated system and to make community care more like hospital care.

The problem, as Johnson (1990) sees it, is that if experts on mental illness from another planet were to visit the United States they "would see a big, chaotic system, uncoordinated and incoherent, one that utterly fails to fulfil its mission, which is the ongoing care and treatment of the mentally ill" (Johnson, 1990, p. 180). Words and phrases like 'fragmented' (Bachrach, 1989; Dill & Rochefort, 1989; Hadley, Turk, Vasko & McGurrin, 1997; Shadish, Lurigio & Lewis, 1989; White Paper, 1997), 'lack of integration' (Hadley, Turk, Vasko & McGurrin, 1997) and 'disorganisation' (Dill & Rochefort, 1989) leap out at one from the literature on post-deinstitutionalisation; against these are ranged the desiderata of 'coordination', 'continuity' and 'effective management' (Dill & Rochefort, 1989; Hadley, Turk, Vasko & McGurrin, 1997; White Paper, 1997). It is argued that Community Mental Health Centres should have established more formal linkages to state hospitals (Morrissey, Goldman, & Klerman, 1980b); more places should have been provided in local authority hostels (Barham, 1992); perhaps those who refuse treatment should be issued with Community Treatment Orders, the equivalent of certification (cf. the discussion in Barham, 1992; Lawson, 1988); psychiatry should abandon the acute care model and develop a longitudinal perspective (Mechanic, 1980); and patients should be trained in community living before release (Gittelman & Freedman, 1988).

In short, community care should "attempt to provide for its patients the full range of functions that are associated with institutional care, namely: long-term care; asylum or place of refuge; accommodation and food; medical treatment; social and vocational help; supervised accommodation (custody) for those who have broken the law or engage in behaviour which will not be tolerated elsewhere; a comprehensive service; and secure

employment for professionals" (Ekdawi & Conning, 1994, p. 30).

Exemplifying this notion of turning the community itself into an institution, Ekdawi and Conning (1994) discuss the idea of 'hostel-wards', a cross between hospital wards and community hostels located on the edge of hospital grounds and providing graded community accommodation: "This arrangement should allow [for] ease of movement into and out of the Community and facilitate continuity of care by maintaining contact with those who move out of the Community" (p. 120). One such service in London "looks after approximately 350 long-term patients, and yet has only 34 hospital beds" (Ekdawi & Conning, 1994, p. 121).

Although complaints about the inadequacy of community care continue unabated, it is clear that much has been done recently to bring about this kind of utopia for everybody, with two thirds of community residential programs for the mentally ill in the United States having been established since 1980 (News and Notes, 1989), and more than 1000 partial hospitalisation programmes operating in America by the end of the 1980s (Parker & Knoll, 1990). A 1984 survey in 16 American states showed that 93 353 'chronics' were being served, of whom 91% had at some point been in hospital, and 87% were on psychotropic medication. Although 75% were unemployed, very few were homeless or in prison (Mulkern & Manderscheid, 1989).

Yet the literature abounds with appeals for even greater integration, communication, collaboration and liaison between hospital and community psychiatric staff (cf. Hadley, Turk, Vasko & McGurrin, 1997). In South Africa, the White Paper on health makes repeated mention of the need for psychiatric services to become more 'coordinated' and 'integrated', with greater emphasis on 'intersectoral coordination', even going so far as to recommend that 'collaboration' with traditional healers should be explored (White Paper, 1997).

In a fully integrated system, readmission to a hospital is no longer to be considered a

sign of failure (Simpson, Seager & Robertson, 1993), since "even the most intensive programs cannot eliminate the intermittent necessity of psychiatric hospitalization" (Kanter, 1991, p. 34). Thus, in their programme evaluation of a day hospital, Ferber, Oswald, Rubin, Ungemack and Schane (1985) do not use its capacity to deflect full-scale hospitalisation (the original purpose of such hospitals) as an outcome measure, but rather evaluate its efficacy in recruiting and maintaining patients in the psychiatric world:

This high retention rate appears to result from the day hospital's focus as the entry point to a large and flexible network of long-term services in the same location and with familiar staff ... Because patients may need treatment and other support services indefinitely, the day hospital often is the first stage in a long process of working with the patient (p. 1297-1298).

It is in this context that Ferber *et al.* (1985) can use the fact that 62% of the day hospital patients ("far above the national average") remained in long-term treatment six months after the acute intervention (and that 50% were still receiving services two years later) as an index of success rather than failure.

The name most commonly given to this new therapeutic ideology is rehabilitation - not in the old-fashioned sense of restoring sanity, but of restoring to and maintaining at the optimal level of functioning allowed for by the degree of unalterable mental impairment. According to Mechanic (1986), "good rehabilitation treats acute psychiatric episodes, ensures appropriate medication monitoring, maintains nutrition and general health, makes provision for shelter and reasonable levels of activity and participation, provides crisis support, and builds a patient's personal capacities through continuing educational efforts" (p. 892). In terms of the rehabilitation ideology, schizophrenia, bipolar disorder, and 'related psychoses' have biological aetiologies and "treatment, therefore, involves both psychopharmacologic

interventions to control the primary symptoms and psychosocial interventions to assist the ill person to acknowledge, bear, and accept the illness" (Minkoff, 1987, p. 947). Like those suffering from diabetes or chronic heart disease, mentally ill people must be taught to accept that they have a life-time illness and to value the help they are offered (Barham, 1992; Minkoff, 1987) - "the challenge is to preserve function and limit disability" (Minkoff, 1987, p. 894).

Uys (1991) identifies various eras in the development of psychiatry, and labels the current one the rehabilitation era: "Just as it suddenly was realized that institutions were not necessarily therapeutic, we now realize that simply moving the patient into the community does not necessarily increase the quality of life or level of health" (p. 1). Outcome measures of the success of rehabilitation are functional status (the patient's 'daily living ability'), severity of symptoms, 'quality of life', and hospitalisation - with the latter, as we have seen, no longer interpreted simply as readmission frequency (Uys, 1991). It is fully accepted that "there is an increasing number of disabled people who, until the 1950s, would have been continuously hospitalized for many years but who are now either not admitted to hospital or, alternatively, have brief multiple admissions" (Ekdawi & Conning, 1994, p. 3).

Rehabilitation efforts have been shown to reduce readmission frequency (Belcher, 1993; Hadley *et al.*, 1997), but -

Hospitalization, however, should not be taken at face value as denoting failure of rehabilitation ... In some cases, the purpose of planned hospital admissions is to provide respite and to forestall crises and they may therefore indicate a positive rather than a negative outcome (Ekdawi & Conning, 1994, p. 136).

According to Johnson (1990), one of the most important things chronically mentally ill patients should be given "is permission to regress occasionally in the course of treatment and

the ability to be rehospitalized at once when they need it" (Johnson, 1990, p. 185). In fact, it is often the health care professional's task to get the patient into the hospital rather than keep her out:

[The community mental health care nurse] must be sensitive to changes in behavior that signal that the patient is decompensating psychiatrically ... and possibly arrange for early rehospitalization. Such foresight can result in a shorter acute hospital stay, and the nurse can then continue support in helping the patient to readjust, once again, to community living (Hellwig, 1993, p. 22).

The kind of chronicity thus constituted is not at all like the static (or slowly deteriorating) institutional chronicity encountered at the end of the previous century. Rather, it is a chronicity which is always on the move without ever going anywhere, a 'timeless trajectory' (Rawnsley, 1991):

The crises requiring hospitalizations are followed by periods of stabilization of varying duration ... exacerbations and remissions; difficulty distinguishing between the effects of the disorder and the effects of the interventions; temporary comebacks, but no restoration ... The circular weave of psychosis diffuses direction (Rawnsley, 1991, p. 209).

Yet the new chronicity is also not at all like the mobile curability which came about at the end of eighteenth century. Where in the days of moral treatment the mad-doctor stood at the centre of the patient's therapy, this position has gradually been eroded, so that in the rehabilitation era the psychiatrist (however much he or she continues to be the titular head of the mental hospital ward) has come to occupy a somewhat peripheral role in the overall treatment system.

In the place of the psychiatrist stands the therapeutic team, involving not only

psychiatric nurses, psychologists, social workers and other para-medical personnel, but also the family, because, as everyone agrees, one "should include them in the loop of service delivery" (Belcher, 1993, p. 22). Far from being the cause of mental illness, "there has been an increasing recognition that relatives could be a positive resource in the management of patients when given the opportunity of information, training and support by the psychiatric services" (Ekdawi & Conning, 1994, p. 6). The consensus is overwhelming: Families should be 'engaged' in therapeutic programmes to a greater extent, family interventions should be 'integrated' with rehabilitation programmes, there should be more 'co-ordination', 'continuity' and 'liaison'. Families should be recruited at 'multiple entry points', for example "acute admission units, out-patient and maintenance medication clinics, day centres, and voluntary groups" (Smith & Birchwood, 1990, p. 658) in order to set up an 'informed partnership' (Smith & Birchwood, 1990) between professional care givers and the family.

In South Africa, where psychiatrists have often invoked the idea of an organic African essence which is contaminated by contact with Western culture (Laubscher, 1937; Swartz & Foster, 1984) the need for engaging with the family is given an ethnic twist:

Until recently the majority of psychiatric patients were contained and treated within the community, unless their behaviour represented a major threat to the social order of that community. With the gradual acceptance of the Western concept of institutionalization, however, increasing numbers of Nguni patients are being admitted to psychiatric hospitals. These hospitals are usually far away from the patient's home; the close family ties, generally regarded as prerequisites for successful rehabilitation, are disrupted, and this often leads to rejection of the patients by the family (Cheetham & Griffiths, 1980, p. 168).

Given that the links have been broken it is now incumbent on mental health workers to

restore them. The name of the game is case management (that is, doing a lot of engaging, integrating, coordinating and liaising on behalf of the patient), and the case managers are typically social workers, psychiatric nurses or 'mental health workers', frequently working together as a team (Minkoff, 1987; Hadley, Turk, Vasko & McGurrin, 1997; White Paper, 1997). In the United Kingdom the National Health Service and Community Care Act provides for the appointment of such case managers, who identify people in need of care, assess individual needs, "act as brokers in the planning of care" (Barham, 1992, p. 133), and so on. Although case management services were by the mid-90s only provided upon discharge from one in four American hospitals, the practice is becoming increasingly common (Dorwart & Hoover, 1994).

Case managers and case management teams are encouraged to engage in what is called 'assertive community treatment' (Bond, McDonel, Miller & Pensec, 1991; Santos, Deci & Lachance, 1993) or 'aggressive outreach' (Hadley, Turk, Vasko & McGurrin, 1997). In this new dispensation, one can expect not only to visit one's case manager at the outpatient clinic, but also to have her pay a visit to one's home or place of work. Ekdawi and Conning (1994) describe how when a group of chronic ex-patients are visited by their psychiatric nurse at their place of employment she would "discreetly slip into the rest room to give the injections" (Ekdawi & Conning, 1994, p. 32). Not all case managers are that discreet: "Aggressive outreach, as it is called, means aftercare staff have to call the errant patients up or even go visit them when they do not show up" (Johnson, 1990, p. 185). What becomes important when first encountering a patient in such a system is no longer merely to find out about her symptoms, social background, family history and so on, but also "relevant chronological details of the individual's past treatment and contact with psychiatric services including hospital admission are documented, together with reported factors which may have a bearing

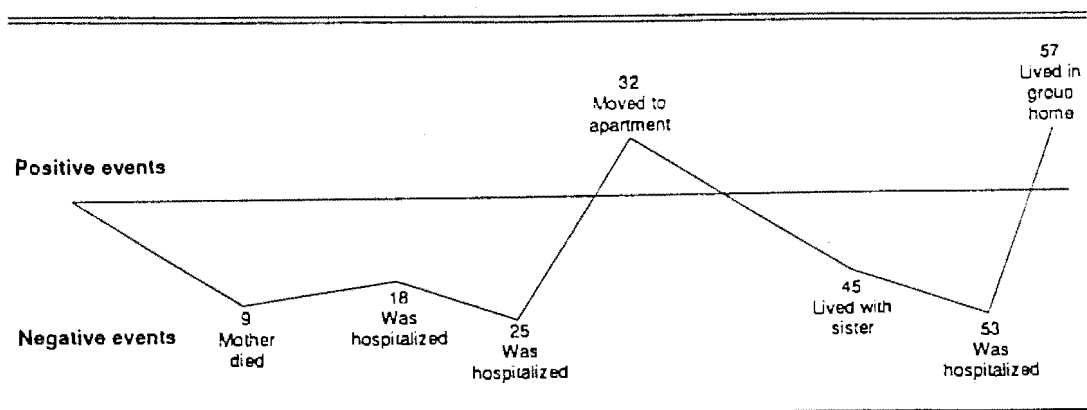
on the course of illness and the frequency of contact with services" (Ekdawi & Conning, 1994, p. 38).

Hadley *et al.* (1997) describe a highly sophisticated and effective case management system instituted after the closure of the Philadelphia State Hospital. The system is aimed at 'empowering' clients by focusing on their "strengths, abilities, vision for the future and aspirations, while also being keenly aware of the medical/psychiatric issues which impact on the client' (p. 81-82). The system makes use of Team Leaders (minimum qualification 'a degree' with three years mental health experience) who supervise Case Managers, whose job it is to draw up 'personal plans' for clients. Case Managers also supervise Case Manager Technicians who provide "hands on assistance to the consumer such as going to the bank, shopping, teaching mobility training and implementing the details of the client's personal plan" (p. 85). In no instance does the time between contacts with clients exceed two weeks. Standing to the side of this is the psychiatrist, who merely provides periodic medication reviews and is 'available for consultation' should the need arise.

The case manager's task is to find the right balance between improving the life quality of the chronic patient and minimising costs while helping clients to "negotiate the maze of community services" (Belcher, 1993, p. 21). Two models of case management are brokering (where the mental health worker acts as a kind of recruiting agent for psychiatry by putting up to 100 clients in contact with community and hospital services), and clinical case management, where the mental health worker looks after 10 to 20 clients more intensively, in which case "chronically mentally ill clients often use case managers as an auxiliary ego" (p. 22). It is to this 'auxiliary ego' that the patient may confess the contours of her timeless trajectory. One approach is the use of time lines and life lines, the purpose of which is to "reframe experiences in a more positive way and to reconstruct memories that reflect the

accomplishments rather than the disappointments in one's life" (Quam & Abramson, 1991, p. 28). The procedure is to 'facilitate' the construction by the patient of a chart on which events are chronologically plotted, positive events above a dividing line, negative events below, thus two-dimensionalising experience on a plane described by the axes of time and affect (Figures 3.3 & 3.4).

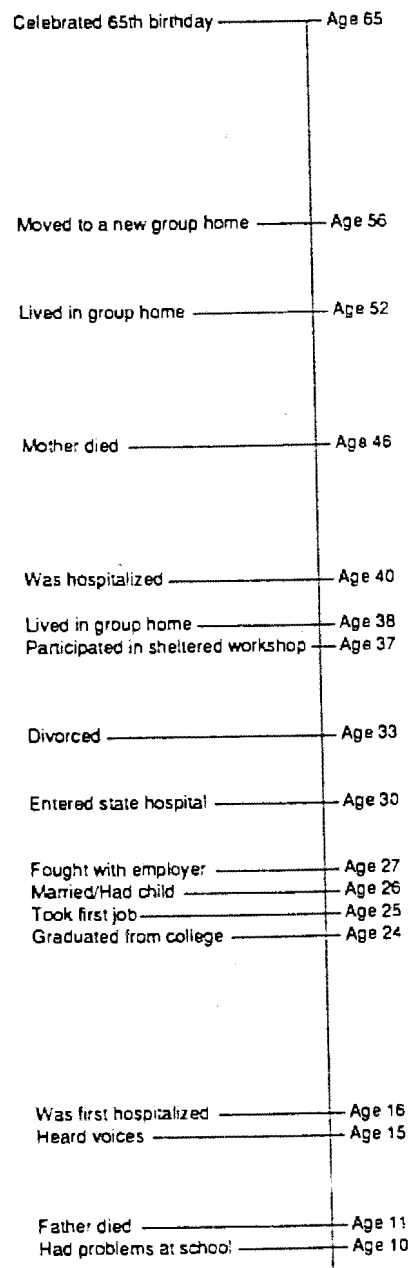
Figure 3.3 A life line (from Quam & Abramson, 1991)



Not surprisingly, apart from the obligatory reference to family and employment history (and the very occasional mention of symptomatology), these life lines trace the extended slow-motion dance between the chronic patient and the psychiatric care system which has created her. Admissions, readmissions, residence in group homes, participation in sheltered workshops - these are the stuff a life is made of. Hospital admissions and readmissions have

a particularly interesting role in this confessional. Although still plotted at the extreme negative end of the scale, they almost invariably represent a turning point for the good. As Quam & Abramson (1991) helpfully speculate, "perhaps a late-life hospitalization may lead to a more stable community placement" (p. 31).

Figure 3.4. Life line of a 65-year-old male (from Quam & Abramson, 1991)



Conclusion: Free at last

Arguing for an end to racial disparities in psychiatric service provision, Dommissie (1987) quotes Nelson Mandela's 1964 Rivonia trial speech, prior to his incarceration on Robben Island, as follows:

Africans want a just share in the whole of South Africa ... Above all, we want equal political rights, because without them our disabilities will be permanent (p. 756).

Although the equal rights agenda has not been fully achieved in either the political or the medical field, there is now for the first time the prospect of steady progress in establishing a human rights culture in South Africa. Although this is without doubt cause for celebration, it is also certain that as the mechanisms of overt repression are removed, South African society will be subjected to ever more sophisticated mechanisms of disciplinary power.

In this and the previous chapter I have tried to show how this process of modernisation has proceeded in Western psychiatry over the past three centuries. Through endlessly repeated cycles of discharge and readmission more and more individuals have been recruited into and confirmed in their status as psychiatric subjects until finally their disabilities have indeed become permanent - not in the sense that they suffer from real chronic illnesses (this may or may not be the case), but in that for many there is no longer any (real) prospect of an existence outside the world of psychiatry.

I would argue, along with Rose (1986a), that "rather than seeking to explain a process of de-institutionalization, we need to account for the proliferation of sites for the practice of psychiatry" (p. 83). This proliferation is clearly evident in the brief historical overview presented in this and the previous chapter, even though my focus has for the most part been limited to practices in some way linked to the psychiatric hospital. Also evident is a

consistent movement, despite frequent oscillations between therapeutic optimism and pessimism, towards a socialising and softening of coercive practices. At least since Pinel, psychiatry has struggled to recognise the 'human rights' of its subjects while maintaining an appropriate degree of control. Today even institutional psychiatry functions by talking of patients as 'clients' and 'consumers', by 'empowering' patients through the drawing up of 'personal plans', by giving them 'permission to regress', by asking for 'patient input' on the colour of the walls in seclusion rooms, and by encouraging patients to narrativise their lives in terms of individualised scripts. It is easy to expose such tactics as threadbare attempts at respectability from what remains essentially a coercive discipline, but this is so perhaps purely because institutional psychiatry has set itself the task of managing and reproducing difficult-to-manage individuals. The system of surveillance, confession, human rights and free choice within which the rest of us become subjectified operates with almost seamless coherence, and it is only at the outer limits of its effectiveness (such as when dealing with serious 'mental illness') that one can begin to recognise its inherent contradictions.

Outside the institution, beyond the reach even of the numerous tentacles that extend from the institution into the community, psychiatry and its allied disciplines have in the meantime found innumerable new sites of practice where they can operate in an economy of free choice and wit, out so much as a hint of scandal:

One can point, on the one hand, to the proliferation of the psychotherapeutic technologies of marriage guidance, child rearing, sexual difficulties, and the problems of everyday life and, on the other, to the ever-increasing demand for pharmacological products to assuage personal unhappiness. The contemporary psychiatric system operates predominantly through free choices made in the personal domain, in which mental health is both a private objective and a personal responsibility; the promotion

of the self is conducted through the voluntary enlistment of help from skilled technicians. Opposition to the 'coercive' aspects of psychiatry has been central to its modernization (Rose, 1986b, p. 213).

Chapter 4

Poised on the brink:

The social construction of a New Biological Psychiatry

You know the difference between a real science and a pseudoscience? A real science recognizes and accepts its own history without feeling attacked.

- Michel Foucault (1988)¹

In Chapters 2 and 3 I reviewed historical oscillations in the practical and ideological management of the insane, showing how they have been repeatedly expelled from and reinducted into an ever-more encompassing system of psychiatric care. In this chapter I consider one aspect of the 'moral confinement' into which psychiatric patients have currently been readmitted, namely the presumed somatic aetiology of the major disorders. In particular I attempt to characterise the way in which present-day psychiatrists who subscribe to this ideology position themselves between past and future.

It is common cause that the past two decades have seen the rebirth in psychiatry of an enthusiasm for somatic explanations and the pharmacological management of mental disorders. The first of the new drug treatments came on the market in the late fifties, by the mid seventies 25% of National Health Service prescriptions in Britain were for psychiatric medications (Rose, 1986a), and by the early eighties, faced with the apparent success of drug therapies academic psychiatry had fully embraced a new biological orthodoxy.

Light (1982) describes how "within a short time the leading departments of psychiatry

¹ In Martin (1988, p. 12)

left their imitators and camp followers behind as they forged a new professional identity around advances in biopsychiatry" (p. 43), while Cockerham (1981), writing at about the same time, states: "Bolstered by recent biochemical discoveries, a current view in psychiatry is that the discipline is entering a new era, possibly making psychiatry one of the most scientifically precise of all medical specialties and ending its traditional dependence upon subjective judgments of and insights into the human mind" (p. 79-80). A review (Pincus, Henderson, Blackwood & Dial, 1993) of research articles published in the two leading American journals of general psychiatry, *The American Journal of Psychiatry* and *Archives of General Psychiatry*, showed that by the early nineties Clinical Psychobiology had become the largest³² content category (25%), having risen sharply from 14.4% in 1969-70, while Social Science (12.8% to 10.2%) and Psychosocial Treatments (3.1% to 3.6%) remained more or less static.

Even psychiatrists who are not positively inclined towards biopsychiatry acknowledge its increasing predominance. Arthur Kleinman (1988), an anthropologically orientated psychiatrist, portrays the eighties as a "period of biological revanchism in psychiatry - when many psychiatrists seem[ed] to believe that understanding the biological basis of mental disorders is, if not around the corner, at most two or three streets away, and that such knowledge will be all the clinician needs to know to treat patients with schizophrenia and depression" (p. xi). He goes on to speak of how psychiatry "has been overtaken in the 1980s with a fervor for biological explanations" (p. 1) and complains that "academic psychiatry aims to become a version of high-technology internal medicine" (p. 140). The nineties, designated the 'decade of the brain' in psychiatry (Wallace, 1997), has

³² The second largest category was Diagnosis/nosology at 21.7%, with Psychopharmacology third at 17.1%.

been dominated by biological research and therapy, and there is widespread agreement that there has been a rapid expansion in understanding of the neurochemistry of the brain (Meador-Woodruff & Watson, 1997). Even at the start of the decade the American Psychiatric Association (APA) president already felt unsettled by "continuing excellent but unbalancing advances in brain biology" (Hartmann, 1992, p. 1137)³³.

These authors for the most part seem to assume that scientific advances constitute the driving force which has catapulted biopsychiatry into its currently 'unbalancing' preeminence. This is typical of 'insider' accounts of the development of science. Insiders tend to place much emphasis on the way in which scientific progress occurs through a process of verification, with incorrect theories replaced by correct ones on the basis of empirical evidence. Thomas Kuhn (1962), whose *Structure of Scientific Revolutions* has been enormously influential in casting doubt on such views, describes them as follows:

If science is the constellation of facts, theories, and methods collected in current texts, then scientists are the men who, successfully or not, have striven to contribute one or another element to that particular constellation. Scientific development becomes the piecemeal process by which these items have been added, singly or in combination, to the ever growing stockpile that constitutes scientific technique and knowledge. And history of science becomes the discipline that chronicles both these successive increments and the obstacles which have inhibited their accumulation (p. 1-2).

³³ As early as the mid-sixties Alexander and Sheldon (1966) complained of the rising new biologism: "The role of the devil now has been taken over by brain chemistry. No longer a devil but a *deus ex machina*, a disturbed brain chemistry rather than the person's own life experiences, is responsible for mental illness. Whatever the cause of faulty brain chemistry may be, the new conviction is that the disturbed mind can now be cured by drugs and that the patient himself as a person no longer needs to try to understand the source of his troubles and master them by improved self-knowledge" (p. 14). From the late sixties the National Institute of Mental Health started targeting biopsychiatric research for nearly all its funding (Light, 1982).

The kind of historiography which Kuhn seeks to debunk has been labelled Whig history, after a phrase used by the British historian Herbert Butterfield to satirise the tendency of some English constitutional historians to portray their field in terms of the continued broadening of human rights resulting from the struggle between forward-looking liberals and backward-looking conservatives (Brush, 1974). In medicine, Mishler, AmaraSingham, Osherson, Hauser, Waxler and Liem (1981) describe Whig histories as follows:

Many discussions of the history of medicine center ... on the history of ideas or on the history of people and events; they view medicine ... as the evolution and advance of important concepts and theories or as the product of key discoveries by researchers. ... These approaches tend to stay within medicine; in them its development is isolated from significant social forces outside the profession. Their implication is that the way medicine developed is the only way in which it could have developed, and - 'should' replacing 'could' - that medicine has been a constant advance of 'better' theory and practice (p. 244-245).

Since Kuhn, many philosophers, sociologists and historians of science have been active in criticizing such justificatory histories and substituting more 'accurate' accounts of their own (cf. Woodward, 1986; and, for psychiatry, Allderidge, 1990; MacDonald, 1990; Miller, 1986; Scull, 1991b; Vander Weersch, 1991), but perhaps more interesting and logically prior to identifying the forces which 'really' shape science, is simply describing the rhetorical and other devices used by scientists themselves to construct the unfolding of their disciplines (Gilbert & Mulkay, 1984). Doing just that, Scull (1991b) describes the general form of Whig histories in psychiatry as follows:

Psychiatric history was here cast as a morality tale, a movement from the dark period when lunacy was not seen as a condition requiring medical treatment, through a

drawn-out struggle in which the steady application of rational-scientific principles by people of good will produced halting and irregular but unmistakeable evidence of progress towards humane and effective treatments for those afflicted with the various forms of mental alienation - a process supposedly culminating in our present state of grace (p. 240).

The philosophical implications of describing science, and particularly psychiatry, in such constructivist terms will be considered in more detail in the next chapter. This chapter has the more limited aim of appraising the ways in which biologically oriented psychiatrists view the past and future of their profession. To distinguish the biopsychiatric movement which has flourished since the late fifties from previous periods of biological dominance in psychiatry, I label it the New Biological Psychiatry (NBP) and identify three distinctive features of the NBP's emerging historiography:

1. Scientific discovery is viewed as the primary mechanism of historical progression;
2. Psychiatry is presented as having only recently emerged from a period of superstition;
and
3. The NBP has strongly millenarian overtones.³⁴

The first characteristic is shared with science and medicine in general, while the second and third appear to be specific to the NBP. The chapter concludes with a consideration of the prospects for a new anti-biopsychiatry.

³⁴ Birley (1990) labels the current somatic phase 'optimistic' or 'manic' organic theory, and cautions that it is liable to be followed by a pessimistic or depressive side.

'Specific questions of fact': The logic of scientific discovery in psychiatry

In a lecture at London's Maudsley hospital³⁵, provocatively titled "Biological Psychiatry: is there any other kind?" Samuel Guze (1989), senior professor at a leading American medical school, spelled out the credo of the New Biological Psychiatry: All good psychiatry is necessarily biological. "Psychiatry," said Guze, "is a branch of medicine, which in turn is a form of applied biology. It follows, therefore, that biological science, broadly defined, is the foundation of medical science and hence of medical practice" (p. 319). Political, religious and philosophical objections to this kind of reductionism are easily dismissed because they are not scientific and, in any case, can themselves be reduced to biology. "I believe," said Guze, "that continuing debate about the biological basis of psychiatry is derived much more from philosophical, ideological and political concerns than from scientific ones ... We will increasingly be thinking and discussing specific questions of fact and their interpretation rather than argue about ideological matters as substitutes for scientific discourse" (p. 322). Thus in the minds of some biopsychiatrists at least philosophy is lumped together with the presumably equally subjective and wordy enterprises of religion, ideology, politics and psychology, and opposed to the 'specific questions of fact' which is the realm of science.

This is Whig history at its best, and if it differs from scientific and psychiatric historiography in general, it is perhaps only in degree. In essence the story remains a tributary of the main medico-scientific tale in which enlightened doctor-scientists gradually, through the painstaking accumulation of facts, overcome the forces of intolerance and superstition. Classics of psychiatric historiography such as Zilboorg & Henry (1941) and Alexander & Sheldon (1966) give dramatic accounts of that great, mythical, upward sweep of

³⁵ Later reprinted in *Psychological Medicine*.

humanism and science with which psychiatry has always wished to align itself. The New Biological Psychiatry simply believes even more firmly that an adherence to medical and scientific principles can guarantee for the discipline an ever-upward trajectory from past to future. The word 'progress' leaps out at one from the pages of biopsychiatric texts; it is used no fewer than five times on the first page of Trimble's (1988) authoritative handbook of biological psychiatry.

The irony is that biological psychiatry, perhaps more so than most branches of medicine, has progressed not through rational enquiry and evolutionary growth, but as a result of serendipitous discoveries. The following is an incomplete list of somatic treatments which, by common consent, were arrived at serendipitously:

Electroconvulsive treatment was introduced by Cerletti and Bini on the apparently mistaken theoretical grounds that psychosis and epileptic convulsions are mutually exclusive. Only when the treatment failed with schizophrenic patients, did they extend their trials to include those with affective disorders.

Cade (who afterwards styled himself as 'a little known psychiatrist with no research training'³⁶) stumbled on lithium treatment for mania in the course of testing his theory that manic patients are intoxicated by an excess of naturally-occurring substances (such as lithium) in the body. On observing lithium's sedative effects, Cade revealed his theory, now speculating that mania is caused by a lithium *deficiency*. However, this theory appears also to have been wrong, and as with electroshock, "the mode whereby it exerts its effects in psychiatry remains unknown" (Kiloh, Smith, & Johnson, 1988, p. 69). Colp (1989) tells another version of the story, namely that Cade thought mania was caused by an excess of natural metabolites (such as urea and uric acid) and that since lithium had been used in

³⁶ As quoted in Kiloh, Smith and Johnson (1988).

medical conditions in which these metabolites were elevated, he speculated that it might also help for mania. It was only when he injected guinea pigs with lithium that he noticed that it produced drowsiness and might for that reason be useful in mania. Cade (1949) himself said he wanted to see if uric acid would *enhance* the toxicity of urea, which he had injected into guinea pigs, apparently with the purpose of bringing about convulsions in the course of research on epilepsy. "The great difficulty was the insolubility of uric acid in water, so the most soluble urate was chosen - the lithium salt" (p. 350).

Chlorpromazine (CPZ), the first major anti-psychotic, was first synthesised in 1883 by a chemist analysing chemical dyes, rediscovered in 1937 in the course of searching for a synthetic antihistamine to counteract allergic shock, tested in 1944 as an antimalarial drug, and in 1951 as a tranquilliser for surgical patients (where it was thought to induce "artificial hibernation"; Johnson, 1990). In 1952 Jean Delay and Pierre Deniker reported that CPZ affected mood, thinking processes, and behaviour in psychotics. It was consequently tried first on manic, and later on agitated schizophrenic patients. Iproniazid, the first of the monoamine oxidase inhibitors was initially used in the treatment of tuberculosis, where it was noticed to have mood-elevating properties. Imipramine, on the other hand, being an analogue of chlorpromazine, was on theoretical grounds expected to have value as an antipsychotic, and only when its clinical effects were found to be different from chlorpromazine was it tried on depressed patients. Moprobamate (Miltown), the first of the now notorious minor tranquillisers such as Librium and Valium, was stumbled upon in the course of animal-testing for new antibacterial drugs, where it was observed to relieve tension. And so on.

Of course attempts at linking the history of biological psychiatry to the logic of scientific enquiry differ in sophistication. Kiloh, Smith and Johnson's (1988) historical

introduction to their standard text on physical treatments in psychiatry is possibly the most detailed account yet given by biopsychiatrists of the historical development of their discipline. Their technique is first to describe with great candour the various inhumane and senseless treatments which have been the province of biopsychiatry, and then to point out how each became discredited through rational scientific research.

Thus their readers learn how "the most pervasive and dangerous aetiological invention of the twentieth century" (p. 6), focal infection, and its treatment by the removal of teeth, tonsils, reproductive organs etc. reigned supreme until Kopeloff and Kirby demonstrated in a controlled study that more of the controls survived³⁷. Similarly, the insulin therapy vogue held sway, one is told, until Ackner and his colleagues published their double-blind controlled trial which showed that insulin coma was no more effective than barbiturate-induced coma. Acetylcholine treatment was long administered to schizophrenic and later neurotic patients, but fortunately Pare and others eventually carried out controlled trials in which they demonstrated that equal numbers improved on active treatment and placebo. Carbon dioxide was used in neuroses, anxiety states and hysteria with initial positive results, but "it was left to Hawkings and Tibbets ...to conduct a clinical trial" (p. 10) in which they demonstrated equal efficacy for inhalations of compressed air.

Another example of this kind of presentation is Colp's (1989) version of how chlorpromazine got to be an accepted drug: "In 1964, a double-blind study by the National Institute of Mental Health, which compared the clinical effects of placebos, chlorpromazine, and two other antipsychotics, when each was administered to hospitalized patients, scientifically demonstrated the effectiveness of the antipsychotics and established guidelines

³⁷ In fact contradictory findings were repeatedly ignored or suppressed. See Scull (1990) for a detailed history.

for the future clinical evaluation of psychoactive drugs" (p. 2141). However, Johnson (1990) has shown that the drug came to be used on a massive scale *before* any controlled studies had been done. Moreover, in their review, Wyatt, Apud and Potkin (1996) could find only nine studies that had ever been done comparing first hospitalisation schizophrenic patients given antipsychotic medications with a control group given other treatments. Even among these studies many were not carefully controlled and only two of the nine "found that patients initially given antipsychotic medications did significantly better than those given nonsomatic treatments" (Wyatt, Apud & Potkin, 1996, p. 362).

Kiloh, Smith and Johnson (1988) admit that scientific refutation was not always immediately followed by the clinical abandonment of a treatment (as for instance with the hard-to-eradicate treatment of focal infection) and that treatments may also have been abandoned simply because more convenient or apparently better treatments came along (as in the case of insulin coma treatment which got overtaken by reserpine and chlorpromazine). However, the overall implication is that it was primarily rational scientific research which has weeded out useless and harmful treatments.

This dressing up of the facts encourages practising psychiatrists to assume that convincing scientific refutation of the efficacy of any currently used treatment or theory will soon enough result in its abandonment by the psychiatric establishment. This is so not only for 'true believers', but also for those such as Charlton (1990) who are highly critical of the New Biological Psychiatry. Charlton believes that biological psychiatry is poised on the brink of a paradigm crisis: "when inconsistencies begin to build up, when good predictions are not forthcoming: when, in other words, things are not working as well as they used to" (p. 6). While there inevitably will be inconsistencies and failed predictions in the biopsychiatric literature, there is little evidence that this is leading to a loss of nerve.

An example is Mellon's (1989) review of genetic linkage studies in bipolar disorder. Once the great hope of biopsychiatric research, linkage studies have increasingly run into difficulties, leading Mellon to conclude that "after 20 years and approximately 30 studies, the status of the bipolar linkage field has not changed much" (p. 155) and that "lack of replication in the field has contributed to a growing skepticism about the usefulness and reliability of the linkage study approach in psychiatric illness" (p. 154). However, despite these devastating conclusions Mellon does not hesitate to add: "Yet it still holds great promise for answering basic questions of etiology and diagnosis" (p. 155).

Similarly Murray, Kerwin and Nimgaonkar (1988) suggest, from their review of the biology of schizophrenia, that "the reader may conclude that the neurochemical findings we have reviewed represent a meagre reward for 25 years of effort" and that the last decade has seen nothing more than "modest progress in understanding the biology of schizophrenia" (p. 176). Nevertheless they remain hopeful that the apparent confusion in the theorising about the neurochemistry of schizophrenia will soon be resolved by the discovery of "some primary but unknown abnormality" (p. 176) in the neurochemistry of schizophrenic brains. Wyatt, Apud and Potkin's (1996) review of the treatment of schizophrenia is equally unenthusiastic about the current state of play (treatments are 'at best palliative', genetic findings are 'tentative' and 'nonspecific'), but hopeful for the future: "Our knowledge continues to grow ... Improved care is on the horizon" (p. 366-367).

A final example: When Harrow, Goldberg, Grossman and Meltzer (1990) found that one of the most taken-for-granted 'facts' in psychiatry, the supposed prophylactic efficacy of lithium carbonate in mania, could not be demonstrated in clinical practice, they did not consider it necessary to question the idea of mania as a condition amenable to biological management or to suggest that the neurochemical theory (such as it is) of mania needs to be

revised. Instead, their proposals were limited to practicalities: The use of alternate drugs such as carbamazepine should be explored and blood lithium levels should be monitored more assiduously.

In a closely argued and carefully documented study suggestively titled *The structure of psychopharmacological revolutions*, Healy (1987) demonstrated that "the catecholaminergic hypotheses of depression and dopaminergic hypotheses of schizophrenia³⁸ appear irrefutable. While apparently testable, negative evidence to date has had little effect and there is almost infinite scope to resist refutation" (p. 367). Much research in the field appears to operate on "the assumption that amines *will* be found to be deranged in the affective disorders despite the evidence ... that the original pharmacological basis for the expectation no longer warrants an exclusive focus on amines" (p. 359). He concludes that, like the Oedipal hypothesis in psychodynamic psychiatry, these hypotheses will never be refuted, no matter how overwhelming the weight of contradictory evidence, but will at best fade away as psychodynamic psychiatry faded away when research interest moved on to other fields.

'A strange antirational period': Discounting the recent past

A catalogue, such as that presented above, of how biological psychiatry has remained unmoved by 'specific questions of fact' prompts a sceptical response to claims by Guze (1989) and others that psychiatry has loosened itself from the fetters of philosophy and will henceforth operate along strictly scientific lines. A tendency to oversell the internal coherence of research work is not however by any means unique to biological psychiatry, and

³⁸ Wallace (1997) terms it "the hallowed dopamine hypothesis" (p. 93).

equally damaging accounts have been given for instance of biology (Meyers, 1990) and physics (Gross, 1991).

Like other scientific historiographies, that constructed to explain and justify biopsychiatry also locates speculative, philosophical and superstitious behaviour in the discipline's past, with rational and scientific approaches supposedly becoming more prominent as one approaches the present³⁹. Critical historians of science have argued that "preconceptions of science as necessarily antagonistic to superstition [have] resulted in a misperception of historical data" (Kirsch, 1980, p. 359), and that the passage of time has rendered practices such as a belief in demonology and witchcraft sufficiently exotic that it is easy to forget that they were once considered established fact by such scientific luminaries as Copernicus, Kepler, Napier, Boyle and Newton.

What is rather special about the New Biological Psychiatry, however, is that it places the era of superstition not in the sixteenth or seventeenth centuries, but only two or three decades away. The culmination of these superstitious tendencies was, so the story goes, the deinstitutionalisation debacle of the 1960s and 70s. Cancro (1989) speaks of "this strange antirational period of massive denial and grandiose expectations" (p. vii) and of the "near delusional beliefs" of those psychiatrists who participated in it. Deinstitutionalisation's failure appears to represent a powerful warning that to trivialise mental illness as anything other than a serious biological disease is to advocate the gross neglect of psychiatric patients. Thus Trimble (1988) feels compelled to explicitly warn fellow biopsychiatrists against again becoming "submerged and lost in a quagmire of new, old or revived psychological theorising" (p. xii).

³⁹ As Colp (1989) puts it: "One comes away with a fresh appreciation of the great differences between ancient and modern - notably, the recent dramatic progress in the diagnosis and treatment of most psychiatric diseases" (p. 2143).

To make things worse, psychiatry is presented as having lost its head not only for a decade or so after the 1960s, but for the better part of a century. The trouble started, as Trimble (1988) explains, with "psychological theorizing, which arose on the neoromantic tide of the turn of the century. This culminated in the psychoanalytic movement, which for a considerable time became synonymous with psychiatry" (p. xi). This 'considerable time' lasted from the 1920s until well into the 1970s, a fact which historians of the New Biological Psychiatry believe should be seen in the context of a much longer period of relative sanity: "this era has provided psychiatry with a legacy that it does not deserve, the main trend of the tradition for over 2000 years being medical and neuropathologically based" (Trimble, 1988, p. xi-xii). It is doubtful if any other scientific discipline, medical or otherwise, has had to admit to such a sizeable recent dip in what is usually presented as the steadily rising line of scientific conquest, and in this respect the New Biological Psychiatry clearly differs from psychiatry in general.

Another curiosity is that the main physical treatments in psychiatry, the treatments which have given biopsychiatry such a central place in everyday psychiatric practice, were instituted not before or after the 'strange antirational period', but while it was still in full swing: Electroshock in 1938, lithium in 1949, chlorpromazine in 1952, and imiprimine in 1958. Cancro (1989) explains this anomaly by presenting biopsychiatric research as an ongoing enterprise which, although periodically repressed, continued with the painstaking task of scientific knowledge accumulation:

The period was primarily dominated in America by psychoanalytic thinking.

Biological studies were going on, but they were not in the mainstream. It was not until the mid-1950s, with the introduction of pharmacologically effective compounds, that American psychiatry began to move into the pantheon of medicine. Despite this

scientific movement of the 1950s, the exuberance of the 1960s swept much of the previous rational enquiry and evolutionary growth aside (p. vii).

Is it true that psychiatry has just returned from a half-a-century long psychoanalytic detour in the course of which it lost contact with the grand old traditions of its biomedical past, or are both the detour and the grand old traditions New Biopsychiatric inventions?

That psychoanalysis had a certain prestige in psychiatry in the period from the 1920s to the 1970s, and that it in turn conferred a degree of prestige on the psychiatric profession, cannot be denied. However, it is clear that somatic views of mental illness were by no means discounted. Among the more horrific treatments advocated and administered by biopsychiatrists during the 'neoromantic' period are pre-frontal lobotomy, of which over 50 000 had been performed by the mid-fifties and hydro-therapy, which (in one of its variations) required that patients be kept tightly cocooned for up to four hours in sheets which were regularly drenched, first with cold and then with hot water. Then as now, it was only a small minority of hospitalised patients who were ever psychoanalysed. For the vast majority of hospitalised patients the facts of psychiatric life revolved around closed wards, restraint, and somatic treatment.

Two textbooks for lower-level psychiatric personnel published on the eve of institutionalisation are suggestive of the things omitted from biopsychiatric accounts of what we are asked to believe was a neoromantic/psychoanalytic interregnum. Rodeman (1956) starts her guide for American psychiatric aides with the following confident assertion, so very reminiscent of latter-day biopsychiatric statements: "The history of the care and treatment of psychiatric patients reveals that this care has progressed from abuse and punishment in the early days to the present-day care and treatment based on scientific knowledge and understanding of human behaviour" (p. 1). She goes on to advise aides to

bear in mind that psychiatric patients perspire more than ordinary people, to never show either approval or disapproval of patients' behaviour ("remember always that he is ill and that his behaviour is a symptom of his illness"; p. 13), and so on. Much attention is given to the mechanics of preparing patients for insulin coma therapy and hydro-therapy, and aides are repeatedly urged to "reassure the patient and emphasize that this is a treatment," (p. 44) and to "avoid any details of the treatment which might frighten the patient" (p. 98). In case there are some aides who harbour doubts of their own, Rodeman is quick to reassure them: "It is not yet known how the insulin coma produces improvement in the patient, but improvement occurs in all aspects of his personality" (p. 97).

The second textbook, by Houlston (1955), matron at Crichton Royal Mental Hospital at Dumfries, was written for British psychiatric nurses, but the picture she paints is very similar. Confinement, seclusion, supervision of patients with 'tendencies to wander or escape' - these are presented as the stock in trade of a nurse's life in a mental hospital. Psychotherapy gets just more than a page, in which the reader is informed that it has two varieties: Suggestion and Persuasion. All-in-all Houlston is as confident as Rodeman that science is still carrying us all upwards and forwards and that things are much better now than they were in the bad old days: "The modern treatments available to mental patients include such things as electro-shock, insulin therapy, prolonged narcosis, hydro-therapy, occupational and recreational therapy, the various forms of psychotherapy, and prefrontal leucotomy, the brain operation recently introduced in psychiatry with success" (p. 7).

Rodeman and Houlston's textbooks were chosen for purposes of illustration, but are not unique. A similar ethos for instance pervades Ingram's (1949) *Principles of Psychiatric Nursing* and Altschul's (1957) *Aids to psychiatric nursing*, although Trick and Obcarskas' (1968) more recent *Understanding Mental Illness and its nursing* is perhaps not quite in the

same category. A somatic orientation towards mental illness during the 'neoromantic' period is not confined to nursing texts either, as is demonstrated by the preface to the sixth edition of Henderson & Gillespie's (1944) *Text-book of psychiatry* in which they state that: "The dramatic successes attained by methods of physical treatment, such as those conducted by chemically or electrically induced convulsions and by surgical division of the white matter of the frontal lobes, have prompted us to add a special chapter on these triumphs of empiricism" (p. vii).

Interestingly, both Rodeman and Houlston have historical introductions in which psychiatry's imagined progression from superstition to science is mapped out. Houlston's historiography is particularly interesting in that she divides psychiatric history into various eras ('demonological', 'political' and so on), locating the then present firmly in the scientific era. Ironically this era is said to have started with the dawn of the twentieth century, just at the precise moment that Trimble (1988) sees the 'neoromantic tide' coming in.

If the story about psychiatry's neoromantic aberration is illusory, what then about the grand-old-tradition story? The short answer to this question is that, with the exception of clearly organic brain syndromes such as Alzheimer's disease and General Paralysis of the Insane (cerebral syphilis), which as early as 1822 was understood to be a physical disease and by 1909 "had moved from the stormy waters of psychiatry into the safe harbor of neurology" (Gilman, 1988, p. 211), the neurological basis of mental illnesses remains unexplicated. Similar views have been expressed by Kleinman (1988) and Kleinman and Cohen (1997). Kleinman (1988) states the case quite bluntly:

There is still, after more than 30 years of intensive biological investigation, no clear-cut understanding of the biology of schizophrenia ... This does not deter psychiatrists and those who write the advertisements for drug companies from

asserting without any hesitation that schizophrenia is a biologically based disorder.

This belief is a central tenet of professional orthodoxy (p. 188).

Trimble (1988) is probably correct in stating that the main trend in psychiatry over the past 2000 years has been neuropathological, but unfortunately there is little in this tradition, except for its general sentiment, which is of much use to modern biopsychiatry. Hippocrates and Galen may have set an example in their insistence that mental illness has a somatic origin, but their aetiological ideas concerning the correct mixture of phlegm, bile and so on now seem fanciful. The same goes for the seventeenth century British biopsychiatrist Thomas Willis, the details of whose theory relating to animal spirits circulating through the cortex are of course no longer accepted. The list goes on: Griesinger (insanity is caused by changes in circulation, nervous irritation or disturbed nutrition); Morel (insanity is a hereditary form of 'degeneration'); Foville (neuroses are localised nervous system diseases).

It is instructive to look at the original texts of some of these great figures from the prehistory of biopsychiatry, for instance that of James Prichard (1837). Prichard is mainly famous for creating the now-defunct disease of moral insanity "consisting in a morbid perversion of the natural feelings, affections, inclinations, temper, habits, moral dispositions, and natural impulses, without any remarkable disorder or defect of the intellect or knowing and reasoning faculties, and particularly without any insane illusion or hallucination" (p. 16). The great danger in moral insanity is that "persons labouring under this disorder are capable of reasoning or supporting an argument upon any subject within their sphere of knowledge that may be presented to them; and they often display great ingenuity in giving reasons for the eccentricities of their conduct, and in accounting for and justifying the state of moral feeling under which they appear to exist" (p. 21). A typical example of moral insanity would be a previously submissive adolescent girl who runs away from home or a housewife who

questions her husband's authority; and for many decades after the publication of Prichard's book the concept of moral insanity was referred to by psychiatrists making commitment decisions.

Although it was accepted that social and psychological factors could play a role in moral insanity, at root it always had a physiological cause: the person's inherent 'temperament', a 'natural predisposition', or perhaps "some disorder affecting the head, a slight attack of paralysis, a fit of epilepsy, or some febrile or inflammatory disorder" (p. 21). And what is to be done about insanity, moral or otherwise? Prichard endorses the whole plethora of what now appear to be wilfully cruel and senseless treatments: bleeding, cold showers, purgatives ("no fact in medical practice has been longer established than the utility of purgatives in madness"; p. 195), emetics, digitalis, opium, mercury and the rotating chair.

'A thing of the past': Millenarian qualities of the New Biological Psychiatry

In his foreword to Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* Robert Cancro (1989) refers to "this brief historical summary" (p. vii). However, the preceding two paragraphs are historical only in the sense that they rehearse the by now familiar idea of an irreconcilable difference between 'theological' intuition and rational science. Instead, pride of place goes to Neural Science (Chapter 1) and Neurology (Chapter 2), with history relegated to the last 21 pages of the two volume work.

This was not always the case. Stepping back a mere decade one finds that the third edition, published in 1980, opened with a lavishly illustrated historical chapter by George Mora, spread over 94 pages. By the fourth edition, five years later, this had been cut to 20 pages and moved to the end of the book, although the opening chapter still tackled

'theoretical trends' in psychiatry. The fifth edition, as mentioned, gets straight to business with Neural Science and Neurology; and the history chapter at the end, no longer by Mora, has degenerated into a lack-lustre catalogue of great men and their achievements. The most recent, seventh edition of Kaplan & Sadock (Kaplan, Sadock & Grebb, 1994) has no separate history chapter and opens with a full-colour guide to commonly prescribed drugs.

Why have history's shares, as reflected in the 'bible' of American psychiatry, dropped so precipitously over the past two decades⁴⁰? At one level it is no doubt simply a matter of space. To accommodate the mass of new material being produced in fields such as brain imaging and neurochemistry it is only natural that 'old-news' items such as history and philosophy should be jettisoned. At another level it is an ideological shift which requires that psychiatry distances itself from aspects of its own history in order to 'make itself anew'. This is essentially the same conclusion as that arrived at by Foucault (1980), who asks:

Why should an archaeology of psychiatry function as an 'anti-psychiatry', when an archaeology of biology does not function as an anti-biology? Is it because of the partial nature of the analysis? Or is it not rather that psychiatry is not on good terms with its own history, the result of a certain inability on the part of psychiatry, given what it is, to accept its own history? (p. 192)

The gradual silencing of history's voice in the halls of biopsychiatry is not due to a loss of faith in the essentials of psychiatric historiography (progress through rational scientific discovery), but to a certain discomfort with regard to that history. There is little that the NBP can do with psychiatric history before 1955, except to warn against the dangers of

⁴⁰ As reflected also in psychiatric training: "The subject has been largely dropped from the Royal College of Psychiatrists' examination curriculum, has no academic base within the psychiatric establishment, and little following among the younger generation of more 'scientific' psychiatrists" (Turner, 1990, p. viii).

unscientific theorising, or to show that for a very long time psychiatrists have believed in organic aetiologies and treatments of one sort or another despite the lack of empirical warrant.

For biopsychiatry the past is shrinking while the future is looming ever larger. The little history chapter at the end of the fifth edition of Kaplan and Sadock is called "Psychiatry: Past and Future", and from the 'future' section we learn:

The good news is that, because of progress both in scientific understanding and in clinical practice (all of which is likely to continue at the present brisk pace), the public will increasingly see mental illness as illness and psychiatrists as physicians who treat mental illness - more and more effectively. The stigma that was once attached to the psychiatric profession is likely to become, fairly soon, a thing of the past (Pardes, 1989, p. 2157).

Pardes may well be right. Popular magazines such as *Time* and *Scientific American* and television programs such as *Beyond 2000* increasingly reproduce biopsychiatric orthodoxies regarding the aetiology and treatment of syndromes like schizophrenia and the major affective disorders. They also reproduce the promissory notes which biopsychiatrists almost routinely append to the end of their research reports. This is how, for example, Gershon and Rieder (1992) conclude their *Scientific American* article: "We expect our understanding of the biology of schizophrenia and mood disorders to expand dramatically, fuelled by the impressive advances in neurobiology, cognitive neuroscience and genetics" (p. 95).

Similar expressions of hope and expectation are very common in the professional literature. Some examples from genetic studies: "There is good evidence, especially from studies of twins and adopted children, that genetic factors are important in minor psychiatric disorders ... the recent tentative location of genetic sites associated with manic-depressive

psychoses gives hope that such sites may also exist, and be found, for the cyclothymic and dysthymic traits" (Hare, 1991, p. 44). "Once a gene is identified a whole new era will begin" (Mellon, 1989, p. 155). "It seems likely that if major genes operate on schizophrenia, these will be identified in the next few years" (Murray, Kerwin & Nimgaonkar, 1988, p. 176). "We can be confident that, if genes of major effect are involved reasonably commonly in the aetiology of schizophrenia, they will be detected and localised during the next few years" (McGuffin, Owen & Farmer, 1995, p. 681).

Despite the passing of each successive 'next few years' the putative genetic mechanisms behind schizophrenia and other psychiatric disorders continue to remain elusive, and much the same is true concerning a viable theory of the neurochemical mechanisms involved, and of the effects of psychotropic medications (Wyatt, Apud & Potkin, 1996). Ingleby (1981) speaks of "the myth which helps to keep orthodox psychiatry on the move: the belief that what we need are simply more 'findings' - that round the corner lies some vital new fact which will settle the arguments once and for all" (p. 23). While persuasive evidence may yet become available in the 'next few years' (for instance from the human genome project), the New Biological Psychiatry has manoeuvred itself into a position where a post-millennarian scenario, in which it becomes evident that the arguments will not or cannot be settled, is at least conceivable.

'More than a science': The new anti-biopsychiatry

At the start of the chapter it was mentioned that not all psychiatrists and other mental health workers are equally comfortable with biopsychiatry's successes. In an article in the *British Journal of Psychiatry* Robert Cawley (1993), emeritus professor of Psychological Medicine

at the University of London, argues that psychiatry is more than a science - more even than an applied science - and that certain aspects of the assessment, management and prognosis of mental illness can therefore not be reduced to (or deduced from) scientific findings. Like other practitioners of a possibly embryonic new anti-biopsychiatry Cawley is circumspect in his criticism. A formula commonly used in this emerging literature is to start by acknowledging the achievements of biopsychiatry up front. Thus already in the second paragraph Cawley (1993) talks of "the neurosciences, in which we have seen staggering advances in the last couple of decades" (p. 154). Similarly, Gabbard (1992) in his rear-guard defence of psychodynamic psychiatry refers in the first sentence to the "remarkable discoveries from the neurosciences [which] fill the pages of our journals" (p. 991); Person (1989) starts his argument against mindlessness in psychiatry by admitting that "psychoanalysts cannot ignore the biological revolution that has occurred in academic psychiatry" (p. 182); Hartmann (1992) refers to "continuing excellent but unbalancing advances in brain biology" (p. 1137); while Wallace (1997) speaks of the "gargantuan literature" in the field of biopsychiatry and the "tremendous scientific and clinical fruit" (p. 92) borne by this branch of the discipline.

Such attempts to downplay differences occur throughout nominally critical texts now found in psychiatric journals. Cawley (1993) readily admits that psychiatry is a science, asking only that we don't forget that it is also *more* than a science, while Gabbard (1992), who argues not against biopsychiatry, but against "the 'either-or' polarization of the psychodynamic and the biological" (p. 991), strenuously attempts to blend the discourses of neuroscience, psychodynamics and behaviourism, as exemplified by the following:

Painful events, such as separations and losses, early in life may sensitize receptor sites, leading to vulnerability to recurrent depression in adulthood ... ideas and images

associated with depressive states could ultimately act as conditioned stimuli capable of eliciting a major depressive episode without a concrete loss or external stressor in the environment (p. 992).

While speaking of subjective early childhood experiences and receptor sites in one breath may at first seem strange, it is a distinct possibility that an amalgamation of bio- and psycho-jargon may become common in psychiatric circles, with the language of neurology gradually taking on metaphorical meanings, particularly if a hard scientific understanding of mental disturbance continues to elude researchers.

Sensitive to the requirements of the times, Shevrin (1988) attempted to imbue psychoanalysis with neuroscientific respectability, and neuroscience with psychoanalytic meaning, using what might previously have been seen as absurd methods such as event-related potentials to prove the existence of the unconscious. Another example in this genre is Post's (1992) work, which attempts to straddle the gap between the literatures on psychosocial stress and neurological deficits in affective disorders, with formulations such as the following being common: "[social] stressors and the biochemical concomitants of the episodes themselves can induce the proto-oncogene c-fos and related transcription factors, which then affect the expression of transmitters, receptors, and neuropeptides that alter responsivity in a long-lasting fashion" (p. 999).

Abroms (1993) describes at length how he reconciles psychodynamic and biological approaches in his psychiatric practice, devoting entire chapters to topics such as "staging the treatment" and the "dynamics of drug therapy", pointing out, in terms reminiscent of moral treatment, that "therapists may have to work hard to become better attuned to the patient's special needs, to provide the support and tenderness that enlists cooperation, and the caring firmness that curbs rebellion" (p. 160). According to Abroms, without such precautions drug

treatment may fail due to psychodynamic factors such as 'performance anxiety', 'castration anxiety', 'oral rage', the 'incest taboo', and 'fear of penetration'. A case study of "Carla, the lonely, divorced patient" ends as follows:

Her psychotic mother was so poisonous that Carla regarded all gifts of food or medicine emanating from a parental figure as bad milk. After much reassurance and insight, she was finally able to swallow her antidepressant and let it work (p. 169).

While most biologically oriented psychiatrists would perhaps balk at using this kind of formulation, they are happy to concede that the giving of medication has to be seen in a psychological and social context: "We are fully aware that current biological treatments work best when they are combined with psychosocial intervention, and expect that future biological treatments will also involve appropriate nonbiological considerations" (Wyatt, Apud & Potkin, 1996). In addition to suggesting that therapy might help pills to work, it is equally commonly suggested that the relationship between the two modes of treatment runs the other way around. Cooper (1989), for example, says that "in instances in which an underlying biologic malfunction is suspected, there is powerful warrant to attempt a biologic intervention that may then facilitate psychological interventions" (p. 209). Alternately a peaceful coexistence may be achieved by carefully demarcating separate professional and philosophical territories for mind and brain: "Psychoanalysis is a powerful instrument for research and treatment, but not if it is applied to the wrong patient population" (Cooper, 1989, p. 216).

Where the new anti-biopsychiatry offers alternatives to hard-core biopsychiatry these tend to be quite low-key and bland, a far cry from the strong medicine once prescribed by antipsychiatrists. Cawley's (1993) list of those aspects of psychiatry which are beyond science include, for example: individuality, subjectivity, self awareness, interpersonal

processes, empathy and communication. Since, according to Cawley, these are the "six, and only six, crucial aspects of our discipline which are in principle unrelated to the basic sciences and yet are central to what we are doing" (p. 155), one must assume that such stocks in trade of antipsychiatry as free will, morality, and creative deviance are amenable to scientific treatment, not crucial aspects of psychiatry, or not central to what psychiatry is doing.

It may in fact be overstating the case to claim that such a thing as the new anti-biopsychiatry exists, even in embryonic form. The impression of important scientific advances having been made in the last three decades, and of even more important advances being imminent and inevitable, is so strong that all can now afford to be magnanimous in allowing diverse views a place in the psychiatric sun.

American Psychiatric Association (APA) president Hartmann's (1992) appeal for a return to Engel's (1979) biopsychosocial model is perhaps more typical of the discourse one can continue to expect from psychiatry than the Guze's (1989) polemical biologism. Joseph English (1992), then APA president-elect, called for balance and tolerance in the mind-brain debate and praised the average psychiatrist as "the most tolerant of medical specialists" (p. 1142). This is the kind of middle-ground discourse where psychiatrists and psychiatric commentators have long been accustomed to meet. Both Arthur Kleinman (1988) and Sander Gilman (1988), neither of whom are anywhere near the psychiatric mainstream, can for instance be seen to be calling for much the same thing as the APA president: "The extreme relativism of some antipsychiatry anthropologists is as outrageously ideological as is the universalistic fundamentalism of some card-carrying biological psychiatrists" (Kleinman, 1988, p. 33); "I find the middle ground - where culture and biology reciprocally interact - the best vantage point from which to make sense of the cross-cultural data base and to avoid the

excesses of its extremist neighbors" (Kleinman, 1988, p. 187). Or Gillman (1988):

Such writers as Thomas Szasz and R.D. Laing began to see mental illness as an artifact of society. Then the resurgence of a biologically oriented psychiatry in the past decade has led to the illusion that mental illness is simply an artifact of biology. Both views ignore the fact that the *idea* of mental illness structures both the perception of disease and its form (p. 18-19).

To the extent that a new anti-biopsychiatry might therefore exist, it is at most an attempt to tone down the shrillness of extreme biological positions, and to ensure that the baby is not thrown out with the bath water. At the same time, it provides a back door for psychiatry should the strong biological programme not deliver on its promises. Rather than a millennial religion, prone to falling apart when its prophecies are not fulfilled, the New Biological Psychiatry may have the capacity to expand back into psychosocial territory should this prove necessary. Wallace (1997) explains how such a feat could be justified:

A species-specific physiology, ethology, and ecology of *Homo sapiens* must encompass the image- and symbol-laden dimensions of both personal experience/behavior and its sociocultural surround. In short, the naive and energy-wasting warfare between "biological" and "psychosocial" psychiatrists is founded on a breathtakingly constricted construct of human biology and on an unacknowledged "mind" - "body" split (p. 90).

Drob (1989) identified six possible ways for psychiatry to deal with theoretical diversity, of which three seem to describe the positions reviewed in this chapter: Relativism ("The emergence of a single dominant paradigm for psychiatry, if it occurs at all, will be determined by historical, economic, sociological, and other nonscientific factors", p. 63 - i.e., the traditional outsider historiographical position), commensurability (the best theory will

win - i.e., the 'hard' biopsychiatric position) and reductionism (different modes of understanding can ultimately be translated into each other - i.e., the new anti-biopsychiatry or the 'soft' pro-biopsychiatric position).

A new scientific language for psychiatry, which may create the conditions for using apparently hard-edged neuroscience terms as metaphorical codes for mental concepts, is being forged not only as a by-product of projects such as Post's (1992) stress-deficit work, but also quite consciously in DSM-IV. Spitzer, First, Williams, Kendler, Pincus and Tucker (1992) describe their proposal for doing away with the term "organic mental disorders" in DSM-IV, arguing that psychiatry has now superseded the Cartesian mind/body duality, formerly reflected in "the two great divergent trends in psychiatry during the later part of the nineteenth century" (p. 240), *viz.* 'brain psychiatry' and psychodynamics. While the inclusion of 'organic mental disorders' in DSM-III and DSM-III-R may not be meant to imply that the other disorders are non-organic, Spitzer *et al.* are seriously concerned that such connotations may nevertheless exist:

The connotative meaning of the word 'organic' always returns to its historical roots, which imply a functional/structural, psychological/biological, and mind/body dualism ... These original dichotomies may have been valuable when we had little understanding of how the CNS functions, but they are at variance with the growing body of evidence of the importance of biological factors in the etiology of the major 'nonorganic' mental disorders (p. 241).

Spitzer *et al.*'s proposed solution is a trichotomy, classifying all disorders as either primary (e.g., schizophrenia proper), secondary (i.e., secondary to some non-psychiatric medical disorder, e.g. dissociative disorder due to epilepsy) or drug-induced (e.g., cocaine-induced erectile dysfunction). The beauty of this system, now by and large implemented in DSM-IV

(which no longer uses the term "organic mental disorders"; Kaplan, Sadock & Grebb, 1994), is that it eliminates any remaining suggestion that the major psychiatric disorders are nonorganic, without on the other hand explicitly identifying them as *necessarily* organic. DSM-IV, as the official style manual of psychiatric discourse, has yet again moved along with the new biopsychiatric fashion, without having committed itself to an extreme biological view which may eventually prove untenable.

Throughout its history psychiatry, more so than the rest of medicine, appears to have been unable to operate without an attendant anti-psychiatry. As Dain (1989) points out, hostility to psychiatry even predates the establishment of psychiatry as a profession in 1844, and has often come from psychiatrists themselves - sometimes taking on a relatively benign (although influential) form as was the case for the group of psychiatrists around Clifford Beers at the turn of the century, and sometimes involving a thorough-going rejection of most of psychiatry's scientific and institutional basis, as was the case more recently with Szasz, Laing and company. As Rose (1986b) has argued, opposition to psychiatry has in fact been central to its modernisation.

From the current evidence it seems likely that the future new anti-biopsychiatry, if it is to be led by psychiatrists, will be of the Beers rather than the Szasz variety. However, it remains possible that the more radical challenge from outside psychiatry, particularly from ex-patient groups and their allies, may gain in power. According to Parker and Burman (1993), who have worked extensively with groups critical of psychiatry, such groups are currently defining community-based treatment of mental illness as a thinly disguised device for regulation and control, much as has been done in Chapters 2 and 3, and the concerned academic's job should therefore be "to publicize the analyses presented by these groups rather than expropriate them, rather than presenting them as if they were *ours*" (p. 165).

Unfortunately, some patient and family lobby groups, such as SANE (Schizophrenia - A National Emergency), seem at present as likely to adopt conservative positions⁴¹. Dain's (1989) gloomy prognosis perhaps best summarises the state of play:

What form both psychiatry and anti-psychiatry will take in the future is unclear. It is probably safe to say that short of achieving definitive knowledge about mental disorder and how to treat and prevent it and without the public will to care adequately for mentally disabled persons, both psychiatry and anti-psychiatry do have a future (p. 19).

⁴¹ A spokesperson for SANE is quoted (by Barham, 1992) as follows: "Never in the history of research into the workings of the brain has there been such hope that the cause or causes of this illness will soon be discovered. What is known is that schizophrenia is most likely to be a biochemical disorder of the brain". The advantages for patients and families in having conditions such as schizophrenia accepted as a 'real' disease are obvious.

Chapter 5

Beautiful and inexorable systems:

The discourse of discourse analysis

So much depends

upon

a red wheel

barrow

glazed with rain

water

beside the white

chickens.

- William Carlos Williams, Red wheel barrow

Jonathan Swift tells of a country where the inhabitants for the sake of unequivocal communication resolve to use objects rather than words, each object corresponding to a particular concept. The problem is that intellectuals soon find themselves burdened down with the weight of their ideas while their less intellectual (but more brawny) rivals are able to support arguments of considerable complexity. God, as we see around us every day, is not subject to the same constraints in terms of either brains or brawn, and has consequently allowed his or her vocabulary to grow to universal proportions.

There is however a certain moral ambiguity in coming to understand the everyday solidities of our existence as mere hieroglyphs in a more profound system of discourse; an

ambiguity which is perhaps present in one form or another in all attempts at turning things into talk or talk into things. On the one hand the mundane is imbued with meaning - God speaking in the exact juxtaposition of wheel barrow, rain water and (white) chickens; on the other that which was substantial, immediate and particular is devalued - a mere token which derives currency from its place in an abstract system, but in itself is worthless.

However, the disconnection between language and reality which is the basis of Swift's satire is, according to Benjamin Whorf (1956)¹, by no means ubiquitous. He claims that "the idea, entirely unfamiliar to the modern world, that nature and language are inwardly akin, was for ages well known to various high cultures whose historical continuity on the earth has been enormously longer than that of Western European culture" (p. 249).

Whorf, who is unjustly remembered for helping to formulate the discredited Sapir-Whorf hypothesis (that, crudely put, individuals in certain cultures are unable to think of certain concepts because their language does not encompass these), was given to seeing the "skull beneath the skin"² of human discourse. He speaks of "the PREMONITION IN LANGUAGE of the unknown, vaster world - that world of which the physical is but a surface or skin, and yet which we ARE IN, and BELONG TO" (emphasis in original, p. 248).

Whorf describes language as follows:

It is as if, looking at a wall covered with fine tracery of lacelike design we found that this tracery served as the ground for a bolder pattern, yet still delicate, of tiny flowers, and that upon becoming aware of this floral expanse we saw that multitudes of gaps in it made another pattern like scrollwork, and that groups of scrolls made letters, the

¹ All references to Whorf are from his collected works edited by Carrol (1956).

² Webster was much possessed by death / and saw the skull beneath the skin. - T.S. Eliot, *Whispers of immortality*

letters if followed in proper sequence made words, the words were aligned in columns which listed and classified entities, and so on in continual cross-patterning until we found this wall to be - a great book of wisdom! (p. 248)

It is said that William Durant, the founder of the General Motors empire, cribbed the well-known Chevrolet symbol from the wallpaper of a motel room. It is debatable who experienced the more intense 'epiphany upon gazing at wallpaper' (Whorf sitting at his desk, or Durant reclining on his motel room bed), but we do know that Durant, at least, realised his epiphany in the form of the Chevrolet motorcar while Whorf never got beyond talk.

The relation between Whorf's sublime speculation and Durant's functional machine is the same as that between the exquisitely wrought but apparently ineffectual 'talking cure' of psychoanalysis and the crude but apparently efficacious psychopharmacology which has now largely replaced it. However, just as psychoanalysts' talk about talk must ultimately emanate from mindless electro-chemical activity taking place in their brains, brain biologists' talk about real things must inevitably be constrained by the 'prison house of language' within which they are forced to conduct their investigations.

After demonstrating that there are definite rules for generating English-like syllables, Whorf observes:

It is as if the personal mind, which selects words but is largely oblivious to pattern, were in the grip of a higher, far more intellectual mind which has very little notion of houses and beds and soup kettles, but can systematize and mathematize on a scale and scope that no mathematician of the schools ever approached ... And now appears a great fact of human brotherhood - that human beings are all alike in this respect. So far as we can judge from the systematics of language, the higher mind or "unconscious" of a Papuan headhunter can mathematize quite as well as that of

Einstein; and conversely, scientist and yokel, scholar and tribesman, all use their personal consciousness in the same dim-witted sort of way, and get into similar kinds of logical impasse. They are as unaware of the beautiful and inexorable systems that control them as a cowherd is of cosmic rays (p. 257).

To decode the 'beautiful and inexorable systems' of language, to achieve communion with the 'higher, far more intellectual mind' which steers our thinking, and which in the end is 'inwardly akin' to the physical realities of our being - this is the vision of mystics such as Whorf. Others, while sharing his conviction that we are caught in a relentless but invisible linguistic grip, are less convinced that when the code of language is finally broken we shall find it to be a 'great book of wisdom'. Rather than a font of wisdom, language is suspect - at best a vulgar plagiarism of the Durant variety, at worst a methodical conspiracy to naturalise and legitimate particular relations of power.

The critique of the new biological psychiatry presented in Chapter 4 belongs to this latter category, attempting as it does to show that there is something shady about the way biopsychiatrists use and are used by their discourse. In what follows I present an overview of the work of some of those who have articulated "the belief that underneath what is said and done in modern Western states, there is something disreputable waiting to be unmasked" (Minogue, 1989, p. 139). Starting with a brief recapitulation of the role of language in critiques of psychiatry, I successively broaden the focus to include medicine in general, linguistics, post-structuralism and discourse analysis in social psychology.

*Discourse
analysis*

'Stammered, imperfect words without fixed syntax': The language of psychiatry

As already suggested in the preface, the idea of madness has always been closely linked to that of linguistic disorganisation (cf., Berenbaum, 1992; Gilman, 1983, 1988; Lidz, 1968).

Biological psychiatrists may ascribe the bizarre speech of schizophrenia to brain dysfunction while antipsychiatrists may frame it as the communication of unacceptable ideas in an unusual idiom, but all are agreed that there is something special and different about the way psychiatric patients talk, a strangeness which has been duly inscribed in the DSM diagnostic criteria for schizophrenia. Yet, as Kleinman (1988) observes, "the entire cultural apparatus of language, symbols, and interpretations is a source of great ambivalence for the contemporary psychiatric researcher." (p. xi) In part this is due to modern biopsychiatry's general distaste for philosophical and ideological discourse, but in part it may stem from an awareness that not only the mentally ill, but also those who attempt to heal them, can become linguistically entangled.

The danger occurs when researchers turn away from patients, and start recording the healers' talk. Just as patients construct delusional systems, so "the silent master builder, psychiatry ... constructs the house of language, metaphor, and culture in which the drama of parents, spouses, friends, and other social control agents coping with emotionally troubled individuals takes place" (Light, 1982, p. 33). Light describes how

Residents learn to characterize the whole patient by his or her diagnosis, so that the patient does not have *paranoid schizophrenia* but is a *paranoid schizophrenic*. This is a fundamental change from medical diagnosis and the rapidity with which residents incorporate this perspective is startling (p. 40).

It could be argued that other physicians do much the same thing, as in surgeons talking among each other of "the ruptured spleen in bed 103", but it does appear as if in psychiatry the linguistic identification of the patient with her diagnosis is more frequent and pervasive.

Virtually every aspect of psychiatry is susceptible to this kind of switch of research interest from patient to doctor. Rather than the aberrant speech of mentally ill women, one may investigate the way psychiatrists talk *about* women, discovering for instance that despite the fact that the majority of psychiatric patients in almost all settings are women, they are almost invariably referred to in the abstract as 'he' (Allen, 1986). Similarly in researching the history of psychiatry one may change from a literal marshalling of the facts of the Zilboorg and Henry (1941) variety, to a realisation that:

The gauze of language, woven on a loom of convention by people whose concerns were different from ours, inevitably distorts our vision of past reality. To understand anything at all about the history of madness, we must examine first the patterns formed in the records themselves and the people and institutions that created them ... In other words, historians of insanity do not in the first instance study the insane at all: they study observations of the insane (MacDonald, 1987, p. 209-210).

Perhaps the most far-reaching and subtle critique of the strangeness of psychiatric language was that invented by Foucault (1967) which served as inspiration for the historical account of readmission given in Chapters 2 and 3. Paired with Foucault's conception of the need for a 'Great Confinement' which arose with the Enlightenment, is that of a radical break between the languages of madness and reason. Since its inception, mad-doctoring has been concerned with talking about rather than to mad men and women; and rather than champions of humane treatment of the mentally ill, figures such as Pinel and Tuke further entrenched this tradition:

As for a common language, there is no such thing; or rather, there is no such thing

any longer; the constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason *about* madness, has been established only on the basis of such a silence. I have not tried to write the history of that language, but rather the archaeology of that silence (Foucault, 1967, p. xii-xiii).

Later Foucault (1980) would say of this enormously influential 'archaeology of silence', and of his subsequent works:

I am well aware that I have never written anything but fictions. I do not mean to say, however, that truth is therefore absent ... One 'fictions' history on the basis of a political reality that makes it true, one 'fictions' a politics not yet in existence on the basis of a historical truth (p. 193).

Gordon (1980) explains what appears from the viewpoint of conventional 'histories of the past' as a lack of concern with historical veracity thus:

We can say that the object of Foucault's critique is the status of the present. If Foucault poses a philosophical challenge to history, it is not to question the reality of 'the past' but to interrogate the rationality of 'the present' (p. 242).

Whether one is willing to accept this kind of justification or not, the danger for psychiatry once it declares itself willing to enter the domain of language is that it may be overcome by the onslaught of the likes of Foucault who writes "faster than we can read him" (Minogue,

1989, p. 138)³.

'To penetrate the veil while retaining its hallucinatory quality': The language of Medicine

Although perhaps a special case, psychiatry is hardly the only social or professional institution or scientific discipline to be made the target of linguistic criticism. In this section the critique of psychiatry is contextualised within a broader critique of medicine, while in the following sections the context is extended even further to encompass critical language studies in general.

As in psychiatry, any study of the role of language in medicine is likely, at least in the first place, to focus on the linguistic deficiencies of the ill person, rather than those of the physician. In an early study of this sort Redlich (1945) asked 25 patients to define 60 medical terms⁴. His rather predictable findings were that:

Two-thirds of the 25 patients knew too little about medical matters, their illnesses, and the implications of their illnesses. A small group possibly knew 'too much', but their knowledge was rather erratic, poorly integrated, and often quite irrational. Both groups might be helped considerably by sensible information (p. 447).

This kind of study embodies what Barthes (1973) called "a terror which threatens us all, that

³ Since Foucault's original work, there has moreover been a proliferation of texts equally concerned with the history of discourses of insanity, and of insane discourses, but presented in a more conservative idiom and making use of the usual convention of close reference to sources of evidence (cf., Ingram, 1991; Porter, 1987a; Porter, 1987b; Scull, 1991b; Turner, 1990).

⁴ Including a few now outmoded psychiatric terms such as *functional*, *organic* and *nervous disease*.

of being judged by a power which wants to hear only the language it lends us" (p. 46).

However, as with psychiatry, the way in which physicians themselves use language soon enough became the target of research. A typical example is Anspach's (1988) study of the language of case presentation. While the ostensible purpose of a case history is informational, in fact "it is an arena in which claims to knowledge are made and epistemological assumptions are displayed, a linguistic ritual in which physicians learn and enact fundamental beliefs and values of the medical world" (p. 357). Anspach identified various features of medical language in case presentation (such as using the passive voice and account markers to emphasise the subjectivity of patients' accounts), pointing out, for instance, that: "Physicians 'note,' 'observe,' or 'find'; patients 'state,' 'report,' 'claim,' 'complain of,' 'admit,' or 'deny' " (p. 368).

A very prolific area of research with regard to language and medicine concerns the interaction between doctor and patient. Here too, the doctor is often cast as the villain.

Hauser (1981) summarised the literature as follows:

Two themes are interwoven and frequently alluded to in the studies of language ...

The findings describe physicians as (1) narrow in their sensitivity to patients' feelings and more subtle requests for help, and (2) withholding in their disclosure of relevant medical information (p. 114).

Many of these sorts of studies (e.g., Fisher & Todd, 1983; Marshall, 1988; Mishler, 1984; West, 1984) substantiate their findings by means of highly detailed sample transcripts of medical interviews, complete with paralinguistic information such as *chair noise*, *uhm*, *hh*, *hm hm*, and *uh:m*, and time indications like *1'25'*, but fail to indicate to what extent the identified phenomena are representative of the sample as a whole. There are, however, some exceptions, as in West's (1983) study in which she reports that of 773 questions in her

transcripts of 21 doctor-patient exchanges, only 9% were patient-initiated. Patients were also more likely to respond to questions (98%) than were doctors (87%).

Criticism of this sort, although perhaps unpalatable, is in fact useful to medical practitioners, for instance in providing suggestions on how to reduce misunderstandings between doctor and patient. Although through the centuries doctors have perhaps always given more weight to what they learn from listening to the heart or palpating the abdomen, they are not unaware of the importance of conducting their verbal investigations in such a way as to obtain the most accurate information possible, and modern textbooks of clinical medicine place a strong emphasis on how to 'take a patient's history' (Butchart, 1998). However, despite its potential utility linguistic research poses a serious threat to medicine in that, at least implicitly, it tends to invalidate the bodily realities which are medicine's reason for existence. The implication is that language not only provides a pathway to the non-linguistic reality of the patient's illness, but that the illness is itself in some sense constituted in language. As Mishler (1981) observes: "The implications of constructivism are profound and far-reaching because its theorists propose that reality is constructed through human action, and does not exist independently of it" (p. 141). Some attempts to deal explicitly with medicine as a social construction are briefly reviewed below.

In the post-communist world it is easy to forget the academic prestige until recently accorded Marxist analyses. Although perhaps often obfuscatory, materialist critiques of fields such as medicine helped to refocus attention away from a purely technical, individualising approach to disease, discovering its origins instead in political and economic iniquities. Early Marxist thinkers such as Engels, Virchow and Allende did much to trace poor health to class oppression, economic underdevelopment and imperialism (Waitzkin, 1981), but more than the political economy of medicine, Marxism also tackled its ideological

(and therefore linguistic) presuppositions.

Althusser (1971) in particular helped to steer Marxism away from an exclusive focus on the economic to the ideological reproduction of capital and labour in Western economies. According to Althusser modern Western democracies are kept in place not only by Repressive State Apparatuses (government, administration, police, courts, prisons), but also by Ideological State Apparatuses (churches, schools, the family, the press, the medical profession), because "the reproduction of labour power requires not only a reproduction of its skills, but also, at the same time, a reproduction of its submission to the rules of the established order, i.e. a reproduction of a submission to the ruling ideology for the workers, and a reproduction of the ability to manipulate the ruling ideology correctly for the agents of exploitation and repression, so that they, too, will provide for the domination of the ruling class 'in words' " (p.127-128). Althusser along with other post-Marxists emphasised the importance of mere words:

Why does philosophy fight over words? The realities of the class struggle are 'represented' by 'ideas' which are 'represented' by words. In scientific and philosophical reasoning, the words (concepts, categories) are instruments of knowledge. But in political, ideological and philosophical struggle, the words are also weapons, explosives or tranquillizers and poisons. Occasionally, the whole class struggle may be summed up in the struggle for one word against another word. Certain words struggle amongst themselves as enemies. Other words are the site of an *ambiguity*: the stake in a decisive but undecided battle (p. 24).

Apart from those inspired by Marxists ideas, there has also been a proliferation of other critical approaches to medicine since the 1970s. These include Kleinman's (1988) cross-cultural psychiatry; the 'New Cross-Cultural Psychiatry' (Littlewood, 1990; Littlewood &

Lipsedge, 1987); critical medical anthropology (Lazarus & Pappas, 1986; Scheper-Hughes, 1990; Singer, 1989, 1990; Singer, Baer & Lazarus, 1990); Foucaultian accounts of medical history (Armstrong, 1995; Butchart, 1996, 1998); and Taussig's (1980, 1987) socialist-anarchist engagement with the healing process in which he attempts to "penetrate the veil while retaining its hallucinatory quality" (Taussig, 1987, p. 10).

Despite bitter in-fighting among the different approaches, they have in common a critique of biomedicine which draws attention away from disease as a physical reality, to the ways in which it is socially constructed. There is considerable variation in the degree of conviction with which the constructionist agenda is pursued, with Butchart (1998), for example, accusing all non-Foucaultian constructionist approaches to medicine of somehow still preserving a space for the 'real' world and 'real' diseases. Methodologically, constructionist methods in medicine most commonly rely for data on archival material and participant observation, the latter ranging from Kleinman's professional respectability to Taussig's immersion in South American revolutionary politics. Analysis typically takes the form of scholarly explication.

A constructionist orientation to medicine and psychiatry is part of a much wider shift towards a social understanding of language and a linguistic understanding of society. The constructionist idea that reality is in some sense a facsimile of language (rather than the other way around) has its roots in antiquity, and it would be impossible to give a definitive account of how it has come to occupy such a prominent place in academic thought, but an attempt is made to trace a few of its origins in brief outline below.

'Neither difficult nor contentious': The language of linguistics

The linguistic origins of structuralist and post-structuralist critiques of modernity are usually traced from De Saussure (1974), who in conceptualising language as a system of differences without any positive terms (in which signifier and signified are arbitrarily related), glimpsed, like Whorf, the possibility of a linguistic order more basic than, and prior to, the apparent solidity of 'houses and beds and soup kettles'. From Saussure the argument is taken via other structuralists in linguistics, anthropology (Lévi-Strauss, 1961), politics (Althusser, 1971) and 'semiotics' (Eco, 1986, and the early Barthes, 1973) - all intent on mapping the systems of meaning which produce society and subjectivity - and on to figures such as Lacan (1977) and Foucault (1967, 1973, 1979, 1980) and their more unequivocally post-structuralist brethren (Derrida, 1976; Kristeva, 1982; Deleuze & Guattari, 1977; Baudrillard, 1983) who forsake the promise of an eventual scientific blueprint of the social superstructure for the more immediate pleasures of intellectual guerilla warfare. In this narrative, continental philosophers are concerned to show how the discourses of modernity have carved up reality for us in advance, starting with the ubiquitous binary opposition between objective facts and subjective experience, while their Anglo-Saxon counterparts, by contrast, are usually shown to be obsessed with the idea of language as a representation of reality, concentrating (as in Swift's satire) on how words are used to substitute for ideas and things.

It nevertheless seems worth maintaining a space of legitimacy for lesser figures from the English-speaking world who, albeit in a small way, contributed to the constructionist

approach to language⁵. One such is J.L. Austin who, like Saussure, never published his magnum opus, but had it reconstructed from a series of lectures, delivered at Harvard in 1955⁶. Austin's opening remark - "What I shall have to say here is neither difficult nor contentious; the only merit I shall claim for it is that of being true, at least in parts" (p. 1) - is richly ironic given the polemical content of the lectures and the greatly diminished role they accord issues of truth in the study of language. The impetus for Austin's work came from a concern with the descriptive fallacy, or what he termed the constative fallacy. Starting with a distinction between constatives (which are true or false) vs performatives (which are happy or unhappy), Austin gradually worked to the view that in general all utterances have both happiness/unhappiness and truth/falsehood. Although many of Austin's examples illustrating the shaping function of language involve ceremonial acts ("I name this ship the HMS Bounty"), he firmly established the principle that language should be seen in its social context where it not only describes (truly or falsely) a pre-existent reality, but acts to *constitute* social reality (happily or unhappily).

J.R. Searle (1969), a student of Austin's and later professor of linguistics at Berkeley, did much to systematise and formalise Austin's work and to extend it to everyday contexts. In his book on *Speech Acts*, he asked the question which in one way or another also plagued Swift, Whorf, Foucault and the various students of language, medicine and psychiatry

⁵ Van Dijk (1987b) also attempted the impossible task of sketching the rise of the discursive approach in the social sciences without reference to continental linguistics and philosophy: "Structural and generative grammars in the 1960s and 1970s have been busy developing formal systems of analysis, in which language users and social contexts were nearly fully ignored. Pragmatics introduced the notion of speech act, and thereby came a step closer to the study of social interaction, but its approach remained fairly philosophical and abstract. Textlinguistics and more generally discourse analysis (including conversation analysis) broke the rigid sentence boundary of current grammars, and focused on the more natural units of language use and communication, viz. text and talk" (p. 15).

⁶ Published posthumously in 1975.

discussed above:

How do words relate to the world? How is it possible that when a speaker stands before a hearer and emits an acoustic blast such remarkable things occur as: the speaker means something; the sounds he emits mean something; the hearer understands what is meant; the speaker makes a statement, asks a question, or gives an order? (p. 3)

Although he did not pretend to be able to answer the question, Searle argued with Austin that in getting closer to an answer linguists should take the minimal unit of communication not as the word or sentence, but rather as the speech act.

Speech acts, also called 'locutionary acts', are not as easily defined as words or sentences (Searle's, 1969, p. 16, rather vague definition is "the production or issuance of a sentence token under certain conditions"), but numerous taxonomies of speech acts have been proposed (e.g., Searle, 1976; Hancher, 1979; Stiles, 1981) and it has been suggested (Fashold, 1990) that there may be a nested hierarchy, ranging from specific speech acts (such as jokes), through speech events (such as conversations) to speech situations (such as a party). Although rather insipid compared to the more sociopolitically aware continental attempts at delineating the localities and technologies of discourse, it is evident that, at some level, the impulse is the same. The crucial difference would appear to be that the Anglo-Saxon speech-act theorists still think of the individual subject as a relatively unproblematic entity who goes about emitting 'acoustic blasts' to achieve certain concrete ends, while the structuralist and post-structuralist position is founded upon the recognition that the individual subject is itself both produced by and productive of the system of 'acoustic blasts'.

Fashold (1984, 1990) reviews various aspects of linguistics which have been influenced by speech act theory, including the ethnography of communication, linguistic

pragmatics and discourse analysis. The latter ("possibly the field within sociolinguistics that has undergone more research activity in recent years than any other"; Fashold, 1990, p. 65) to an extent overlaps with a methodology of the same name in social psychology (which usually traces its roots not to speech act theory but to structuralism and post-structuralism). Before discussing discourse analysis in more detail, the following section presents an overview of the larger social contexts within which such methodologies have come to flourish.

'A bit like a whale': Postmodernity

Foucault (as presented in Parker, 1989a) claimed that Western discourse since the Renaissance can be divided into *epistemes* lasting roughly 150 years each. These were the Renaissance period from about 1500 to the middle of the seventeenth century when all attention was directed at recovering the true voice of God; the Classical Age lasting until the end of the eighteenth century which was characterised by an obsession with rationalism, natural science and mechanism; and the modern period which created the individual subject and which is possibly now being replaced by postmodernity. In this view both psychiatry and psychology are still largely in thrall to modernity "in which the world is experienced by people as tied together by stories of humanized science, progress, and individual meaning" (Parker, 1989b, p. 2). This modernist belief in progress "promises to release us from modern times while actually shackling us to them" (p. 12).

Postmodernity is both a critique of modernity and a condition of existence. As a critique of modernity, Ermarth (1992) describes it as follows: "Across a broad range of cultural manifestations a massive reexamination of Western discourse is under way: its obsession with power and knowledge, its constraint of language to primarily symbolic

function, its ethic of winning, its categorical and dualistic modes of definition, its belief in the quantitative and objective, its linear time and individual subject, and above all its common media of exchange (time, space, money) which guarantee certain political and social systems" (p. 6-7).

As a condition of existence, postmodernity decentres the individual subject and instead gives priority to the text⁷. Human subjectivity, if it exists at all, finds its expression in a shifting zone of intertextuality. Table 5.1, adapted from Brooker (1992)⁸ details some of the contrasts between modernity and postmodernity. Where modernity believes in the possibility of a unifying synthesis, postmodernity playfully exposes as sham the apparent coherence in scientific or political programmes, works of art and texts of all sorts.

Structuralism and post-structuralism (and the 'method' of deconstruction) represent a kind of thinking which has only become possible with the advent of the postmodern era. In its search for the underlying structures of meaning which operate regardless of individual intentions, and its insistence that "individuals do not speak language but that language speaks through them" (Tallis, 1989, p. 20), structuralism repudiates what Shotter and Gergen (1989) call the 'single dominant text' of modernity, which tells of the centrality and sovereignty of the individual. In its contention that truth is "a product, not a discovery, of the method that produces it" (Berman, 1983, p. 46), post-structuralism aligns itself with the postmodern idiom which thrives on chance, anarchy and play and relies on gadgets such as Derrida's *sous rature* (placing under erasure) to signal that what is being said and the way in which it is said is

⁷ There is, however, considerable controversy about the role of text among theorists who could broadly be described as 'postmodern'. While some give priority to language and text as conventionally understood, others merely wish to interpret social practices and institutions as if they were texts, while yet others consider the postmodern emphasis on textuality a distraction from researching the concrete practices and effects of power.

⁸ Who took it from Hassan (1985).

merely a temporary device to move the discussion forward. "Thus, we must use the terms that we believe to be inaccurate and inappropriate, under erasure, in order to reveal their status as useful, necessary and wrong" (Sampson, 1989, p. 7).

Table 5.1 **Characteristics of Modernity versus postmodernity (adapted from Brooker, 1992)**

Modernism	Postmodernism
Purpose	Play
Design	Chance
Hierarchy	Anarchy
Mastery	Silence
Art Object/Finished Work	Process/Performance/Happening
Distance	Participation
Synthesis	Deconstruction
Presence	Absence
Centering	Dispersal
Genre/Boundary	Text/Intertext
Semantics	Rhetoric
Depth	Surface
Narrative	Anti-narrative
Master code	Idiolect
Origin/Cause	Trace

Postmodern academic discourse, whether of the structuralist or post-structuralist variety, is of course not without its critics. Cox (1989) calls it "an astonishing exhibition of coyly 'technical' nouns and adjectives, falsely dramatic verbs, and sentences that have lost track of their insides" (p. 73) and is at best willing to admit that it might be a "species of poetry". Minogue (1989) also complains of the lack of clarity and decries the excessive piety with which the texts of 'Continental Gurus' such as Sartre, Lukacs, Bloch, Gramsci, Habermas, Derrida, Lacan and Foucault are treated.

Foucault (1980), demonstrating both the convoluted prose and the poetic charm that Cox speaks of, admits:

For my part, it has struck me that I might have seemed a bit like a whale that leaps to the surface of the water disturbing it momentarily with a tiny jet of spray and lets it be believed, or pretends to believe, or wants to believe, or himself does in fact indeed believe, that down in the depths where no one sees him any more, where he is no longer witnessed nor controlled by anyone, he follows a more profound, coherent and reasoned trajectory (p. 79).

Behind the displeasure with post-structuralist or structuralist style lie substantive concerns about the subjectivity and extreme abstraction of the methods employed, and the radical constructionist conclusions drawn from them. Given Foucault's (1980) admission that he 'fictions' history, why should we believe that a new discursive *episteme* suddenly came into being just at the time that Pinel freed (or did not free) the insane? Should we put equal store in another writer of fiction's claim that "in or about December, 1910, human character changed" (Virginia Woolf, quoted in Brooker, 1992, p. 5)? As Tallis (1989) cuttingly observes: "With only an infinitely pliable logic and their intuitions to guide them, the structuralists' journey into or away from truth is quite unfettered" (p. 26).⁹

A related problem is how seriously to take claims that reality is constructed in or from language. Cox (1989) is of the opinion that "just as we are unlikely to mistake a mime's self-conscious artistry for a plausible argument against our ability to speak, so we are unlikely, once we discover the artificiality of the Derridean method, to find in it a plausible argument for the referential inadequacy of language," (p. 66) while Tallis (1989) states:

⁹ The extent to which such critiques talk past the structuralist/post-structuralist enterprise is illustrated by Foucault's (1980) remark about truth as itself a construction: "We are subjected to the production of the truth through power and we cannot exercise power except through the production of truth ... we *must* speak the truth; we are constrained or condemned to confess or to discover the truth. Power never ceases its interrogation, its inquisition, its registration of truth: it institutionalises, professionalises and rewards its pursuit. In the last analysis we must produce truth as we must produce wealth." (p. 93)

No one would wish to challenge the obvious truth that language is implicated in the construction of reality. What is at issue, however, is the *extent* to which reality is intra-linguistic and language the agent or medium in virtue of which reality is structured or constituted; more particularly, the radically nominalist assumption, common to many ... critics, that the traffic is all one way: that language structures reality but reality does not influence the structure, the system of differences, that is language (p. 13).

Anglophone lucidity is not however in itself an adequate antidote for continental grandiloquence. As Berman (1989) observes, "all this enviable clarity yields no more consensus than does the most vexatious and cumbersome prose of philosophers elsewhere; and it certainly cannot (and some say it is not supposed to) yield 'truth'. Issues are never resolved, only perpetually reopened" (p. 46).

What is needed, perhaps, is for the theory to be fortified with a leavening of concrete demonstration. Although the works of some poststructuralists (such as Foucault, Barthes and Baudrillard) draw on richly detailed historical and cultural material it often appears as if this material is forced into predetermined theoretical patterns. Other poststructuralist works (such as by Derrida, Deleuze and Guattari) seem curiously empty and self-referential. In the words of Cox (1989): "These salt-flats of abstraction inspire one with a new respect for all the beautiful specifics of culture, specifics of which deconstruction takes notice only while trying to shove them into its theory" (p. 73).

'The knowledge that one seeks to disinter': The language of discourse analysis

The term *discourse analysis* refers to something both very specific and very nebulous. As a social constructionist approach introduced into social psychology in a 1987 book and *British Journal of Social Psychology* article (both with Jonathan Potter as first author), discourse analysis has a quite specific identity, at least in terms of the leading players: the group of British social psychologists around Potter, Wetherell, Reicher and, more recently, Burman and Parker; with Van Dijk and his associates as somewhat more distant European relatives.

As Parker (1989b; 1992) describes it, discourse analysis rides on the back of a series of 'crises' in social psychology periodically announced by academics (Billig, Gergen, Hare, Sampson, Shotter, Urry) disillusioned with the artificiality and triviality of traditional social psychological methods and topics. Tracing its roots to the structuralist and poststructuralist movements outlined above, discourse analysis shares in their agenda, particularly in the drive "to displace attention from the self-as-entity and focus it on the methods of constructing the self" (Potter & Wetherell, 1987, p. 102). Exactly how it differs from these or from other current approaches going by the name discourse analysis is not however always clear. The term has been current in sociolinguistics for a considerable time (Cicourel, 1980), where it is also used quite loosely to refer to approaches as diverse as speech act theory and conversation analysis.

Van Dijk (1987a, 1990) points out that discourse analysis, by virtue of its diverse origins and wide applicability, will of necessity be a cross-discipline, involving linguistics, sociology, social psychology as well as law, history and political science, all of which are "beginning to recognize that texts, documents, talk or other discursive practices constitute the

central object and data of their fields" (Van Dijk, 1990, p. 6).

While it is easy to dismiss discourse analysis in psychology as faddish and ill defined, there can be no doubt that it has made a strong impact on how language is viewed in the discipline. A volume published just on two decades ago and purporting to deal with 'language and social psychology' (Giles & St Clair, 1979) illustrates the freshness of the ideas discourse analysis brought into the discipline. In the introductory essay, Giles (1979) justified social psychology's role in language studies as follows: "If we are going to understand why individuals acquire, use and react to language and its varieties in the way they do, we require a greater understanding of the dynamics of attitudes, motivations, identities and intentions, that is, social psychological phenomena" (p. 2). Social psychology itself is defined as "the study of an individual's behaviour in his or her social context" (p. 2). Contrast this to Parker's (1989b) book on social psychology, which appeared a decade later, and in which the uncritical acceptance of the individual subject as psychology's proper object of research is itself the main topic of discussion.

Where traditional social psychology produces information on the attitudes, motivations and intentions of individual subjects, what (apart from a critique of traditional social psychology) does discourse analysis produce? Potter and Wetherell's (1987) initial answer - *interpretive repertoires* - may at least in part explain why discourse analysis has aroused so much interest in such a short time. An interpretive repertoire is "basically a lexicon of terms and metaphors drawn upon to characterize and evaluate actions and events" (Potter & Wetherell, 1987, p. 138). Interpretive repertoires are typically "organized around specific metaphors and figures of speech" (p. 149). A repertoire relating to the term *community* in radio, television and newspaper reports on, as well as eyewitness accounts of, a 'race riot' in Britain is presented in Table 5.2.

Table 5.2 The community repertoire (from Potter & Reicher, 1987, p. 32)

Paradigmatic alternatives	
Local residents <i>or</i> local residents with specific social organisation	
Black community <i>or</i> White community <i>or</i> Mixed community	
Currently exists <i>or</i> Existed in past <i>or</i> May exist in future	
Sample predicates	Metaphors (where relevant)
Friendly	
Warm	
Happy	
Harmonious	
Close-knit	Spatial
Integrated	
Tight	
Mature	Organic
Grows	
Evolves	
Acts	Agency
Knows	
Feels	

What made Potter, Wetherell and Reicher's work special is that, despite the fact that they drew their ideological inspiration from structuralist and poststructuralist sources (as reflected among other things in the fact that their object of interest is the language being used, not the

characteristics of the language users), they collect, analyse and present data in a format which is intelligible to traditional positivist researchers. Unlike 'hard-core' deconstructionists such as Derrida, they therefore (at least minimally) wish to create the impression that their 'findings' are of the same order as that produced by hard-nosed empiricists in the social sciences.

The idea of constructing such repertoires is not new. Black (1962) in his classic work on metaphors, for instance calls for the identification of 'archetypes' in bodies of speech or writing. By *archetype* he means:

a systematic repertoire of ideas by means of which a given thinker describes, by *analogical extension*, some domain to which those ideas do not immediately and literally apply. Thus, a detailed account of a particular archetype would require a list of key words and expressions, with statements of their interconnections and their paradigmatic meanings in the field from which they were originally drawn (p. 241).

Although the exact nature of the discourse analytic product is somewhat in contention, it is certainly more tangible than merely a philosophical critique of modernity. Rather than an interpretive repertoire, Parker (1989a) wishes to expose *discourses*. A discourse is "a system of statements which constructs an object. This fictive object will then be reproduced in the various texts written or spoken within the domain of discourses" (p. 62). Gilbert and Mulkey (1984), on the other hand, produce interpretive *devices*, such as the TWOD (Truth Will Out Device) often used in scientific writing (and of which numerous examples were cited in Chapter 4). Wetherell and Potter (1992), in some of their later work no longer speak of interpretive repertoires, but of 'maps', which (much like repertoires) refer to the organisation of discursive "practices, arguments and representations" (p. 1).

There are also relatively specific descriptions of how to arrive at these repertoires,

maps, discourses or devices. Potter and Wetherell (1987) offer ten steps to discourse analysis; Parker (1989b) explains how to deconstruct a text in three steps; and again (Parker, 1990a; 1992) how to analyse discourses in twenty steps. Although these steps are not formulated as techniques that can be mechanistically implemented, they are clearly a far cry from the Foucaultian whale. Potter & Wetherell (1987) expressly acknowledge that one of the weaknesses of earlier approaches, such as ethnomethodology is that "the reader of the ethnographic report of this kind is dependent on the researcher's description both for what they know about the data and for their evaluation of the researcher's conclusions" (p. 30), while Gilbert and Mulkey (1984) emphasise the importance of providing "closely documented descriptions" (p. 14) of whatever features are identified in texts.

Discourse analysis and the dangers of reification

Even as they have moved away from the 'salt flats of abstraction' towards the 'beautiful specifics of culture', discourse analysts seem to be gripped by a fear that they will reinstate a regime of truth as oppressive as the subjectifying empiricism they are trying to subvert. Thus to counteract any negative side-effect of his 'three steps', Parker (1989b) warns that "it might be tempting to think of deconstruction merely as a method." (p. 58) and, again, that his 'twenty steps' do not "constitute a method" (Parker, 1992, p. 5). Even as he generates more detailed methodological specifications, Parker (1992) protests more and more vehemently that he is not advocating a method, e.g., "discourse analysis is not, or should not be, a 'method' to be wheeled on and applied to any and every topic" (p. 122). To use Parker's own methodology, this is clearly a case of a putative 'discourse analysis discourse', meeting criterion 6 (steps 11 and 12) for official certification - that is, employing disingenuous

reflexive strategies of the 'don't get me wrong' variety.

Of Potter and Wetherell's ten steps, Parker (1989b) says that they "can be taken with a pinch of salt, but ... can be used as part of the presentational rhetoric to get through institutional barriers" (p. 160). Potter and Wetherell for their part (Potter, Wetherell, Gill & Edwards, 1990), accuse Parker of having an overly reified vision of discourses, describing his position rather graphically as "endorsing something akin to the geology of plate tectonics - great plates (discourses) on the earth's crust circulate and clash together; some plates grind violently together; others slip quietly over top of one another; volcanoes burst through while massive forces work unseen below" (p. 209). Perhaps for the same reason they reject the reifying obsession with sampling which traditional empiricist research supposedly suffers from.

In the post-structuralist world the sin of reification is of course a grievous one, and even Foucault (1980) at times feared that he might succumb:

And after all, is it not perhaps the case that these fragments of genealogies are no sooner brought to light, that the particular elements of the knowledge that one seeks to disinter are no sooner accredited and put into circulation, than they run the risk of re-codification, re-colonisation? (p. 86)

It can however be argued that no degree of looseness in one's methodology can protect one against this sin, as the looseness itself soon enough becomes a reified article of faith.

Burman (1991) argues that although discourse analysis as currently practised has helped to draw psychology's attention to how language "produces and constrains meaning, where meaning does not, or not only, reside within individuals' heads" (p. 327), it does not hold the monopoly on 'progressive' research. Although the application of a particular methodology may be radical and politicising, the method itself may be as open as any other to being used

in a falsely value-free way.

Discourse analysis and the danger of subjectivity

Not only does indifference to traditional research concerns such as sampling issues not guarantee an escape from reification, it invites the usual positivist criticisms of subjectivity and lack of replicability. That this is not a trivial issue is demonstrated by two book-length publications produced in the discourse analytic spirit.

Salomon Rettig's (1990) *Discursive Social Psychology of Evidence* illustrates just how seriously things can go wrong when Potter and Wetherell's (1987) instruction to underplay sampling issues is followed. Rettig's book consists of 40 pages of theory, followed by 160 pages of transcription and (very minimal) analysis of half a dozen or so conversations. In case one mistook this for any form of serious research, Rettig (1990) is quick to point out that:

There is no claim to universality, nor to scientific rigor. There is, however, a claim to the authenticity of the material. I hope that the reader will enjoy the material as much as those of us who participated in its production, for it has been a very satisfying human enterprise, in: ed (p. vi-vii).

As one may expect from contexts in which authenticity and enjoyment are privileged over rigour, there are numerous factual errors of the most elementary kind, such as a claim (p. 83) that three participants in a conversation about the sex of a particular participant in another (transcribed) conversation all agreed that she was a woman, when the transcription indicates that one thought she was a man and another was uncertain.

The second example, Labov and Fanshel's (1977) classic analysis of a therapeutic

encounter, although published long before discourse analysis came on the scene, and not prone to the same sorts of infelicities as Rettig's (1990) work, also helps to illustrate the importance of attending to sampling issues. Just the opposite of Rettig's, theirs is a 361 page analysis of 15 minutes (8 pages transcribed) of a therapy session. Their central concern is to explicate "the sequencing rules [which] operate between abstract speech actions" (p. 350) and in order to do this they have to analyse exchanges in microscopic detail. In part Labov and Fanshel limit themselves to 15 minutes from a single conversation for purely practical reasons (15 minutes each from 100 conversations would presumably require an impossible 3600 pages of analysis)¹⁰, but additionally they rely on an assumption that the kinds of sequencing rules they will discover operate in other conversations as well. This assumption simply does not hold for the discourses or interpretive repertoires with which discourse analysis wishes to work, and larger (and more diverse) samples are in fact better, as Potter and Reicher (1987) and Potter and Wetherell (1987) argue in drawing their texts from a range of sources such as broadcast media, Hansard, newspapers and interviews. Parker (1992) also emphasises (in step 11) the importance of finding and describing a discourse as it occurs in more than one kind of text. This does not mean that these analysts necessarily see individuals as the source of language or wish to relate linguistic features to the characteristics of individual subjects.

To gain respectability within the current status quo, which may be necessary if it is to have a real impact on psychological research, discourse analysts therefore have to pay some attention to traditional signs of scientific rigour, such as using representative sampling

¹⁰ One suspects that practical considerations are also in part behind Potter and Wetherell's (1987) argument, as is evidenced by their observation that the ratio of recorded to transcribed time is easily 1:10. Some suggestions for overcoming this difficulty are presented in the next chapter.

strategies, replicable analyses, and succinct modes of reportage. This is exactly the kind of call that has long been made by others involved in 'qualitative' data analysis, such as Miles and Huberman (1984) and Kirk and Miller (1986) who are adamant that qualitative research "does not imply a commitment to innumeracy" (Kirk & Miller, 1986, p. 10).

Discourse analysis: Variation and commonality

Despite its genuflections to methodological rigour, discourse analysis has thus far certainly succeeded in avoiding becoming a mere methodology. A survey of the discourse analytic studies published in Burman and Parker (1993) reveals a reasonable degree of heterogeneity. Although the data source for these studies were almost invariably interview transcripts¹¹ (Gill, 1993; Macnaghten, 1993; Marks, 1993; Marshall & Raabe, 1993; Moir, 1993; Stenner, 1993; Widdicombe, 1993), the number of people interviewed varied from unspecified (Widdicombe, 1993) to ten or fewer (Gill, 1993; Marshall & Raabe, 1993; Stenner, 1993) to 40 (Moir, 1993), while the type of person interviewed included students (Moir, 1993), people classed as conservatives or liberals on a psychometric measure (Marshall & Raabe, 1993), disc-jockeys (Gill, 1993), members of the 'gothic' subculture (Widdicombe, 1993), a married couple (Stenner, 1993), and helping professionals (Marks, 1993).

The aim of these analyses seem to be twofold: 1) To identify the kinds of socially conditioned repertoires or discourses used by and reproduced in the interviews; and 2) to show *how* these are used, together with other conversational and textual techniques or gambits, to achieve purposes such as coherence or the silencing of less powerful participants.

¹¹ Showing perhaps the extent to which these authors, despite their professed allegiance to post-structuralism, are still subject to phonocentric biases. One exception is Macnaghten (1993) who also uses official documents.

In Widdicombe's (1993) formulation, "the object of analysis is to explicate the culturally available resources and tacit reasoning procedures which seem to inform what is said, and to identify the nature of the interactional tasks thereby addressed" (p. 97). However, what counts as 'culturally available resources' and 'interactional tasks' vary widely. Some of the 'culturally available resources' identified in these studies are sexist constructions of women's capacities and men's willingness to listen to women (Gill, 1993); the different ways in which nature can be depicted (Macnaghten, 1993); the 'subject positions' available to men and women (Stenner, 1993); and the therapeutic and reflective obligations of professionals versus the 'needs' of clients (Marks, 1993). The 'interactional tasks' that these are used to address include justifying the small number of female DJs (Gill, 1993); justifying or opposing a new land-fill site (Macnaghten, 1993); making the adoption of 'gothic' style appear as an authentic individual choice (Widdicombe, 1993); making the choice of a particular career appear authentic (Moir, 1993) and deflecting talk from interprofessional conflict (Marks, 1993).

Most commonly, deductions are warranted by means of short illustrative extracts from interview transcripts (e.g., Gill, 1993; Macnaghten, 1993; Moir, 1993; Stenner, 1993), and sometimes by the device of presenting a close reading of a single longer extract (Widdicombe, 1993). Apart from discourse theory, eclectic reference is made to a variety of other approaches, such as Holland's occupational types (Moir, 1993), feminism (Gill, 1993), sociological and social psychological work on youth subcultures (Widdicombe, 1993) and action research (Marks, 1993).

Similarly, South African discourse analytic studies - such as the collection of studies in Levett, Kottler, Burman and Parker (1997) and papers by amongst others Dixon, Foster, Durrheim and Wilbraham (1994), Durrheim and Dixon (1998), Duncan (1996), Durrheim (1997), Kaminer and Dixon (1995), and Wilbraham (1996) - also show considerable variation

in analytic methods and products.

It should not however be thought that discourse analysis is nothing more than a particular ideological orientation with no specific methodology. Two aspects distinguishing discourse analysis as a methodology stand out. The first, which has already been alluded to, is that, to a far greater extent than the philosophical movements from which it draws its inspiration, it relies on traditional empiricist distinctions between theory, method and data. Discourse analysts, despite all they may say against positivism, feel compelled to back up their claims about how people use language and language uses people with the kind of evidence recognisable to empiricists as 'data'. The second distinguishing feature is that in discourse analysis a conscious attempt is made to work 'from the bottom up', that is, to derive theoretical insights from data rather than to impose theoretical systems on the data. Although most pronounced in 'Grounded Theory' (Glaser & Strauss, 1967), this is a common theme in most forms of qualitative research. Thus Gilbert and Mulkey (1984) call for discourse analysts to stay 'close to their data': "Instead of applying an abstract, preconceived language to our data in order to show how discourse arises from and reproduces complex social structures, we ... begin with an examination of those terms and interpretative features which seem to arise naturally in the course of participants' own discourse..." (p. 16)

This principle is sometimes presented in discourse analysis as entailing having to stay near the surface of the data. Potter and Wetherell (1987), for example, call for researchers to 'range over' rather than penetrate texts, saying that "we do not intend to use the discourse as a pathway to entities or phenomena lying 'beyond' the text" (p. 49). It can be argued that analysts such as Potter and Wetherell do indeed wish to discover entities 'beyond' the text, and that these entities are merely of a different sort from that typically discovered by for example psychologically oriented content analysis - that is, trans-personal discourses rather

than individual attributes. Although the surface-depth distinction may therefore be suspect, the principle is clear - discourse analysis is in the first place concerned with understanding how language itself works, rather than treating it as a window onto some other reality. In Gilbert and Mulkey's (1984) phrase, accounts are treated as "topic instead of resource" (p. 13) - it is discourse which is of interest, rather than the individual actors through whom the discourse speaks.

Discourse analysis: Quantity and quality

As currently constituted, discourse analysis is a qualitative approach. This is so for both historical and methodological reasons. Historically, quantitative positivist research has dominated the social sciences, and discourse analysis is therefore 'naturally' allied with the various qualitative approaches which have been formulated in opposition to this hegemony. Methodologically, quantitative research has been perceived as imposing preconceived categories on data as, for example, in quantitative content analysts counting the number of words showing 'negative affect' in a text. This is clearly incompatible with the 'bottom-up' discourse analytic approach discussed above. However, imposing versus discovering categories in data is clearly a matter of degree, and it is possible to imagine quantitative approaches that approach the discourse analytic ideal of letting the data speak for itself. The advantage of incorporating quantitative techniques into the discourse analytic repertoire would be that this would help discourse analysis escape from the unproductive quantitative-qualitative dichotomy into which it has been historically interpellated.

One possible source of quantitative techniques which can be applied to language is the discipline of linguistics. Currently available highly structured, automated and

computational approaches to linguistic analysis are therefore reviewed as a possible tool for discourse analysis in Chapter 6; and in the following chapters new techniques developed from these are applied and evaluated. The dissertation concludes, from a methodological point of view, with an assessment of the extent to which the adoption of such techniques leaves discourse analysis vulnerable to reification and "recuperation"¹² by positivist research" (Burman, 1991, p. 334).

¹² A Marxist term, meaning to render opposition harmless by recruiting it back into the political mainstream.

Chapter 6

Objective tools for analysing linguistic structures

Each venture

Is a new beginning, a raid on the inarticulate

With shabby equipment always deteriorating

In the general mess of imprecision of feeling.

- T.S. Eliot, East Coker

Despite all that has been said in the previous chapter about language fabricating reality, it is perhaps nevertheless most easily imagined as some kind of message delivery apparatus:

Words and sentences trundling back and forth like cocopans on the overhead rails of an automated office mail system, transporting the ore of meaning from 'sender' to 'receiver'.

Whether language really functions as a message carrier, or has a more sinister purpose, it should in principle be possible to draw up a blueprint showing the exact arrangement of gears, pulleys, springs, counterweights, and so on which keeps the system moving.

Unfortunately, or perhaps fortunately, language does not come with a user's manual and more indirect methods have had to be resorted to to expose its inner workings. The problem with many of these methods (some of which were reviewed in the previous chapter) is that they are themselves constituted in language. The reflexive absurdities which result are aptly described by Richards (1989): "trying to see what 'see' means, trying to hold onto the meaning of 'hold', looking for the meaning of 'look', following the meaning of 'follow' round in circles" (p. 61). While it would be naive to imagine that some kind of artificial language

could be invented to analyse 'natural' language (perhaps using physical tokens as in Swift's satire), it is not unreasonable to assume that there may be some utility in surveying language by fitting an intentionally synthetic grid over it. This is indeed precisely what structuralist and post-structuralist authors do, for example Derrida's *sous rature*, Lacan's bogus algebraic formulas involving combinations of signifier and signified, or Deleuze and Guittarri's proliferating neologisms.

In this chapter I evaluate a number of more traditional quantitative approaches to language analysis in linguistics and psychology with particular emphasis on the automation of procedures, and conclude with an assessment of their implications for a proposed quantitatively informed discourse analysis. Despite the technical and hyper-quantitative nature of the material in his chapter, the intention is not to propose quantitative language analysis as a substitute for qualitative analysis, but to ask how quantification may be used in conjunction with what must necessarily remain an essentially qualitative enterprise.

Corpus studies

Perhaps the most obvious empirical approach to language studies is to examine, quantitatively, the frequencies and patterns of occurrence of various linguistic features in large samples (or corpora) of speech or writing. The purpose of this, to revert to structuralist terminology, is quite simply to study *langue* (the structure of language) through redundant patterns in *parole* (actual utterances) (Engwall, 1994). Zipf (1935)¹, one of the earliest proponents of what later came to be called corpus linguistics, described the impulse behind

¹ Illustrating the difference in mentality between discourse analysis and corpus linguistics, Miller (1965) says of Zipf that "he was the kind of man who would take roses apart to count their petals" (p. v).

corpus work as follows:

It occurred to me that it might be fruitful to investigate speech as a natural phenomenon, much as a physiologist may study the beating of the heart, or an entomologist the tropisms of an insect, or an ornithologist the nesting-habits of a bird. That is, speech was to be regarded as a peculiar form of behavior of a very unusual extant species; it was to be investigated, in the manner of the exact sciences, by the direct application of statistical principles to the objective speech-phenomena (p. xi).

At the most superficial level this kind of approach may do little more than confirm already known facts, such as that 'e' is the most frequent letter in the English language or that the word 'shall' is now virtually extinct in Australian English (Collins, 1991). However, by calculating exhaustive statistics not only on the frequency of various linguistics categories, but also on their patterns of co-occurrence, corpus linguists hope that a more profound understanding of how language works may emerge.

In Johansson's (1994) wide definition, a corpus is "a body of texts put together in a principled way¹, often for the purposes of linguistic research" (p. 3), and can refer to virtually any collection of writing (or transcribed speech), such as the psychiatric textbooks or set of interview transcripts used in this dissertation. The term now most often refers to a large collection of texts and transcripts captured into a computer database. The earliest and best known computer corpora are the Brown corpus (Francis & Kucera, 1964) which contains just over a million words of American English extracted from sources such as newspapers, magazines and books, and the London-Lund Corpus of Spoken English (Svartvic & Quirk,

¹ Engwall (1994) details criteria which should be used in collecting corpus material, placing particular emphasis on careful sampling from text category (e.g., literary, scholarly, newspapers, conversations), genre (e.g., imaginative prose, drama, scientific texts, dialogue), and period (e.g., diachronic or synchronic).

1980), which consists of approximately half a million words transcribed from radio broadcasts, surreptitiously and openly recorded telephone conversations, and the like. However, there has since been a proliferation of corpora, with Taylor, Leech & Fligelstone (1991) listing no fewer than 36 English corpora, ranging from the relatively tiny Corpus for Dialectometry (38 000 words) to the over 5 million words of the American Heritage Intermediate Corpus. The total number of words in the corpora listed by Taylor *et al.* is of the order of 45 million, and a single corpus currently under development by the Longman group is set to double this figure. Edwards (1993) lists projects intent on establishing corpora of 100 million words each.

Computer corpora vary considerably in the purposes for which they were originally intended and the format in which they have been captured. Many make use of standard English orthography augmented by minimal text markers indicating the source of each text fragment, its date of recording and so on. Others have been extensively tagged or annotated to identify features such as voice pitch (Whichmann, 1991), grammatical categories and the like.

The number of ways in which corpora can be annotated² is endless. The three basic components of language identified by Longacre (1976) - lexis, grammar, and phonology - are each imperfectly represented in standard orthography and special markers have to be added to the text to signal the occurrence of particular lexical, grammatical or phonological events.

² I use 'annotated' here interchangeably with 'coded', or 'tagged' to refer to any system for marking up text so as to identify features not visible in the surface orthography. As is typical of linguistic research in general, there is a proliferation of mark-up conventions, some of which are reviewed in Edwards and Lampert (1993). One of the oldest and most common formats is the COCOA format, which is similar to Standard Generalised Markup Language (SGML), the most widely accepted current convention and the one on which Hypertext Markup Language (HTML), the de-facto standard for internet documents, is based (Johansson, 1994).

One may for instance wish to tag different 'case roles' (agent, goal, instrument, location, patient; Starosta, 1978) or lexical categories such as Human Noun, Concrete Noun, Motion Verb, Physical Verb and Locative Verb (Longacre, 1983) or stative, action and process verbs (Gervasio, Taylor & Hirschfield, 1992). Another approach is participant indexing (Grimes, 1975) which is used to identify the characters in a story or the participants in a conversation. Phonetic markers of varying complexity can also be added to texts.

Whatever theoretical perspective a linguist or social scientist may adopt towards language, there is usually an abundance of classification schemes which can be used for coding purposes. An example is Austin (1975) and Searle's (1969) work on 'speech acts', which helped popularise the idea that language is not only descriptive but also a form of action. Apart from Austin and Searle's own taxonomies of speech acts (Searle, 1969, 1976), rival taxonomies have been suggested by at least five other theorists (reviewed in Hancher, 1979; Stiles, 1981), and there is thus no shortage of coding schemes which may be used by an analyst wishing to annotate texts in terms of speech act theory.

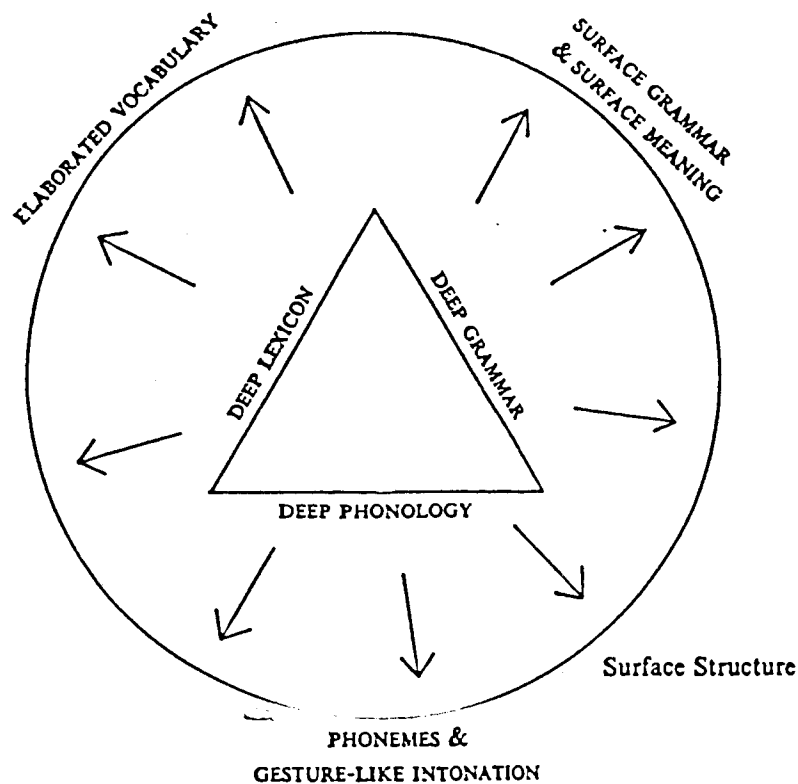
According to Longacre (1976), language has deep structure and surface structure in its lexical, grammatical and phonological components³ (see Figure 6.1), and it is probably accurate to say that text annotation is in essence an attempt to move beyond the surface phenomena to the deep structure. In the lexical field, for instance, one finds the phenomenon that an elaborated vocabulary including words such as 'saunter', 'amble' and 'trot' all belong to the more basic meaning category of walk/run. Much also depends on the size of the textual chunks which one uses as unit of analysis - vastly different deep and surface structures exist

³ In this Longacre draws, of course, on Chomsky (1957). However, Chomsky's work on formal linguistic transformation rules, which relied heavily on contrived examples and artificially limited domains, contributed to the waning of interest in corpus linguistics during the 1960s and 1970s. This interest has only fully revived since the 1980s (Ide & Veronis, 1998).

at different levels such as phoneme, sentence, plot or dialogue (what Longacre calls 'repartee').

The types and complexity of deep and surface structures which can be identified are virtually limitless, depending as much on the kinds of phenomena of interest to different researchers as on objective qualities of language. As Simons and Versaw (1992) point out, ordinary English orthography tends to mislead one into thinking that text is a one-dimensional string of characters, while in fact it could more accurately be viewed as a string of (more-or-less) 'ordinary' orthography, plus "a multidimensional set of annotations provided by the analyst" (p. 1.3), the 'analyst' being not necessarily a linguist, but also, for example, an ordinary person engaged in conversation.

Figure 6.1 Surface structure and deep structure for three components of language
(from Longacre, 1976)



However, hand-annotated texts are not cheaply or easily produced. A grammar tagging project initiated by Leech & Garside (1991) illustrates the difficulties encountered when extensive annotation of a large corpus is attempted. Although the authors based their work on a simplified phrase structure grammar, automated several aspects of the annotation process, and set up a "grammar factory" of more than 15 highly trained individuals to parse sections of text, the project repeatedly floundered under the sheer volume of work. So time-consuming is the task of even relatively simple annotation, that projects such as these often seem to lose sight of the original purpose for which the annotations were required (such as to generate a probabilistic grammar of spoken English), and are presented in academic forums as if the act of annotation were in itself a sufficient achievement.

The effort involved in coding is one reason why the proportion of corpora containing text annotations is likely to remain small. Another is that the production, distribution and consumption of large bodies of computer text is increasingly in the hands of individuals other than professional linguists. With the advent of CD-ROM drives for microcomputers, CDs containing several million words of copyright-free corpus material are now available at very low cost to researchers (Atkins, Levin & Zampoli, 1994). There is also a growing library of encyclopaedias, technical reference books and even magazines available in machine-readable format to the 'ordinary' user. Market forces have ensured that the volume of texts available from these sources has become far larger than the corpora painstakingly assembled by linguists over several decades. In addition to commercially available sources of machine-readable texts, the now almost complete computerisation of office work means that large corpora can be collected with little effort from newspaper offices, schools, hospitals and other large and small bureaucracies. One of the text samples used in this dissertation comes from such a source.

Finally, the advent of the internet has now made literally billions of pages of machine-readable text available to virtually anybody.

Carefully constructed and thoroughly annotated corpora will no doubt remain much sought-after commodities (Ide & Veronis, 1998), as will corpora containing transcribed speech. However, social scientists interested in language are increasingly finding themselves awash in machine-readable texts with no hope of even the tiniest proportion of these ever being hand-annotated. If, as post-structuralists claim, "the reality that any individual inhabits is a vast inverted pyramid of discourse poised on a tiny apex of experience" (Tallis, 1989, p. 13), then the availability of machine-readable texts in large quantities opens up hitherto unheard of possibilities for exploring that reality. These possibilities can however only be realised if ways are found to extract anything but the most trivial information from 'plain-English' texts. Although techniques from corpus linguistics have not progressed far beyond the trivial (Church, Gale, Hanks, Hindle and Moon, 1994, compare a lexicographer to "a person standing underneath Niagara Falls holding a rainwater gauge, while the evidence sweeps by in immeasurable torrents", p. 153), their combination with discourse analytic methods could enrich both approaches.

Three broad classes of techniques used in automated analysis of unannotated texts can be identified. These are word frequencies and type-token ratios; concordances and collocations; and automated tagging.

Word frequencies and type-token ratios

The most obvious way of processing machine-readable text is simply to count words. Thus it may be of some academic interest that the total number of words in an earlier version of the previous two pages was 677, that 343 unique words were used, and that the most frequently used word ($n=37$) was *the*, as indeed it is in the Brown corpus where it occurs more than 68 000 times (Hofland, 1991). A sorted list of words from the two pages in question (Table 6.1) may seem to provide extremely trivial information compared to an actual reading of the pages. However, faced with the task of reading the 3 500 or so pages of the Brown corpus one may well be grateful for such scraps of information as can be revealed by frequency counts.

Table 6.1 Sample word frequency list from two pages of text

N	%	Word	N	%	Word
0037	5.26	THE	0034	4.84	OF
0019	2.70	TO	0016	2.28	AND
0015	2.13	IN	0013	1.85	IS
0012	1.71	AS	0011	1.56	A
0007	1.00	TEXT	0006	0.85	BE
0006	0.85	SUCH	0006	0.85	THAT
0005	0.71	CORPORA	0005	0.71	OR
0005	0.71	WHICH	0005	0.71	ARE
0005	0.71	ANNOTATION	0005	0.71	ONE
0004	0.57	LEXICAL	0004	0.57	DEEP
0004	0.57	TEXTS	0004	0.57	FOR
0004	0.57	DIFFERENT	0004	0.57	STRUCTURE
0004	0.57	LARGE	0004	0.57	ON
0004	0.57	SURFACE	0004	0.57	WORK
0003	0.43	SOURCES	0003	0.43	FROM
0003	0.43	THESE	0003	0.43	EVEN

Note. The table has been truncated

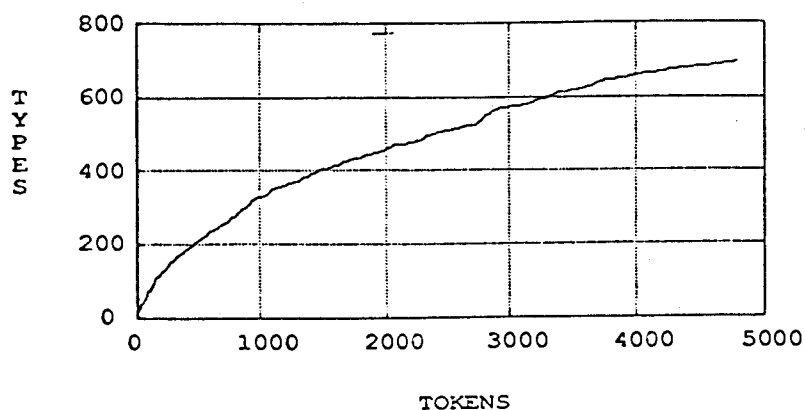
Comparative counts may be particularly informative. Thus the fact that *shall* occurs 0.9 times for every 10 000 words in an Australian corpus compared to 4.2 in the Lancaster-Oslo/Bergen corpus of British English (Collins, 1991) is more interesting than the Australian data alone. Similarly, the fact that the word *corpora* occurs five times in the two sample pages from this dissertation, but not once in the Brown corpus, does give some idea of the nature of the discourse produced on these pages. Words such as *text*, *annotation* and *lexical* also appear much more frequently in this chapter than one would expect from their prevalence in other general English texts.

Methods of comparing texts in terms of word frequency vary in sophistication. A typical example is the work of Kukulska-Hulme (1992) whose comparison between frequency word lists (function words removed) from a data security handbook and a user's manual for a particular computer system reveal a low degree of overlap or 'hit rate' (20%), from which he concludes that the handbook would prove confusing to many users. However useful word frequencies may prove for particular purposes, it is hard to escape the impression that for the most part the inferences which can be drawn will remain inconsequential. One attempt to use word frequencies in a more sophisticated manner is the so-called type/token ratio.

'Tokens' refer to the total number of words in a section of text, while 'types' are unique words. The type/token ratio is therefore quite simply "the number of different words as a ratio of the total number of running words" (Butler, 1985, p. 14). What the type/token ratio reveals is 'vocabulary richness' and it is for instance used to compare different authors' writing styles. Together with other stylistic 'fingerprints' such as word and sentence length, vocabulary richness can, amongst other things, help settle questions of disputed authorship.

A major drawback of the type/token ratio is that it depends not only on the author's style, but also on text length: The longer the text, the smaller the ratio. Thus the very high type/token ratio of 0.51 (343/677) for the two sample pages taken from this dissertation says as much about the shortness of the sample as about the richness of the vocabulary. If the size of the sample is doubled, the ratio drops to 0.44, while in a 30-page sample it is 0.32. If the type-token ratio at different points in a discourse is graphed, a parabolic curve such as that in Figure 6.2 is produced as the writer or speaker gradually 'uses up' the vocabulary available to him or her in the particular context. Despite this drawback, type/token ratios may have some utility, provided that care is taken to keep text length constant when different corpora are compared.

Figure 6.2 Sample type/token graph



Another disadvantage of type/token ratios is that a single index can hardly be expected to provide an adequate summary of an entire body of text. This problem is addressed to some extent by an extension to the type/token ratio, the Vocabulary-Management Profile (VMP),

introduced by Youmans (1991). The VMP involves plotting a curve which shows the number of new types over a moving interval thirty-five tokens long. According to Youmans, peaks and valleys in VMP curves are closely related to constituent boundaries (such as breaks between paragraphs and chapters) and 'information flow' in works of fiction. One would expect similar peaks and valleys in accounts by psychiatric hospital patients, corresponding, for example, to the initial admission, an induction phase, discharge and so on.

Concordances and collocations

While counting word frequencies and computing type-token ratios could be compared to trawling for fish and using the catch to estimate the variety and number of species present in a particular area, concordance building is an attempt to describe the kinds of ecological interdependencies which exist among the different species.

A concordance is essentially an indexed word list indicating the location of words in a text, in terms firstly of formal positional markers (such as Act and Scene in a play) and secondly in terms of the surrounding text (Klein, 1991). An excerpt from parts of a concordance (Wright, 1893) for the King James Bible dealing with the words *word* and *fish* is reproduced in Table 6.2. The table has been re-arranged to be similar to the popular KWIC (Key Words In Context) format for concordances which prints key words in a column down the centre of the page with sections of surrounding text on either side.

Constructing a concordance by hand, as Wright (1893) and others have done for the bible, requires years of painstaking work, and it is therefore not surprising that concordance-building was one of the first literary and linguistics tasks to which computers were put. Computer-generated concordances are less prone to clerical errors than their manually

produced counterparts, but usually require some manual editing to make them suitable for publication. The earliest concordance programs were the COCOA (word COunt and COncordance on Atlas) package and the Oxford Concordance Program (Hockey & Marriott, 1979), and most programs for analysing text corpora now include concordance building as one of their standard features. The indexing facilities available in high-end word processing and desk top publishing programs can also produce output similar to standard concordances.

Table 6.2 Part of a concordance for the King James Bible⁴

Deut 4.18	likeness of any fish in waters
	Eccl. 9.12 fish taken in an evil net
Hab 1.14	makest men as fish of the sea
Matt 7.10	if he ask a fish ?
Matt 17.27	take up the fish that first cometh
Lk. 24.42	piece of broiled fish
	John 21.9 they saw fish laid
	1 Cor 15.39 shall fish them
	Matt. 4.4 every word of God
	Rom. 10.8 the word is nigh
Job 38.3	darkeneth council by word
	Ps 19.14 let the word of my mouth be acceptable
	Prov. 15.11 a word fitly spoken
Ps. 68.11	the Lord gave the word
Is. 29.21	an offender for a word
	Dan 7.25 speak great word against the Most High
Jer. 18.18	nor shall the word perish

Where type/token ratios represent the quantitative pole of automated textual analysis, concordances represent the qualitative pole. Wright's (1893) biblical concordance entry for

⁴ This extract from Wright (1893) is based on what remains the standard concordance compiled by Alexander Cruden (1700-71). Cruden's other notable publication, in 1739, is *The London-Citizen Exceedingly Injured or A British Inquisition Display'd in an Account of the Unparallel'd Case of a Citizen of London, Bookseller to the late Queen, who was in a most unjust and arbitrary Manner sent on the 23rd March last by one Robert Wightman, a mere Stranger, to a Private Madhouse*. Cruden was repeatedly confined in Bethlem and elsewhere for disruptive behaviour consequent upon religious fanaticism (Porter, 1987a).

fish is certainly useful in forming an impression of the kind of submarine ecology within which the word thrives, but this information remains essentially qualitative. Unlike the type/token ratio, which purports to summarise a central feature of a text in a single number (or a series of numbers in the case of the VMP), a full concordance is more bulky than the text itself, leading Brodda (1991) to suggest that one should limit a concordance to between 500 and 1000 'relevant' words. Deciding relevancy is of course not an easy matter. One strategy, that of including the most frequent words, certainly will not work, as high frequency words, such as *the*, *of* and *in* are often semantically the least interesting.

A derivative of the concordance idea but which is somewhat more quantitative in flavour is the tabulation of word collocations, that is, words that habitually occur together. The term 'collocation' was popularised in 1951 by Firth (quoted in Ide & Veronis, 1998), who explained it as follows: "One of the meanings of *ass* is its habitual collocation with an immediately preceding *you silly ...*" (p. 19). Similarly, the collocations of *sin* in the Bible are all those words which occur within a span of a certain number of words of *sin*. In effect collocations are multiple word frequency lists, with a separate list computed for each key word. The list of collocates for *sin* may for instance include *fathers*, *deadly*, and *repent* as relatively high frequency items, while *ass* is most likely a low frequency collocate, or not a collocate at all.

The assumption behind the idea of collocation is that words are not evenly distributed through semantic space, but clump together in more or less distinct constellations separated by lesser or greater tracts of meaninglessness (or unsaid meaning), and furthermore that the force with which words attract and repel is reflected in their relative distance in spoken or written language. Unlike the stars, however, which (as the King James tells us) have been 'set in the firmament' (Gen. 1.17), the ways in which words are constellated may vary from

one discourse to another.

That words do tend to fall into each other's gravitational fields is supported by the fact that "roughly 70% of the running words in the London-Lund Corpus form part of recurrent word combinations of some kind" (Johansson & Stenström, 1991, p. 5). However, the forces which impel words to come together or propel them away from one another are not all of a purely semantic nature. As a weakly inflected language English, as an example, relies heavily on word order to differentiate between the functional elements in a sentence, and the grammatical constraints thus placed on the co-occurrence of words are of a different order from the more abstract semantic similarities and differences which cause words to repel and attract. In general it is likely that the sorts of results obtained from a collocational study will, amongst other things, depend on the distance allowed between collocates (e.g., adjacent words only or all words within a span of say 15 words) as well as on the boundaries which are set (e.g., all collocates, or only those occurring in the same sentence or paragraph). Unfortunately there is currently no consensus on the optimal size of the span of words to use for different purposes, and the value fluctuates among different studies "more or less arbitrarily" (Ide & Veronis, 1998, p. 19).

Automated and semi-automated tagging

Accepting that annotated text is in principle more informative than 'plain English' as it allows glimpses into lexical, grammatical and phonological 'deep structure', one may ask if the task of text annotation itself cannot somehow be automated. To an extent this is indeed possible, and in many cases a thorough automated analysis of unannotated text can be thought of as proceeding in two passes: First, automated tagging of particular features of the text; second,

automated analysis based on the higher-level units thus identified.

Before discussing the successes so far achieved in the automated tagging of texts, it is important to acknowledge that automation is not necessarily an all or nothing affair.

Although more reliable than hand-annotation, automated annotation is, due to the deterministic nature of computer algorithms, incapable of assigning correct codes to text sequences not explicitly provided for in advance. Thus the output from automated tagging programs often has to be manually checked and adjusted (e.g., Leech & Garside, 1991) before being submitted to further analysis. Another strategy is to start by annotating the text manually, but with gradually increasing automated assistance. Simons & Versaw (1992) have developed a method where the analyst assigns codes to text strings (e.g., synonyms in a dictionary project), which are then suggested as possible codes by the computer program when similar instances occur. As the analyst works her way through a text she will therefore start by having to type in most of the codes herself, but eventually reach a point where, for the most part, she simply has to indicate acceptance of the codes suggested by the program.

Moving from computer assisted to more fully automated text annotation, progress has been made in phonological, grammatical and lexical tagging, of which only the latter two will be discussed here⁵. In the field of grammatical tagging, Gervasio, Taylor and Hirschfield (1992) describe a system which assigns a grammatical class to each word in a sentence with an accuracy of more than 80%. This is done without recourse to a large dictionary, but rather by deducing each word's class from its position relative to a small number of 'function' words (articles, auxiliary verbs and prepositions). Words are also automatically grouped into

⁵ Details of the tagging process are also omitted. Thus the first step in an automated analysis is usually text normalisation (Brodda, 1991), i.e., removal of 'noise' such as control characters and (in some cases) punctuation, the expansion of abbreviations and (in some cases) converting the text to upper case.

phrases and clauses with a high degree of accuracy. The frequency of different verb types identified by the system has been used to track changes in the language used by patients and therapists in the course of psychotherapy, and to study the impact of assertiveness training.

DeRose (1991) describes a stochastic tagging system which achieves an even higher accuracy level (96%) in assigning grammatical classes to words. DeRose's system is based on conditional probabilities derived from the Brown corpus. Thus in the sentence *To everything there is a season, and a time to every purpose under the heaven* (Ecclesiastes 3.1), *time* would be judged a noun both because articles are far more likely to precede nouns than verbs (collocational probability) and because time occurs 1000 times more frequently in the Brown corpus as a noun than as a verb (absolute probability). The system determines word class by assigning a 30-35% weight to absolute probabilities and a 65-70% weight to collocational probabilities.

Automatic tagging of grammatical categories is valuable (amongst other reasons) because of the increased fidelity of word frequency, collocational and other analyses performed on tagged texts. Roughly 11% of word types and 48% of word tokens in the Brown corpus belong to more than one grammatical category, depending on context (DeRose, 1991). Even at the most simple level, frequency or collocational information on a word such as *swallow* in any particular text (such as a therapy transcript) would therefore be more accurate if reported separately for its different grammatical senses - according to the dictionary, a verb meaning "to make or let pass down one's throat" or a noun meaning "a kind of fork-tailed swift insectivorous bird".

Unfortunately grammatical category is not the only source of lexical ambiguity, and a word may not only belong to several grammatical categories, but also have several different possible meanings within a particular category. The word *parade*, taken as a noun, is for

instance given six different meanings in the Little Oxford Dictionary (Ostler, 1969), ranging from "muster of troops for inspection" and "ground used for this" to "public promenade". Fortunately the various meanings of a word within a particular grammatical category are often related - even if only metaphorically - so that misclassification only becomes an issue in circumstances, such as automated translation, where finer distinctions in meaning are important. This is not however by any means always the case. For example: Like *swallow*, the word *hawk* may refer either to a kind of bird or to an action performed by the human throat (depending on whether it is used as a noun or a verb), but as a verb it also has another quite unrelated meaning, namely "to carry about for sale".

The phenomenon of one word form having several different meanings may be due to a variety of factors, including homophony (similar-sounding but different words), homography and homonymy (words of the same form but different meaning), and polysemy⁶ (identical words with related but different meanings, e.g., head of a body and head of an organisation). The resulting lexical ambiguity is, according to Brekke (1991), "an all-pervasive phenomenon in Modern English" (p. 83). Brekke points out that "the common core vocabulary of English contains hundreds of high frequency items like *board*, *stamp* and *wall*, which in isolation carry no clue as to which of their specific meanings is intended" (p. 83). In ordinary language use humans perform very rapid disambiguation of such words by referring to the context, but (as Brekke demonstrates for the word *wall*) this is not an easy process to simulate by means of computer algorithms.

As if the problem of single word forms having multiple meanings were not enough, natural language is also plagued by the opposite phenomenon of synonymy - apparently

⁶ Lacan of course claimed that such quirks of language constituted not a problem of disambiguation, but a model for the workings of the unconscious.

different words having closely related or identical meanings. In highly inflected languages this is a particularly common problem. The German verb *aufnehmen* for instance appears in over 30 different forms, while the Finnish verb *ottaa* appears in about 60 forms (Butler, 1985). Often the underlying lexical unit, called a lexeme or lemma, is of more interest than its various forms. Thus one may wish to know the frequency and collocations of the lexeme LOVE, rather than of *love*, *loves*, *loved* and *loving* separately, or of BE rather than of *be*, *is*, *am*, *are*, *was*, *were*, *been* and *being*.

The process of grouping together the forms of a lexeme, called lemmatisation, is according to Butler (1985) difficult to automate, because "the rules for recognising a form as an instance of a particular lemma are complex and have not been specified in a completely explicit way for any language" (p. 14). An additional difficulty is that the nature and degree of lemmatisation required may differ from application to application. In certain circumstances it may be important to consider word forms entirely separately, while in others very loose semantic groupings (such as all colour terms) may be treated as if they formed a lemma. The principles governing depth of lemmatisation, that is, the choice of which thesaurus to use to sort words into semantically related groupings, have not been explicated.

Automated tagging can be conceptualised as the implementation of rewrite rules (Brodda, 1991), that is, applying a set of rules to a text so as to produce a systematically transformed version of the text as output. A rewrite rule concerned with lemmatisation of BE will thus produce output in which all instances of *be*, *is*, *am* and so forth have either been changed to *be* or marked as belonging to the same lemma. The rules which have been discussed thus far apply to the traditional linguistic categories of grammar and lexis, but rewrite rules are of arbitrary complexity, and may be set up to identify and transform any kind of language unit, including those used in content analysis.

Content analysis

Where the kinds of automated and semi-automated linguistic analyses discussed thus far originate from linguistic and literary studies, content analysis historically very much belongs to the social sciences, especially psychology. Now often referred to as a qualitative technique, content analysis in fact straddles the divide between numerical and scholarly approaches, and thus may provide some clues for developing a quantitatively informed discourse analysis

Berelson (1952), one of the early developers of the technique, defined content analysis as the "objective, systematic and quantitative description of the manifest content of communication" (p. 18) - hardly the kind of language that one would normally associate with a qualitative procedure. A decade or so later Stone, Dunphy, Smith & Ogilvie (1966) had dropped *quantitative* from their definition, but stayed with *systematic* and *objective*: "Content analysis is any research technique for making inferences by systematically and objectively identifying specified characteristics within the text" (p. 5). A more recent review of content analysis studies (Viney, 1983) seems to veer back towards the quantitative, focusing mainly on content analysis scales, and discussing these in terms of psychometric properties such as correction factors, reliability and validity.

However, despite its claim to core scientific characteristics such as being objective, systematic, and even quantitative, content analysis also has inescapable qualitative elements. In part this is perhaps simply because it deals with qualitative data (relatively unstructured samples of speech or writing), rather than with discrete physiological, psychometric or behavioural indices. Equally importantly, however, content analysis is partially qualitative because inferring content categories from a sample of text and subsequently identifying

category instances in other samples is a subjective rather than an objective enterprise. The use of multiple raters and reporting of inter-rater reliability coefficients serve to underscore rather than diminish this point.

Attempts have been made to apply computer techniques to improve content analysis as a tool both for discovering appropriate classification schemes to describe texts and for applying these schemes to other texts. Brown, Taylor, Baldy, Edwards and Oppenheimer (1990) describe a system designed to assist in the qualitative exploration of textual data, similar to a manual system which involves the sorting and grouping of index cards. The advantage of the Brown *et al.* method is that a particular section of text can conveniently be related to more than one classification scheme at the same time, instances of any category can be automatically retrieved, while hierarchical and other relations among categories are easily represented in the system. Many of the popular computer-aided qualitative analysis techniques such as Atlas and Nudist (reviewed in Kelle, 1995) work along the same principles.

Rather than assisting in the induction of classification schemes, Gottschalk and Bechtel's (1982) system is aimed at automating the parsing of texts in terms of predetermined classification schemes. Many such schemes (also known as content analysis 'scales') have been developed. Viney (1983) mentions scales for anxiety, hostility, sociability, locus of control (the origin and pawn scales), hope and positive affect; Schnurr, Rosenberg and Oxman (1992) refer to scales measuring pessimism, optimism, rumination and helplessness; and Peterson, Bettes and Seligman (1985) describe a scale for measuring causal attributions to negative events. Gottschalk and Bechtel's (1982) program is based on the well-known Gottschalk-Gleser anxiety scale, which produces scores for death anxiety, mutilation anxiety, separation anxiety, guilt, shame and diffuse anxiety. The Gottschalk-Gleser method of

analysing transcribed speech involves three steps, of which only the second and third have been computerised by Gottschalk and Bechtel. They are: Dividing the text into grammatical clauses (defined as language structures which contain an active verb); scoring each clause for the presence (and in some cases intensity) of a particular construct; and applying correction factors to the summed scores to adjust for text length.

Identification of scoreable instances is achieved by checking each phrase against dictionaries containing key words and word combinations thought to be indicative of the different kinds of anxiety. Content scoring of this sort is therefore an exact analogy of lemmatisation, although a lemma such as DEATH ANXIETY would no doubt appear rather strange to classical linguists. Gottschalk and Bechtel (1982) do not report any attempt to resolve the lexical ambiguity problem which inevitably limits the success of any lemmatisation attempt. Nevertheless, correlations between hand scoring and machine scoring range from .58 to .92 with a mean of .85 (although machine scores are consistently lower).

Towards a quantitatively informed discourse analysis

It would be difficult to imagine a body of work more clearly different in temperament from discourse analysis than that reviewed in this chapter, yet it seems possible that discourse analysis could benefit from borrowing some of the principles and techniques of corpus-based linguistics and content analysis. The two major shortcomings of discourse analysis as viewed from a traditional empirical perspective (insufficient concern for sampling and subjective analysis) are both to a greater or lesser extent addressed in corpus studies.

Corpus studies could represent something of a model of how discourse analysts could go about ensuring more adequate sampling. Potter and Wetherell's (1987) bald statement that

"for discourse analysts the success of a study is not in the least dependent on sample size" (p. 161) was probably provoked by a desire to distance themselves from the kind of social science which takes the individual as its basic unit and considers studies employing more of these units as (potentially) superior. However, as has been shown in the previous chapter, there is nevertheless an effort to sample texts for diversity of origin. Likewise, the constructors of linguistic corpora, while usually quite unconcerned with sample size and composition in the social scientific sense, also make use of such (at least minimally) stratified random sampling techniques to select textual fragments for inclusion. There appears to be a tacit consensus that a 'good' corpus (from the point of view of sampling) is one that a) includes texts from a variety of different sources (oral and written, published and unpublished, dialogues and monologues, spontaneous and prepared, formal and informal); b) clearly identifies the nature and source of each fragment as well as the overall proportions of different kinds of fragment in the corpus; and c) is large. The immense diversity in language use, even in terms of narrowly defined syntactic features, makes it imperative that large, well-structured samples of text should be studied. The question is not if the sample is representative of a population of individuals, but if it adequately represents a certain kind of language situation (e.g., British written English in general or British tabloid newspaper reportage on the royal family during the 1990s)⁷.

As discussed in the previous chapter, an issue which is related to that of the initial sample selected is the extent to which it is exhaustively surveyed in the course of the analysis. Unlike some discourse analytic studies which quote selected illustrative examples in corroboration of whatever inferences are made, corpus studies and content analyses are

⁷ However, in the conclusion to this dissertation I reconsider the implications of specifying the boundaries of textual data sets.

explicitly concerned with systematically parsing the entire text, and presenting results in the context of their frequency in the text as a whole. While type/token ratios, collocational frequencies or content analysis scale scores may not contain quite the sorts of information useful from a discourse analytic perspective, similar kinds of indicators can, as will be shown below, be developed.

In terms of subjectivity, discourse analysis could also benefit from the relative success of attempts at automated analysis reviewed in this chapter. While one has to bear in mind warnings by Potter and Wetherell (1987) and other discourse analysts (reviewed in the previous chapter) against an overly mechanical application of analytic techniques, it is difficult to see why at least certain aspects of the process could not be executed by means of objective algorithms. The product of a discourse analytic study of the Potter and Wetherell variety is an 'interpretative repertoire' which is "basically a lexicon of terms and metaphors drawn upon to characterize and evaluate actions and events" (p. 138), and "often a repertoire will be organized around specific metaphors and figures of speech" (p. 149). Potter and Reicher (1987) return to the same theme in their definition of a discourse as "terms which are used with stylistic and grammatical regularities, often combined with certain metaphors" (p. 27)⁸.

To identify a discourse, or a category in a discursive repertoire, one therefore has to identify certain lexical terms, metaphors, figures of speech, and stylistic and grammatical regularities. At least at face value this seems rather similar to the application of rewrite rules in content analysis or lemmatisation studies, and may be equally susceptible to automation. One could, for example, imagine discourse studies that not only identify discourses in texts,

⁸ The reader may recognise that this and the next paragraph themselves contain phrases recycled from previous chapters of the dissertation, thus demonstrating the emergence of a discursive repertoire in the current text.

but that report on the frequency and distribution of previously identified discursive elements in different textual situations, in the same way as different sorts of content analytic studies are concerned either with developing novel content categories or with applying previously developed content analytic scales.

This kind of scenario of course immediately raises the spectre of reification, precisely the issue which is the main bone of contention in the debate between Potter, Wetherell, Gill & Edwards (1990) and Parker (1990a, 1990b) reviewed in the previous chapter. The moment we give discourses and technologies for discovering their presence in texts explicit definition, we may have created a pseudo-scientific regime every bit as totalitarian as the one currently set up to detect and describe individual subjectivity. A partial rebuttal to this argument is contained in the observation that reification is inevitable, even desirable, and that the question is rather one of degree: Not if discourse analysis should create reified objects, but for how long it should leave them standing. This issue is returned to more fully below.

Apart from the obvious danger of reification, there is also another reason why discourse analysts have avoided adopting more explicitly structured techniques. As discussed in the previous chapter, this has to do with discourse analysis' identity as a 'bottom-up' qualitative technique. The objects discovered by discourse analytic research differ from those of, for example, quantitatively oriented content analysis not only in their theoretical underpinning, but also in how they are constructed. While the latter are often deduced from psychological constructs (such as depression or anxiety) and then rediscovered in individual texts, the former are supposed to emerge directly from the texts, remaining as far as possible at the level of describing how texts are organised.

Rather than the dictionary approach used in lemmatisation studies or automated content analysis (i.e., matching textual fragments to predetermined categories), a

quantitatively informed discourse analysis should therefore ideally approach texts without any preconceived ideas as to the entities which will be found there. This almost a-theoretical posture is not unlike that adopted in collocational studies, which seek to describe the internal ecology of texts from the point of view of nothing more complex than the co-occurrence of lexical items. Potter and Reicher's (1987) definition concerning "stylistic and grammatical regularities, often combined with certain metaphors" (p. 27) as well as similar definitions quoted earlier suggest that the idea of collocation may be the minimum ingredient for a quantitatively informed version of discourse analysis.

One way of using techniques from corpus linguistics in discourse analysis while maintaining the latter's identity as a 'bottom-up' and qualitative technique, is to start the analysis using linguistic techniques for purposes of gaining an overview of the text and then to use this information to guide more in-depth qualitative analysis. This progression is the reverse of that commonly found in discourse analytic studies, in which the units of interest are first determined qualitatively, followed, in some cases (e.g., Gilbert & Mulkey, 1984; Levett, 1988; Van Dijk, 1987a) by tabulation of the frequency with which the different units are found in the text. Content analytic studies similarly follow a progression from qualitatively (or 'rationally') derived content categories to quantitative frequency counts and content scales (e.g., O'Dell & Weideman, 1993; Laffal, 1990; Schnurr, Rosenberg & Oxman, 1992). More generally, the idea that qualitative analysis precedes and prepares the ground for quantitative analysis, that it is good at identifying which questions to ask but less so at providing definitive answers to these questions, is intuitively appealing and often stated (e.g., Kirk & Miller, 1986; Miles & Huberman, 1984).

The inversion of the qualitative-quantitative sequence, although a significant departure from the norm, has a similar purpose as most attempts to combine quantitative and

qualitative methods, namely to render the analysis more rigorous while retaining flexibility and richness of detail. The reason why such an inversion is worth exploring relates to the issue of representativeness, which is often identified as the achilles heel of qualitative research⁹.

Qualitative research not infrequently makes strong claims with regard to representativeness, such as the discourse analytic assertion that the phenomena it identifies somehow emerge spontaneously from the text rather than being imposed on it, but as often has difficulty in demonstrating such representativeness when reporting on the results of an analysis. An apparent lack of representativeness may manifest on at least three levels, each of which is sometimes addressed by recourse to quantitative data, although in each case at the risk of reification.

The first level at which qualitative research may appear unrepresentative, which is the level Miles and Huberman (1984) appear to be alluding to, is when there is the possibility that instances are incorrectly or arbitrarily assigned to categories, i.e., when there is the suspicion of inadequate inter-rater reliability. As has been shown in the proliferation of computer-based content analytic scales, the appearance of unrepresentativeness is perhaps most easily overcome at this level. However, although it is always possible to devise a perfectly consistent classification algorithm, the categories used may themselves lack adequate justification, and it can be argued that content analytic researchers (like psychometrists) have been quick to find solutions for what are essentially trivial measurement problems, while ignoring more fundamental theoretical questions with regard to what they are measuring. As has often been stated, objects such as 'authoritarianism',

⁹ An example is Miles and Huberman's (1984) warning: "Avoid the 'sprinkling' of vivid or interesting examples to spice up the narrative. Rather, look for genuinely representative exemplars of the conclusions you are presenting" (p. 213).

'depression' or 'anxiety' easily acquire a spurious substantiality by virtue of the reliability with which they can be identified.

The second level at which qualitative research may appear to lack representativeness is where there is no indication of the frequency with which particular phenomena occur in a text. An example is Potter and Reicher's (1987) 'discursive repertoire' which details the kinds of metaphors used to construct the idea of community in various accounts of a 'riot', but does not reveal the relative frequency of the different elements of the repertoire. Again, this problem is relatively easily overcome. Some discourse analytic studies, such as those of Levett (1988), Van Dijk (1987a) and Gilbert and Mulkey (1984), take care to report the frequencies of the different discursive phenomena they identify so that it is possible to gauge the relative importance of each. Thus the racist themes 'They have a different mentality' (N=20) and 'They do not respect women' (N=15) can be seen to be much more frequent in the discourses about 'our neighbourhood' analysed by Van Dijk (1987a) than, for instance, the theme 'They steal, are dishonest' (N=7).

The third level at which qualitative research may appear to lack representativeness concerns the ubiquitousness of the identified categories in the text as a whole. Not only would it be interesting to know how frequent the metaphors in Potter and Reicher's (1987) community repertoire are relative to each other, but also how frequent they are relative to the total volume of talk. Did Potter and Reicher have to sift through piles and piles of transcripts before coming up with the occasional nugget, or were community metaphors relatively common in talk about the riot? Did Van Dijk's (1987a) field workers have to plough through hours and hours of conversation before racial issues were introduced by their respondents, or was this one of the main themes when people were asked to talk about the neighbourhood? Even if Van Dijk's textual universe is limited to those extracts which deal with racial issues,

there is the suspicion (particularly in the absence of a catch-all 'other' category) that the racial sub-themes he identifies may cover only part of a larger, less easily organised, domain of talk about race.

The danger of reification at this level of reporting compounds that found at the previous two: Not only is the implication that the identified phenomena stand out as definite topographical features above the general textual landscape, but that the text studied is itself a representative sample of some naturally demarcated region of discourse. Content analytic scales again provide the most obvious example. These usually report on the frequency of particular content categories as a ratio of the total text (measured either in words or phrases) produced by an individual - the unspoken assumption being that individuals are the source of meaning and that the natural fault lines in discourse run between individuals, rather than, for instance, between discourse situations, between different strata of social power or between different discourse communities.

What such quantitative adjuncts to qualitative research appear to have in common is that they tend to be introduced after the fact, as a means of minimally demonstrating the extent to which the illustrative examples provided represent a larger collection of similar instances. The proposed use of corpus linguistic techniques in discourse analysis is also concerned with representativeness, particularly at the third level discussed above (i.e., the prominence of the identified phenomena in the text as a whole), but rather than as a post-hoc check it is intended as a tool to help ensure from the outset that the overall features of the text are used as the ground against which more specific elements are selected for discussion. Thus quantitative information about the text is used to guide qualitative analysis, not to summarise qualitative information.

Corpus linguistic techniques adapted for discourse analysis

In this section I discuss specific ways in which corpus linguistic techniques can be applied as a precursor to qualitative discourse analysis. Seven kinds of techniques are discussed here: lemmatisation, manual mark-up, frequency counts, target-word collocations, collocation counts, contextual markup and lexical nets. Of these, the first four are essentially the same as those commonly used in corpus linguistics, as reviewed above, while the last three constitute elaborations on corpus linguistic techniques. The use of these techniques in actual analysis is demonstrated in the next two chapters.

Manual annotation

The corpus linguistic technique of manually annotating texts using the COCOA (word COunt and COncordance on Atlas) markup scheme, the most commonly used standard (Butler, 1985), can be useful in preparing texts for further analysis. Although complex markup of syntax is probably of little use in discourse analysis, more basic annotations labelling particular sections of text is helpful in later isolating these sections for further analysis. Markup is done by enclosing in angle brackets an identifier or category, followed by a space and then the actual identification. Some typical examples are: <ACT III>; <AUTHOR SHAKESPEARE>; <SOURCE BROADCAST>.

'Root form' and 'Parts of speech' lemmatisation

As discussed above, in principle any text consists not only of a one-dimensional string of orthographic markers, but also of a multi-dimensional set of implicit 'annotations'. One way in which textual analysis can be facilitated is by making such annotations explicit, thus identifying diverse linguistic forms as belonging to a smaller set of lemmas. While the overly psychologicistic types of assumption involved in content analytic lemmatisation may be unacceptable from a discourse analytic perspective, more 'neutral' linguistic lemmatisation could be useful.

Although numerous exceptions and special cases had to be provided for, I found it possible to write a relatively simple computer program to strip away several word suffixes without altering the root form. The program does this with a greater than 90% degree of success. This was the case both for suffixes with a largely grammatical function - the final 's' from most words (which has the effect of converting nouns from plural to singular and verbs to their infinitive form) and the present participle (*-ing*) and past participle (*-ed*) from verbs (which also converts to the infinitive) - as well as suffixes which form nouns (*-ness*), adjectives (*-able*) and adverbs (*-ly*). Other suffixes which can in certain cases be stripped away are *-al*, *-able*, *-ance*, *-ment*, *-ive*, and *-ion*.

The effect of stripping away suffixes is to greatly reduce the degree of (possibly spurious) variation in a text at the cost of giving up some finer distinctions between word forms. Thus *act*, *active*, *actively*, *activist* and *activity* would all be lemmatised as ACT; *emotion*, *emotional* and *emotionally* would become EMOTION; and *sociable*, *sociably*, *social*, *socialise* and *socially* would become SOCIAL. Apart from the information which is lost, this form of lemmatisation is of course also rather inconsistent. The past tense form of a

regular verb, e.g., *passed*, would for instance be changed to the infinitive, while an irregular past tense form such as *could* remains as a separate type.

Root-form lemmatisation of this sort was, after much experimentation, not used in the studies reported on in the next two chapters on the grounds that it tended to obliterate too much of the rhetorical and stylistic texture of the texts. Once tokens were reduced to their root forms, there appeared to be little that could be done with the text other than counting of content categories as is done in computerised content analysis. There may however be types of text other than verbal transcripts for which this may be the most sensible option, and the relative ease with which the kind of automated root-form lemmatisation outlined above was possible, suggests that it may yet prove a useful aid in certain analyses.

Another form of lemmatisation, based on parts of speech, also proved practicable and was eventually used. The procedure is primarily aimed at differentiating grammatical from lexical words¹⁰. Grammatical words identified by the program are articles (*a, an and the*), auxiliaries (*can, could, have, has, had, may, might, must, should, would, ought* and in some cases *be, being, been, is, am, are, was, were, shall, will* and *do, did, doing, done, does*), conjunctions (*after, and, because, but, for, however, since, until, till, yet, while, although, as, moreover, either, so, only and also*), prepositions (*about, above, across, after, against, along, amid, around, at, before, behind, below, beneath, beside, between, beyond, by, down, except, for, from, in, inside, like, near, of, off, over, since, through, till, to, toward, under, until, up, upon and with*) and pronouns (*I, me, my, mine, myself, you, your, yours, yourself, yourselves, he, him, his, hers, himself, she, her, herself, it, its, itself, we, us, our, ours, ourselves, they,*

¹⁰ Grammatical words are words such as articles, auxiliaries, prepositions and exclamations which seem to carry less semantic weight than, for instance, main verbs and nouns, which are lexical words (Butler, 1985). The proportion of lexical words in a text is termed the 'lexical density'.

them, their, theirs, themselves, who, this, that, these, those, such, what, whose and which). In addition, a list of colloquial and contracted forms provided by Butler (1985) which may be considered as grammatical words are coded as such, supplemented with additional South African colloquial forms (Table 6.3). Ambiguous words are coded as grammatical rather than lexical.

Lexical words are semantically richer than grammatical words and a frequency list of lexical words provides a good initial overview of the basic content of a text.

Table 6.3 Grammatical and ambiguous words (adapted from Butler, 1985)

didn't	i've	not	there	why	no
or	very	all	that's	some	uhm
any	going	yes	one	more	when
other	can't	whether	then	want	nothing
go	there's	outside	anything	couldn't	everybody
less	wasn't	OK	haven't	ag	uh
something	weren't	if	anyway	where	you're
they've	shouldn't	within	whatever	i'd	i'll
both	everyone	isn't	that'll	what's	aren't
mmm	oneself	many	mustn't	put	than
they're	how	oh	few	everything	gonna
doesn't	having	should've	never	i'm	don't
here	it's	ja			

Frequency counts

Frequency counts constitute the most obvious means of summarising a text and can be used in discourse analysis to provide an initial overview of the material prior to more detailed analysis. Counts can be given of all types, and of lexical types only. The former tend to provide information on stylistic and pragmatic features of the text, while the latter give an

indication of the substantive topics addressed.

Target-word collocations

These are lists of words which co-occur in close proximity to selected word types, and can be used to describe the general lexical environment in which high-frequency word types occur.

Collocation counts

These are sorted lists of highly collocated types and provide a somewhat more comprehensive idea of the patterns of redundancy which characterise a text. While target-word collocations require only that the collocational probability of a selected sample of types be computed, collocation counts are derived from a matrix of all possible collocations among word types in the text. This matrix is systematically examined, and the most highly related word pairs (calculated as described below) extracted. Although this would seem a natural extension to the idea of target-word collocations, I have not seen this method used in corpus studies. It is however ideal for use as a precursor to qualitative discourse analysis as it provides an overview of the entire text while imposing minimal assumptions about the types of themes or categories to be looked for.

Contextual markup

This technique is also derived from the idea of collocation, although again I have not seen it used in corpus linguistics. It involves the modification of transcripts based on the collocational redundancy of words as revealed by a matrix of all possible collocations. The markup reveals the extent to which the lexical environment of each word token in a transcript is typical of the word type's positioning in the text as a whole. The procedure is to systematically determine the positional 'typicalness' of each word token by computing the average strength of association (described below) between the corresponding word type and the word types in its immediate vicinity. Thus if the types *unable* and *struggle* often occur in the vicinity of *cope*, then *cope* will be marked as being in a highly typical situation in a text fragment such as: "I am unable to cope - I struggle to survive." Each of the other words in the fragment will be similarly marked, depending on the extent to which they find themselves in a lexical neighbourhood which is typical of their occurrence in the transcript as a whole.

Different forms of contextual markup have been developed for the studies presented in the next two chapters, the most sophisticated of which translates strength of association into font size. The program developed to perform this markup determines the font size of each token in a transcript and then re-encodes the token in Rich Text Format, a protocol which is recognised by most word processing and desktop publishing programs. However, the resultant text tends to be quite cumbersome with some words printed in very large font while others appear in a very small font, and this form of markup is therefore probably best used sparingly for illustrative purposes. A markup method which proved more practicable was simply to capitalise all words for which the strength of association (described below) with any word within a certain span of surrounding words exceeds a certain minimum level.

Lexical nets

Finally, lexical nets can be drawn using the information contained in the table of collocations. This is a newly developed method in which the collocational pattern in a text is graphically represented by manually drawing lines between pairs of words which are statistically related (as described below). Various forms of lexical net were experimented with, including ones in which the thickness or length of the lines between pairs of words reflected the strength of the relationship. However, this again proved impracticable and cumbersome, and in their final form lines of uniform thickness were drawn between all words where the strength of the relationship exceeded a certain minimum. The way in which reasonable values for this and other parameters were established is described in greater detail in Appendix 2. The length of the line between words is arbitrary and depends on the way in which words are arranged for each net so as to produce a coherent picture with as few lines crossing each other as possible.

Z-scores

Target-word collocations, collocation counts, contextual markup and lexical nets are all based on some indicator of the strength of association between words. The statistical index used in this study was the z-score (Miall, 1992; Bradley, 1990). The z-score was chosen as this is the most frequently used index of collocation in corpus linguistics. Other measures, such as Yule's Y or mutual information have however also been proposed (Church, Gale, Hanks, Hindle & Moon, 1994; Church & Hanks, 1990). Given the total number of words in a text, the 'span' of words considered to be a target word's typical context (e.g., 5 words on either side), the frequency with which the target word occurs in the text, and the frequency

with which another word (or 'collocate') occurs within the target word's context, the z-score returns a coefficient of collocation which is significant at the 1% probability level when it reaches 2.57 or above.

The formula used in the program used for the analyses in the next two chapters was taken from Bradley (1990), and is computed as follows:

$$z = \frac{C - (P \times L)}{\sqrt{(P \times L \times (1-P))}}$$

- where C = the frequency with which a collocate occurs in the same context as a target word type;
- L = the total number of word tokens in the same context as the target word (at most the span x the total frequency of the target word); and
- P = the frequency with which the collocate occurs in the text as a whole divided by the total number of tokens in the text as a whole.

It is worth noting that the z-score is not symmetrical, so that the probability of word *a* occurring as a collocate of word *b* is not the same as the probability of word *b* occurring as a collocate of word *a*. This may be illustrated as follows: If *a* occurs 500 times in the text, *b* occurs 3 times and the two words occur in the same context 3 times, then *a* is a strong collocate of *b* (since it is present whenever *b* is present), but *b* is unlikely to be a strong collocate of *a* (since it is only present in 3 of 500 cases when *a* is present). In practice, however, the discrepancy between the two z-scores is usually small and where the direction of the association is not of importance the average is taken.

In order to generate a comprehensive overview of the collocational patterns in a text, a matrix of z-scores for each possible pair of the 1000 most common word types is computed, consisting of (1000 x 500) - 500 = 499500 (just less than half a million) individual z-scores.

This matrix can be computed separately for each section of text analysed, and using various different lengths for the 'span' of words constituting a context. This is described in greater detail in Appendix 2. While it may have been desirable to include all word types in the matrix, available computer resources did not allow for this. However, the 1000 most common types account for the majority of tokens in most texts.

Conclusion

In this chapter an overview was provided of various techniques used in corpus linguistics and related fields and ways suggested in which these could be adapted for use with discourse analysis. The use suggested for corpus techniques in discourse analysis goes beyond an adaptation of techniques however, but also encompasses a reversal of the usual quantitative-qualitative sequence, with quantitative techniques employed as a precursor to further qualitative analysis. This is demonstrated in the next two chapters.

Chapter 7

'The unreturning stylus':

Interviews with psychiatric patients

A conversation begins
with a lie. And each

speaker of the so-called common language feels
the ice-floe split, the drift apart

as if powerless, as if up against
a force of nature.

A poem can begin
with a lie. And be torn up.

A conversation has other laws
recharges itself with its own

false energy. Cannot be torn
up. Infiltrates our blood. Repeats itself.

Inscribes with its unreturning stylus
the isolation it denies.

- Adrienne Rich, 1978

In this chapter I present an analysis of interviews conducted in 1993 with a group of patients at a mental hospital in what is now the Gauteng area. The 120-bed hospital, which I shall call Valhalla, was organised into 'bottom' and 'top' wards. The bottom wards were for the more well-defined psychiatric conditions - depression, bipolar disorder, schizophrenia, dementia and mental retardation - while the top wards were for adolescents thought to have behavioural problems, those presenting as anorexics or bulimics, as well as a 'psychotherapeutic' ward for adults thought to have adjustment problems. The patients

included in the study were all from this latter ward, commonly referred to as the 'personality disorder' or PD ward. These patients were chosen as subjects for the study not so much by design, but rather as a result of the process of gaining access to the hospital.

Briefly, I was assigned to the hospital as part of the compulsory national service for whites then in operation in South Africa. My appointment was as a clerk, and much of my time was taken up with administrative duties. However, I was also at times, especially in the first two years, given an opportunity to assist psychiatric registrars and psychology interns with their research work, and it was accepted that I could do some work on my own. On this basis I got to be on reasonably friendly terms with some of the key figures in the PD ward - the psychiatrist, the psychiatric registrar, the matron and several of the nurses - and they allowed me access to ward rounds, and (after a formal proposal had been submitted to the medical superintendent) to individual patients.

Valhalla hospital was at the time of the study still almost exclusively for whites, although legal constraints on admitting black patients had been lifted some time previously. In other respects also the hospital's demographics probably closely reflected that of similar hospitals for short-stay non-certified patients in 'western' countries. The mean age for patients in the PD ward was 31.59 (N=258, SD=9.9); and 37.53 (N=587, SD=19.92) for patients in the other wards. In common with most psychiatric institutions internationally, the great majority of patients in both the PD ward (70.3%) and the other wards (63.5%) were female. Almost a third (27%) of admissions were readmissions. The hospital did not cater for certified patients, although patients were occasionally certified and transferred to other institutions (mainly Sterkfontein and Weskoppies) in the area.

Although a state-funded institution, Valhalla was well equipped (pools, tennis courts, a creche, a nurses' residence, sports fields, spacious gardens) and it had an extremely

favourable staff to patient ratio. A newspaper article described it as looking "like a five-star hotel with well-groomed gardens and lawns, a nine-hole golf course, two tennis courts and a swimming pool" (Weekly Mail & Guardian, 1997). The hospital officially catered for 120 patients, but in practice this rarely rose above 110. To cater for these patients' needs (as well as those of about 1000 outpatients) there were 30 or more full-time psychiatrists, psychiatric registrars, medical doctors, psychologists, psychology interns, psychiatric social workers and occupational therapists, more than 50 nursing staff, 15 to 20 administrative staff, and 80 'general assistants' (low-paid black workers). This clearly compares very favourably with other institutions in South Africa where there are on average 501 beds, 1 psychiatrist per 133 patients and 1 nurse per 31 patients. On an average weekday only 63% of South African psychiatric units have access to a doctor, 30% to a psychiatrist and 17% to a psychologist. Only 3% of patients have access to individual psychotherapy (Visser, Haasbroek & Bodemer, 1989).

Diagnostic categories at Valhalla hospital are detailed in Table 7.1, which is based on discharge data for an 18-month period. When patients are discharged from Valhalla, as when they are admitted, there is a flurry of official forms to be completed, such as the 'Clearance Certificate', which demands that "before discharge from this hospital, patients will obtain the necessary signatures from the undermentioned departments to the effect that they have been cleared", as well as forms to do with whether towels have been handed in, valuables collected, fees paid and so on. These forms all find their way into the patient file which, a day or so after the patient's departure, migrates back from the ward into the central registry where it awaits a possible readmission. Perhaps the most important part of this discharge process is the final diagnosis determined by the discharging physician. This diagnosis is used for various official purposes, such as for the Department of Health's annual statistics and for

medical aid reimbursement purposes.

The information on discharge diagnoses presented in Table 7.1 was collected on a daily basis and reflects about 80% of admissions and discharges during the period. The remaining data were unavailable as a result of my sporadic absences from the discharge office and is unlikely to have resulted in any systematic sampling bias. These diagnoses are based on the anachronistic disease classification system then used by the Department of Health, and are replete with outdated terms such as *organic*, *neurotic* and *reaction*, but nevertheless represent the 'official' diagnosis with which the discharging physician in each case released a patient into the world.

As can be seen from Table 7.1, the most common diagnosis in both the PD and other wards was 'affective psychosis', with fully a third of all patients leaving Valhalla with this label. The next most popular diagnosis in the PD ward was 'adjustment reaction' (25%), while in the other wards it was 'special symptoms not elsewhere classified' (13.8%). The relative blandness of these diagnoses, as compared to the third most popular categories - Schizophrenia (10.7% of discharges from the non-PD wards) and Personality Disorder (9.6% of discharges from the PD ward) - may provide one clue as to why they were so frequently used, and is in itself a commentary on the difference between psychiatry and other medical disciplines.

Table 7.1 Discharge diagnoses of patients at Valhalla hospital

Diagnosis	Other wards		PD ward	
	N	%	N	%
ORGANIC PSYCHOTIC CONDITIONS				
Senile organic condition	4	0.6		
Alcoholic psychosis	3	0.4	2	0.8
Drug psychosis	9	1.3	1	0.4
Transient organic psychotic conditions	2	0.3		
Other organic psychotic conditions	5	0.7		
OTHER PSYCHOSES				
Schizophrenic psychoses	78	10.9	3	1.3
Affective psychoses	278	38.8	81	33.8
Paranoid states	4	0.6	1	0.4
Other non-organic psychoses	1	0.1	1	0.4
Psychosis with childhood origin	1	0.1		
NEUROTIC DISORDERS, PERSONALITY DISORDERS AND OTHER NON-PSYCHOTIC MENTAL DISORDERS				
Neurotic disorders	6	0.8	6	2.5
Personality disorders	11	1.5	23	9.6
Sexual deviations & disorders			4	1.7
Alcohol dependence syndrome	3	0.4	4	1.7
Drug dependence	7	1.0	1	0.4
Non-dependent abuse of drugs	2	0.3	20	8.3
Physiological malfunction due to mental factors	8	1.1	1	0.4
Special symptoms not elsewhere classified	99	13.8	1	0.4
Adjustment reaction	33	4.6	62	25.8
Non-psychotic mental disorder due brain damage	14	2.0	2	0.8
Depressive disorders not elsewhere classified	68	9.5	6	2.5
Disturbance of conduct not elsewhere classified	14	2.0		
Hyperkinetic syndrome of childhood	2	0.3		
Specific delays in development			1	0.4
MENTAL RETARDATION				
Mild mental retardation	2	0.3	1	0.4
Other specified mental retardation	3	0.4		
Unspecified mental retardation	2	0.3		
DIAGNOSIS NOT SPECIFIED	58	7.9	19	8.0
TOTAL	717	100.0	240	100.0

Note: Diagnoses with a frequency of more than 10% are printed in bold. In cases of readmission, the most recent diagnosis is given.

Thus one interpretation of the fact that Personality Disorder was only the third most common diagnosis in the PD ward (well behind 'affective psychosis' and 'adjustment reaction') is that it reflects the invidious position medical personnel are placed in when the vocabulary they have to use reads like a dictionary of insults rather than diagnostic categories. As Kleinman (1988)

observes:

Dysthymia will strike many as only a technical euphemism for unhappiness, hysterical personality disorder as a medical shorthand for uncooperation from aggressive or attention-seeking females, who might regard both the term and the doctors who use it as paternalistic and unempathetic (p. 61).

More specific categories of personality disorder have an even less empathetic flavour, the three broadly recognised (e.g., Yates, Seileni, Reich & Brass, 1989) personality clusters being:

- I. Paranoid, schizoid, schizotypal;
- II. Histrionic, narcissistic, antisocial, borderline; and
- III. Avoidant, dependent, compulsive, passive-aggressive.

No wonder that psychiatrists and psychologists, although they make free use of such terms in their research reports and formal communications (in informal settings I as often heard the expression '*vrot*' personality'), prefer to use less damaging labels such as 'depression' when the diagnosis is meant for more general consumption.

Another more straight-forward interpretation of the relative rarity of 'personality disorder' diagnoses in the PD ward is that it confirms the sentiment repeatedly expressed by the psychiatrist in charge of the ward, namely that the ward was not for cases of Personality Disorder *per se*, but rather for all kinds of patients who were considered likely to benefit from psychotherapy and from the ward's therapeutic milieu. The evidence regarding diagnosis would thus appear to indicate that the patients in the PD ward were not necessarily considered less seriously ill than those in the bottom wards, but simply as more amenable to psychotherapeutic intervention.

¹ Afrikaans for rotten.

In the next section I describe the subset of PD ward patients I interviewed in more detail, both in terms of diagnosis and of other biographical data.

'Subjects and sampling'

I conducted a total of 66 interviews with a group of 38 patients in the PD ward (38 first interviews, 23 second interviews and five third interviews). Of the 38 patients, 25 (65.8%) were female, which compares well with the 70.3% females already reported for the PD ward as a whole and the 63.5% females for other wards. The mean age of the patients I interviewed was 29.11 (with a range from 18 to 39), which is somewhat lower than the mean age of 31.59 for the ward as a whole and 37.53 for other wards.

Ten of the 38 patients were readmissions to Valhalla at the time that I interviewed them, while a further four of the first admissions were readmitted within four years after the initial admission. Thus despite the relative youthfulness of the sample, 14 (36.8%) have now been readmitted at least once. Two patients had a total of six admissions each to Valhalla and together the 38 patients had accumulated 62 admissions. Several had also spent time in other mental institutions.

Final discharge diagnoses making use of the Department of Health nosology described earlier were available for 24 of the 38 interviewees and are shown in Table 7.2. This can be seen to fairly closely match the overall figures presented in Table 7.1. In both cases Affective Psychosis and Adjustment Reaction are by far the largest categories, while Personality Disorder and Non-dependent abuse of drugs are the only other categories above 5%.

Table 7.2 Discharge diagnoses of interviewees and of the ward as a whole

Diagnosis	N	%	Ward %
Affective psychosis	10	42	34
Adjustment reaction	7	29	26
Non-dependent abuse of drugs	3	13	8
Personality Disorder	2	8	10
Depressive disorders not elsewhere classified	1	4	3
Paranoid states	1	4	0
TOTAL	24	100	81

Note. The last column indicates the rounded percentage (from Table 7.1) for the PD ward as a whole. The percentages for the ward as a whole do not sum to 100 as only those diagnoses presented in the interviewee sample are listed.

The diagnostic labels assigned to patients were not however as unequivocal as these tables may suggest. In addition to diagnoses coded in terms of the official Department of Health nosology, the psychiatrist or registrar would normally also note his or her final diagnosis in an open-ended format in the patient file, thus allowing greater scope for the notorious indeterminacy of psychiatric diagnosis to emerge. The various discharge diagnoses assigned to the 38 interviewees are recorded in Table 7.3. However, even the relatively complex situation depicted in this table does not begin to do justice to the variety of diagnostic labels which may be used before a more definitive picture emerges and the patient is ready for discharge.

Table 7.3 Biographical details and discharge diagnoses of interviewees

ID	Gender	Age	Diagnosis
1	F	27	a, b & c. Bulimia
5	M	-	Dependent Personality Disorder
8	F	24	Major Depressive Episode
9	F	36	Substance abuse
10	F	-	Alcohol Dependence
11	F	25	a. Adjustment Disorder (ADJUSTMENT REACTION) b. Depressed mood/ cannabis abuse
13	F	-	a. & b. Borderline Personality Disorder c. & d. Psycho-active Substance Abuse (AFFECTIVE PSYCHOSIS) e. Anxiety State f. Deferred
14	M	-	Alcohol Abuse / Adjustment Disorder
16	M	23	Dysthymia (ADJUSTMENT REACTION)
17	F	-	a. Major Depression Single Episode (ADJUSTMENT REACTION) b. Major Depression Recurrent / Bulimia (AFFECTIVE PSYCHOSIS)
18	M	23	Adjustment Disorder with Depressed Mood (ADJUSTMENT REACTION)
19	M	25	Atypical Depression / Substance Abuse (AFFECTIVE PSYCHOSIS)
20	F	18	a. Adjustment Disorder b. Deferred / Bulimia c. Deferred
21	F	-	Adjustment Disorder / ?Anorexia
22	M	39	a. Dysthymic Disorder (AFFECTIVE PSYCHOSIS) b. Major Depression
23	M	20	Adjustment Disorder
24	F	25	a. Organic Hallucinosis b. Organic Delusional Disorder c. Schizoid Traits
27	F	25	Adjustment Disorder with Depressed Mood
28	F	26	Adjustment Disorder (AFFECTIVE PSYCHOSIS)
34	F	-	Panic Disorder / Major Depression / Dysthymia (ADJUSTMENT REACTION)
35	M	39	Alcohol Dependence (NON-DEPENDENT ABUSE OF DRUGS)
36	F	19	a. & b. Schizophrenia (DEPRESSIVE DISORDERS NOT ELSEWHERE CLASSIFIED) c. Substance Abuse / Schizophrenia
37	M	30	Paranoia / Delusional Disorder (PARANOID STATES)
38	F	33	Alcohol Abuse / Agoraphobia (NON-DEPENDENT ABUSE OF DRUGS)
39	F	27	a. Borderline Personality Disorder b. Depression
40	M	24	Bipolar Disorder rapid cycling
41	F	21	Borderline Personality Disorder
42	M	18	Substance Abuse / Major Depression
43	F	-	Adjustment Disorder (ADJUSTMENT REACTION)
44	F	21	a. Major Depression Seasonal (AFFECTIVE PSYCHOSIS) b. Atypical Depression (AFFECTIVE PSYCHOSIS)
45	F	22	a & b Depression
46	F	-	a. Dysthymic Disorder b. & c. Major Depression (AFFECTIVE PSYCHOSIS) d. Dysthymic Disorder (PERSONALITY DISORDER) e. Panic Disorder / Agoraphobia
47	M	35	Substance Abuse
48	F	26	Substance Abuse
49	F	22	a. & b. Dysthymic Disorder (PERSONALITY DISORDER)
51	F	20	a. & b. Substance Abuse (ADJUSTMENT REACTION)
52	F	23	Substance Abuse (AFFECTIVE PSYCHOSIS)
54	M	22	Substance Abuse / Anxiety Disorder (AFFECTIVE PSYCHOSIS)

Note. 1. ID refers to the interview number. 2. Where diagnoses have been labelled a, b, c etc. these indicate readmissions. Department of Health diagnoses are in capitals and brackets. A slash indicates alternative diagnoses

While it may therefore be useful to try and describe the subjects from whom the raw material for analysis was collected in terms of traditional biographical indices such as sex, age and diagnosis, it is also apparent that these matters are themselves part of the swirl of discourse which accompanies each patient in her passage through the institution, and that it is at best difficult (and at worst contradictory) to maintain a distinction between subjects on the one hand and the discourse which produces them *as* subjects on the other. It is likely that it is considerations such as these which have prompted Potter and Wetherell (1987) and others to question traditional notions of sampling. However, reporting on diagnostic and other details such as those in Table 7.3 does have a certain utility, if only in conveying an impression of how the producers (or conduits) of the discourses to be analysed were themselves positioned in the official discourse of the institution.

In trying to locate the transcripts analysed below, it would certainly have made a difference had the subjects all had iron-clad diagnoses of Personality Disorder, or if all were from one of the bottom wards, just as my own role in co-producing the discourse would have had to be differently regarded if my position in the institution had been different.

In addition to background details on the subjects, information on the conditions within which data was collected is crucial in making sense of any text (Potter & Wetherell, 1987; Van Dijk, 1987a) and this is discussed more fully below.

The interviewing process

I conducted interviews at irregular times when not engaged in other duties at the hospital. Nursing staff had agreed to inform me of all new arrivals in the ward, but in practice this almost never happened. In order to obtain subjects for the study I therefore visited the ward

office as often as possible, identified recent admissions (maximum one night on the ward) from the patient register, and then asked a nurse on duty to call the patient for me. While this may appear to be a relatively straight-forward process, patients were often extremely difficult to track down at such short notice, and due to the nature of my position at the hospital I was unable to institute a more regular system. As a consequence roughly every third patient admitted to the ward was interviewed. I am not aware of any systematic bias resulting from this selection process.

Interviews were conducted in an office near the ward and were tape recorded. I informed patients of the scope (two hour-long interviews) and nature of the study ("a project investigating the language people use to describe their difficulties"), emphasising that participation was voluntary and that the ward staff would not be informed of the patient's decision. Two patients declined participation. One (a middle-aged man) had been brought to the hospital against his will and was under the impression that Valhalla was a commitment facility. His expressed intention was to escape, rather than to participate in hospital procedures, and he was some days later recorded as discharged, coded RHT². The other (a woman in her late twenties) started crying incessantly as soon as she came into the office and I did not feel able to continue with the interview. She was subsequently subjected to a lengthy series of ECT treatments, the outcome of which was described by ward staff as reasonably favourable.

My impression of the emotional state at the start of the interview of those patients who did participate was that it varied widely. Some seemed melancholy, others withdrawn; the majority seemed in reasonably good spirits at the time of the interview, although many spoke of a more general sense of gloom. One woman was in an overly exuberant mood, and

² Refused Hospital Treatment

one man seemed at first not to be talking at all coherently. Both subsequently participated in the interview without much difficulty.

Once patients had verbally agreed to being interviewed, they were asked to sign a consent form (Appendix A) which reiterated the points already made as well as giving assurances of confidentiality. I then asked for permission to switch on the tape recorder and start the interview.

Interviews were between 20 and 90 minutes in duration. A predetermined set of topics (derived from a small pilot study involving five unstructured interviews) were covered in a relatively set sequence, but with considerable scope for digression. The strategy was to introduce a topic, trying to get the interviewee to pursue that (using minimal encouragers, reflection, and follow-up questions), and only introducing a new topic when the interviewee had run out of steam. There were also a small number of questions which I put almost verbatim to each interviewee. The ideal interview structure (although no single interview fully achieved this) was as follows:

Reason for admission. I started off by asking each interviewee directly why she was at Valhalla, typically using a phrase such as: "The first thing that I usually ask people is if they could just tell me why they're here." [17/1]³

Events leading to admission. In answering the previous question, many interviewees alluded to events in the weeks immediately prior to admission. If not, I asked about this, using a formula such as: "If you could maybe just tell me the past two, three weeks - what's been happening, how did it...?" [34/1]

Professional opinions. Interviewees would often mention one or other professional

³ The numbers in square brackets identify the interview from which the extract was taken. The code /1 indicates that it was a first interview.

person (such as a GP, psychiatrist or psychologist) in talking about these events. If not, I would try to establish if they had had dealings with such a person and how this person had defined the interviewee's problem. E.g., "What does your GP think about your difficulty, how does he see it?" [10/1]

Lay opinion: Interviewees often dwelt on the process of coercion and persuasion that led up to admission. If they did not raise the topic spontaneously, I would ask directly what a family member or friend made of their situation. E.g., "What about a family member or a friend or something? I'm still kind of fishing for opinions of other people." [24/1]

Defining and managing depression. 'Affective Psychosis' (which in most cases appears to mean depression) was by far the most common diagnosis at Valhalla as a whole, in the PD ward, as well as in the sample of patients interviewed, and most interviewees mentioned depression in talking about the reasons for their admission. In addition, an earlier study involving patients at Valhalla hospital (Strong, 1987) found depression to be the most commonly given reason for admission to the PD ward. I therefore asked them to explain what they meant by the term. In the two instances in which depression was not mentioned by the patient, I introduced the topic by asking if they considered depression to be part of their present difficulties. I asked for the interviewee's definition of depression using a formula such as the following: "I wonder if you could describe depression to me as if I really had no idea [mmm], as you experience it?" [34/1] I also asked a further 3 standard questions relating to managing depression and the purpose of depression. The depression-related questions were not used in the current study.

Short-term prognosis. I closed the interview by arranging for a follow-up interview in two weeks' time and asking interviewees how they saw things changing in that period. E.g., "...if you could perhaps predict now how things will have changed for you between now

and then." [43/1]

In part due to the practical constraints already mentioned, only 23 of the original 38 interviewees could be located for re-interview two weeks later. An additional reason for the attrition was early discharges (which occur in 20% of PD-ward admissions) and patients who are discharged with an RHT code.

The second interview format was very similar to that of the first.

Reason for admission. Interviewees were again asked to explain their admission to Valhalla. E.g., "To start off sort of the same as last time uh if you can this time just give me sort of for the record a summary of why you are here." [23/2]

Last two weeks. Interviewees were again asked to recount events over the past two weeks, but this time with reference to their stay at Valhalla. E.g., "If you can sort of fill me in about the last two weeks since I saw you last, what's been happening around here?" [23/2]

Depression. The same questions regarding depression asked in the first interview were repeated in the second interview.

Prognosis. Interviewees were again asked how they saw things turning out during the next two weeks. E.g., "So if we assume say two weeks from now, uh if you could predict how things will change for you between now and then." [23/2]

Finally, third interviews were conducted shortly before discharge with five individuals. These took the form of informal discussions and were not intended to be used as part of the formal analysis, but to provide background material. Similarly, although this is not an ethnographic study, I also drew on my experiences for background and to illustrate particular points.

The purpose of all interviews was to encourage interviewees to talk as freely as possible about the nature of the problem which brought them to Valhalla while still retaining

a measure of comparability across interviews and ensuring that certain themes were covered in each interview. The structure of the interviews was not as obtrusively apparent as the above description perhaps makes it appear. The format is perhaps most similar to that used by Van Dijk (1987a) in his classic discourse analytic studies of racism, i.e., relatively free-ranging one-on-one interviews in which particular topics are either deliberately introduced or allowed to emerge 'spontaneously'. Importantly, I would in retrospect have preferred to conduct more informal interviews with less concern for comparability across 'subjects'. A complete sample interview is reproduced as Appendix 4.

Group interviews, as used in Levett's (1988) discourse analytic study have many advantages and may also in retrospect have been preferable. However, there is a particular reason why individual interviews may have been more appropriate in this case, namely the individual nature of the psychotherapeutic interventions used with these patients. Although there was a fair amount of group work, for instance in occupational therapy sessions and much talk about the beneficial effects of the ward milieu, patients clearly understood that, apart from medication, one-on-one therapy was the centrepiece of their treatment. Many patients came to Valhalla while in psychotherapy, often as long-standing clients of one of the numerous therapists in private practice in the Johannesburg area. Once in the ward they were interviewed at length in the course of obtaining a history, followed by weekly therapy sessions with a psychologist, psychiatrist or psychiatric social worker, and more frequent informal one-on-one chats with a nurse-therapist assigned to their case. Thus the interviews I conducted could to an extent be seen as analogous to the one-on-one therapy sessions in which interviewees were already accustomed to exploring their emotional and relationship difficulties, despite the fact that it was repeatedly emphasised that these interviews were purely for research purposes. These interviews were therefore arguably analogous to the

kinds of confessional or therapeutic conversations commonly engaged in by those who have become part of the psychiatric system.

Transcription

I transcribed the tape recordings as soon as possible after each interview, usually within a week. Following Levett (1988), Potter & Wetherell (1987) and Van Dijk (1987a), the transcription format was relatively straight-forward, registering the speaker (myself or the interviewee), indicating pauses by means of dots, and demarcating inaudible and comment sections with square brackets. More complex notations of paralinguistic features such as elapsed time, inflection, and overlap in speaking turns were not used.

Despite the relative simplicity of the transcription task, this nevertheless proved to be one of the most time-consuming aspects of the study, fully bearing out Potter & Wetherell's (1987) rule of thumb that the ratio of recorded to transcription time can be as much as 1: 10. The sheer labour involved in transcription is a constraint often mentioned by researchers attempting to analyse relatively large samples of verbal material, such as Levett (1988) who found transcription time to be 10 to 14 hours per tape. In the next chapter the utility of a data source not dependent on such extensive transcription input is investigated. For the present study I transcribed a total of just less than 100 000 words. The transcribed text was spell-checked, which aided greatly in correcting typos and misspellings and in standardising the spelling of unusual word forms. A word count before and after spell-checking revealed that around 300 pseudo-types (typos etc) were removed in the process.

Contractions such as *don't*, *I've*, *could've* were left as is, and not expanded to their original form. In most cases contractions involved two words only, although at least one

colloquial form (*dunno*) sometimes used in the transcription consists of three words (*do not know*) in its expanded form. The text was annotated using the COCOA format as described in the previous chapter. Identifiers used were SPEAKER (with values SELF or INTERVIEWEE), INTERVIEWNO (FIRST or SECOND) and TOPIC. Values used for TOPIC related to the different sections of the interview as set out above.

Analytic strategy

The analysis consisted of qualitative discourse analysis, informed by quantitative indices as set out in the previous chapter. The analysis was concerned with highlighting recurrent patterns of talk about mental illness, chronicity and readmission, rather than to look for the causes of readmission in possible individual differences in language use. The purpose of the analysis was also not to highlight psychiatric patients' experiences of serial incarceration, but rather to reveal something of the architecture of the 'prison house of language' within which they were temporarily or permanently resident. Thus no attempt was made to test for significant differences among different diagnostic groups or between readmissions and first-time admissions.

The text analysed consisted, for the most part, of those sections of the transcripts representing the interviewees' speech. My own contribution was only included where it was necessary for making sense of sample extracts. Although the general tendency to exclude the interviewer's speech from discourse analytic studies can be seen as a weakness of the approach, this is mitigated in this case by the fact that the interviewer's contributions have been described in considerable detail above, so that the context within which interviewees spoke is relatively clear.

The analysis is presented in two parts. First, I analyse the entire first interviews, excluding the sections in response to the standard questions on depression. Second, I compare the first and second interviews in terms of the sections that follow after the standard question on why interviewees were at the hospital. This section, which is at the start of each interview and follows a more-or-less standard question from me, most closely approximates responses obtained under controlled experimental conditions and could therefore more legitimately be used for comparison than the rest of the interviews, which often differed markedly from the first to the second occasion⁴.

Each of the two parts of the analysis were done in two phases. First, quantitative indexes and lexical nets (as described in Chapter 6) were calculated. Second, these were used as a starting point and backdrop for qualitative analysis. As discussed previously, I have throughout excluded my contribution to the conversation from the quantitative indexes, but in the qualitative analysis I have in places included it as part of illustrative extracts to help provide a context for what is said. I have also, towards the end of the analysis, included a number of extracts from third interviews for illustrative purposes, although these were not part of the main analysis.

Each section of qualitative analysis typically starts with a discussion and interpretation closely associated with a particular quantitative index, e.g., part of a lexical net. The procedure followed in constructing this qualitative analysis was as follows. First, I located all extracts containing the collocational pairs (or longer sequences) contained in the part of the net being analysed. Second, I examined these extracts with a view to understanding the typical functions of the collocational pairs or sequences and to identify

⁴ It could be argued, however, that in limiting the comparison to this standard part of the interview I have been unduly influenced by ideas of 'spontaneous' versus induced speech. This point is taken up again later in the dissertation.

types of talk that repeatedly occur in close proximity to the collocations. Third, I selected what appeared to me to be representative extracts and presented these as illustrative material together with the analysis. Finally, I in some cases extended the qualitative analysis to consider thematically, but not necessarily statistically, related issues. No attempt was made to systematically pursue different levels of analysis, such as topics, metaphors, story elements and rhetorical devices separately. Instead, whichever features appeared from the quantitative data to be prominent in the text were brought into the discussion.

Preliminary quantitative overview of the first interview corpus

The corpus of first interviews consists of 33 644 tokens, 2 729 types, 12 377 lexical tokens and 2 545 lexical types. The type-token ratio is 1:12.33 and the lexical density 36.79%. The 60 most common types, representing 18 943 tokens or 56% of the corpus, are shown in Table 7.4.

Table 7.4 Sixty most common types in the first interview corpus

I	2227	and	1257	to	988	the	774	a	643	that	623
of	522	it	519	was	514	you	512	uh	503	my	503
know	458	me	439	in	380	just	307	I'm	300	because	286
but	274	it's*	273	they	273	don't	260	ja	244	she	244
like	242	so	224	for	217	is	214	I've	214	not	206
at	202	with	187	very	182	what	175	had	169	think	166
he	165	have	163	on	161	been	158	no	155	well	154
this	154	then	153	about	146	got	141	all	139	do	136
here	134	be	127	get	127	go	119	there	116	really	115
one	113	if	112	out	110	time	109	that's	108	as	107

Note. Frequencies are shown next to each type. * *it's* = *it is* (*its* did not feature among the first 60 types)

As can be seen from Table 7.4, by far the most common type used is the pronoun *I*, which is almost twice as common as the next most frequent type. In fact, no fewer than 5 of the 60 most common types refer to the first person singular (*I, my, me, I'm, I've*) and, despite representing only 0.18% of types, together account for 10.95% of tokens. Every tenth word uttered by interviewees directly indicated the first person singular⁵. Although this may seem a trivial fact, it underscores the extent to which interviews of this sort constitute what Foucault calls 'confessions' about the self.

Turning to lexical types (Table 7.5), several clusters can be identified. The only types that appear to be directly related to psychological problems are *depressed* (N=64⁶) and *depression* (N=43). A separate count revealed that 66% of interviewees gave depression as the primary reason for their admission, with an additional 15% mentioning suicide attempts or suicidal thoughts as the primary reason, giving a total of 81% (as opposed to 42% who at one time or another were assigned a diagnosis of depression or dysthymia). It is perhaps not surprising that interviewees should be unaware or avoid direct mention of the other common diagnoses (alcohol or substance abuse, adjustment disorder and personality disorder⁷). What is remarkable is that none of the many other more moderate 'lay' and professional terms for mental illness figured in the top 60 lexical types. An examination of the full list of lexical types revealed that types such as *neurosis, neurotic, psychosis, psychotic* and *nervous breakdown* are all absent. Types such as *nerves* (N=5), *nervous* (N=1), *anxiety* (N=6), and stress-related types (*stress* N=9; *cope* N=12; *support* N=4), are nowhere near as frequent as depression-related types. In these interviews *depression* appears to have almost completely supplanted other shorthand formulations as an explanation for being in a mental hospital, possibly because it connotes extreme mental anguish while avoiding any implication of insanity, but also because it has considerable medical and scientific legitimacy.

⁵ Of course words like *you* and *one* are also often used to indicate the first person singular.

⁶ Unless explicitly stated otherwise, all frequencies in this chapter refer to number of types or tokens, not number of subjects.

⁷ *Personality* appears 7 times, although inspection of the transcripts revealed that 2 of these were not in conjunction with *disorder*, while the remaining 5 came from an interview with a single patient (a nurse), who repeatedly identified herself as suffering from *personality disorder*.

Table 7.5 Sixty most common lexical types

know	458	just	307	think	166	well	154
got	141	get	127	really	115	time	109
things	105	thing	100	people	93	say	88
said	86	now	82	feel	75	see	74
lot	69	come	68	work	65	depressed	64
back	63	actually	62	mean	61	help	59
two	58	sort	55	day	54	last	54
much	52	went	51	take	51	problem	51
always	51	getting	49	way	47	quite	45
even	44	life	44	problems	43	depression	43
years	42	good	41	bit	41	started	40
used	40	Valhalla	39	home	38	thought	37
feeling	37	better	36	again	36	talk	35
whole	35	look	34	three	33	understand	33

Note. Frequencies are shown next to each type.

In addition to *depression* and other illness-related words, another group of nouns could be read as specific and non-specific indicators of the difficulties patients describe themselves as having to deal with: *things*, *thing*, *people*, *work*, *problem*, *problems*, *life*, *Valhalla* and *home*. Another group of verbs and adverbs appear to refer to epistemological concerns: *know*, *think*, *really*, *see*, *actually*, *mean*, *thought*, *understand* and possibly *feel* and *feeling*. These will be discussed in the context of the collocational pattern among types in the corpus, reproduced in Appendix 3.

The span of 8 (4 on either side of the target word) used in calculating collocations is the same as that for Figure A2.3 (Appendix 2), as this appeared to represent a fair compromise between more extreme possibilities. This span is likely to highlight typical word pairs and phrases, as well as connections among words that tend to occur in fairly close proximity without being part of the same repetitive phrase. A minimum collocation frequency of 15 was set to ensure that identified collocations would occur on average at least once in

every second interview. To limit the complexity of the web, the first 218 collocations to a minimum z-score of 11 were used. The collocational information in Appendix 3 was used to draw up the lexical net (as discussed in Chapter 6) shown in Figure 7.1. Before discussing Figure 7.1, however, a brief section of text is subjected to contextual markup to provide a foretaste of the types of redundancies that are identified by this method.

Getting into the text

Below is a more or less randomly chosen extract from the first interview with participant number 34, a young woman in her first admission to Valhalla:

- M: Ja, maybe a bit of that, who knows?
I: I don't know. Because you know I explain it to my doctors but what, the thing is there, we, we get our tablets from Valhalla [ja]. Every time you go you just start getting used to a new doctor, you know doctor, then a new one comes [ja, ja]. And she'll have her [-s], you know her say, and then you get used to her, and then another one will come [ja, ja]. And there's this one who keeps on pressuring me I must go and work, I must go and work. And like last year I got an after-school job, you know looked after children after, in the afternoons [yes]. And these attacks, I started getting these attacks in class, you know [ag]. And at the end of this year, December last year, they said to me look you know they, look you know [inaudible]. Ja. That's embarrassing for me. I'd love to go and work. And I do, do you think I like sitting at home and things like that. It's embarrassing.

A bio-psychiatric interpretation of this woman's difficulties would probably depend on collateral information regarding the nature of the attacks and the treatment received, and if these suggested no organic or major psychiatric problem she would be consigned to the wastebasket of 'personality disorder'; a psychological reading would similarly probably want to place the woman as a histrionic personality with passive-aggressive and dependent traits;

while a sociological reading would perhaps try to relate aspects of her form of post-deinstitutionalised existence to classic themes from older forms of institutionalisation (e.g., the ironic story of the long-time inmate having to educate the novice jail-keeper in the ways of the institution). A reading sensitive to issues of power would want to highlight the subtle (although ultimately perhaps self-defeating) ways in which the woman both colludes with and subverts the demands of institutional authority.

All such readings would tend to focus on the semantically rich portions of the account - getting tablets from Valhalla, having to explain things to a succession of new doctors, being pressured into going to work, the embarrassment of an attack, sitting at home - and largely ignore the apparently unremarkable linguistic commonplaces which link the 'purple patches'. It is precisely these normally almost invisible redundancies which are foregrounded when the extract is subjected to contextual mark-up based on the collocational information in

Appendix 3:

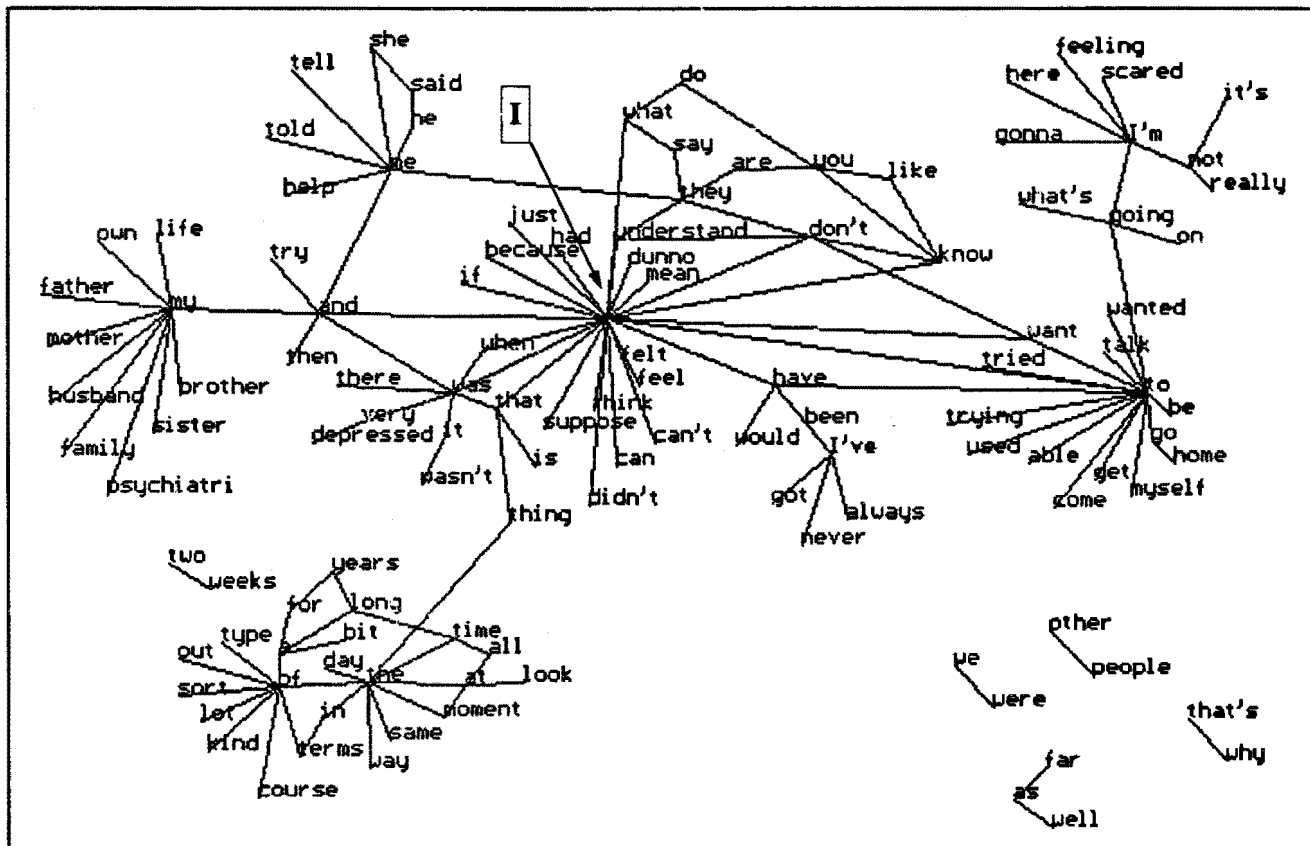
I don't know because you know I
explain it to my doctors but what the thing is there we we get
our tablets from valhalla every time you go you just start
getting used to a new doctor you know
doctor then a new one comes and she'll have her
you know her say and then you get used to her
and then another one will come and there's this one who keeps
on pressuring me I must go and work I must go and
work and like last year I got an after school job you
know looked after children after
in the afternoons and these attacks I started

getting these attacks in class you know and at
the end of this year December last year they said
to me look you know they look you know
ja that's embarrassing for me i'd love to go and work and
I do do you think I like sitting at home and
things like that it's embarrassing

The collocational data used for the markup in a sense represent those patterns of speech closest to the surface. It will be shown, however, that these verbal gestures can be used as a good start for understanding what goes on in 'psychological' conversations. Figure 7.1 is a lexical net of the most prominent connections between words in the interviews, incorporating all the collocations listed in Appendix 3.

Despite the tragic circumstances that the interviewees find themselves in, there is something almost comical about the textual universe shown in Figure 7.1, with all the embarrassing little indispensabilities of everyday talk (*sort-of, and-then, last-year, that's-why*) set out for display. As a (sort-of) sentence generating machine, it can be used to crank out any number of little confessions: *My-mother-and-I-don't-want-to-talk, She-told-me-to-say-what-I-don't-understand, And-then-I-would-have-wanted-to-go-home...* At the same time as facilitating discourse, however, this 'technology of the self' sends it along certain predetermined paths - misquoting Foucault, these are 'stammered, imperfect words with very fixed syntax'.

Figure 7.1 Lexical net of the first interview corpus



Getting to know you⁸

At the centre of the net in Figure 7.1 is of course the first person singular, with a myriad possibilities radiating from this cardinal point: I know, think, suppose, mean feel, felt, want, can, can't, didn't, don't, and so forth. However, the most prominent collocate in Appendix 3,

⁸ I have given somewhat flippant titles to sections of the analysis as a comment on the banal and rehearsed nature of much of the interaction between myself and the interviewees. In doing this I do not, however, intend to deny the very real suffering behind, and in, what was said.

you know, does not involve the first person, but the second - which is connected to the first only through the verb *know*. Some extracts help to give the flavour of the ubiquitous *you know*

know sequence:

- [17/1]⁹ so I DIDN'T really THINK YOU KNOW it necessary
[20/1] I DIDN'T WANT to live any more and uhm YOU KNOW
AND THEN
[44/1] to discover why YOU KNOW I FEEL the way I do
[48/1] and the post mortem and the YOU KNOW all the
other things
[54/1] phoned just at the wrong time YOU KNOW
[48/1] and the police investigation and YOU KNOW

With contextual markup reflected in font size, *you know* screams out from every page of the transcript, as in the following short extract:

- [28/1]
M: I see, so it's all mixed together?
I: yes and even just to be in the ward depresses **you**
know even just to see what those people go through
you know that **you** can actually that a human
being can go through such hard times then you
realise that you **YOUR** problems **are** minor compared to
you know

You know, although I have not seen it referred to in the discourse analytic literature, is very common in spoken discourse and has been extensively studied in corpus linguistics. It has, amongst other things, been referred to as a 'verbal filler', 'fumble', 'softening connective', 'cajoler', 'compromiser', 'hedge', 'plea for cooperation' and 'conversational greaser' (Holmes, 1986) and may have any of these functions depending on the context. However, Holmes maintains that *you know* has a core meaning which leads speakers to choose it over other

⁹ Figures in square brackets refer to interviewee number (before the slash) and interview number (after the slash).

possible 'fumbles' such as *sort of* or *kind of* (present in the bottom left corner of the net). This core is an allusion to the relevant knowledge of the addressee in the context of the utterance - i.e., "you know the kind of thing I mean".

You know may not be more common than usual in the present interviews. Holmes (1986) reports that it accounts for 1.3% of a small (30 000 words) New Zealand corpus of transcribed informal conversation, while it comprises just over 1% of the present corpus.

Irrespective of whether *you know* has a special meaning in these interviews over and above its usual role in interpersonal interactions, it does serve as a reminder that not only myself as the interviewer, but also interviewees were actively engaged in fabricating a sense of mutual understanding, in charging the conversation with what Adrienne Rich called 'its own false energy', and in fostering the illusion of a 'so-called common language'.

At the same time *you know* is also a subtle form of resistance to the tyranny of the confessional. While on the one hand it affirms the existence of a shared understanding between speaker and listener and perhaps even implies the listener's privileged claim to understanding ("you know more than I do"); on the other, by allowing for certain things to remain unsaid, *you know* is also an effective information-withholding device.

Two other collocational pairs at the centre of the lexical net, *I don't* and *I know*, which are often part of the longer *I don't know* sequence, form an apparent mirror image to *you know* but in some ways may have an almost identical function. Extracts featuring *I don't know* as a more-or-less overt knowledge-withholding device are listed below:

- [1/1] I DON'T I DON'T really KNOW, really
- [11/1] I DON'T KNOW. I DON'T KNOW how TO answer that question, it confuses me
- [10/1] I DON'T KNOW what you mean
- [2/1] I DON'T KNOW BECAUSE I'VE NEVER I'VE NEVER really. I DON'T KNOW ja, anyway.
- [8/1] YOU KNOW it's very difficult to tell the truth sometimes. I DON'T KNOW.

[19/1] I DON'T KNOW IF I CAN be more detailed than
that
[46/1] Anyway I DON'T KNOW

These sorts of utterance could of course have many functions (and perhaps often have them simultaneously) - withholding knowledge, incitement to instruction, stalling. The interview is an intricate dance around the precious commodity of knowledge, which starts with my assuring the interviewee of the confidentiality of the material they are about to divulge and ends with snippets of that material being publicly released (as for example in this dissertation). This trading and withholding of confidences occur in the minutiae of sentence construction, as is visible in the lexical net, as well as on a larger scale with the sharing or otherwise of factual information and self-understanding. In a sense the binary tension between revealing and withholding is what keeps the interview, and perhaps the hospitalisation, going.

Apart from the merely linguistic constraints visible in the lexical net, there are of course many other kinds of rules concerning how the flow of information from private to public should be managed. When these are transgressed the interview grinds to a halt and the therapeutic value of the hospitalisation is brought into jeopardy. One patient, for example, scandalised the therapeutic staff by taking photographs around the ward and insisting on tape-recording her therapy sessions (something habitually done by trainee therapists). When she resisted gentle persuasion to stop these activities, legal sanctions against bringing cameras and tape recorders into state mental institutions were invoked.

Although I consciously tried not to encourage interviewees to reveal sensitive information (partly because I was fearful of upsetting them and partly because I did not want to be seen as usurping the role of therapist), I felt inordinately pleased when such information was volunteered. One young man, for example, signalled early in the first interview that he

could potentially make an important confession:

[23/1]

M: Ja [laughs]. Uh, how do you predict will things have changed for you by then?

I: Well, as I'm not here out of my own will, uh I've got to try my best, I can only gain something, I can't lose anything [ja]. So I can only gain something, and go out, and give the world another bash, you know [ja]. See how it goes. Maybe, maybe this place would have helped me, and maybe I don't tell them anything.

M: How do you mean by that?

I: Maybe I don't want to tell them. Maybe, maybe it's too ... personal for me to tell.

M: Right. I don't know to what extent they'll try and dig it out of you.

I: Maybe they haven't got a spade! [laughs]

By the second interview, he seemed much more willing to accept the therapeutic value of confession:

[23/2]

Well I get a lot of things that have been bothering me from maybe when I was in my teen, when I was in my teens, and getting that out, all my worries, and all that, and why I'm really here, because I tried to commit suicide and all that ... And I think [thera] therapists [inaudible] lot of things out that I've wanted to get out for a long time, but I just haven't had the ... right person to talk to about it, in a way, you know ...

When I saw him again shortly before discharge, he finally presented me with the gift of his confidence. I felt both pleased and quite ashamed of having so easily slipped into the role of psychological father confessor:

[23/2]

I: The main thoughts that occupied my mind before trying to commit suicide ... to do with my problems at work and financial problems ... Uh I was still worried about my parents' divorce as well as other things that had been bothering me since my teens ... Mmm ... Like ... What, can I just say something else?

M: Yes.

I: [inaudible] ... Since my teens. What bothered me

- was
- M: Do you find it hard to talk about?
- I: In a way ja. What bothered me was, my relationship with my friends ... and ... getting girlfriends. Like all my friends had girlfriends and not me [mmm].

Despite resorting to therapeutic tricks such as "do you find it hard to talk about?", I at times thought myself more straight-forward and authentic than the hospital's therapeutic staff, many of whom seemed to have cultivated a certain clinical distance. Of course this show of openness (and sometimes collusion) on my part, could equally be construed as just another technique for eliciting disclosure, different in kind but not in effect from that produced by more accomplished therapeutic agents. The following extract both describes the kind of disclosure elicited by therapists and in itself epitomises the type of collusion I sometimes managed to involve interviewees in:

[54/1]

Uh ... my therapist is this very distant person who tries to outstare me all the time [laughs]. She's totally non-committal. She'd make an excellent politico [M laughs]. She nods knowingly all the time. And she could actually wear a mask or, you know, that type of thing. Come in wearing a, wearing a bloody, you know visor and that type of thing. And then she just nods sagely occasionally and, and, OK it's good if, if I'm really worked up and I can go in there and she asks me how I am and I give her like twenty minutes of how bad I am [laughs] and then tell her well you asked, type of, type of thing ...

Unlike *you know, I don't know* and similar epistemological devices at the centre of the net (*they don't know, I don't understand, they don't understand*) in fact explicitly extend the problematic of shared knowledge beyond the dyadic interaction with the interviewer to all such figures of potential medical or psychological authority, at one and the same time acknowledging this authority and signalling a more or less tacit resistance to it:

- [49/1] I DON'T KNOW I DON'T FEEL depressed
 [8/1] I DON'T KNOW what they're gonna do, I DON'T KNOW.
 [11/1] I DON'T necessarily KNOW what they mean but I take it to heart AND I CAN go and sit and cry and get totally depressed about it.

Thus *I don't know* often functions with *they don't know* to construct a domain of privacy which both should and should not be penetrated by the gaze of official knowledge. The inner self should be sacrosanct:

- [8/1]
 I DON'T like people knowing things that I DON'T WANT them TO KNOW. So in other words now, I HAVE nothing secret, nothing. AND I THINK it is very important for a person TO HAVE some secrets. So now I'M GOING TO HAVE TO make up another secret so that THEY DON'T KNOW that.

And however hard they may try to know, they never will understand what is really going on with me:

- [17/1] THEY DON'T live, THEY DON'T UNDERSTAND my world. THEY DON'T, THEY DON'T, you see
 [22/1] I just feel I'm probably A BIT tired from work, A BIT irritable ...and well I [inaudible]. And thing, people around you DON'T UNDERSTAND [yes], THEY can't cope with it, THEY DON'T, THEY DON'T really WANT TO GET involved.
 [39/1] THEY can't UNDERSTAND it. They tell me YOU KNOW, how, but why, YOU KNOW, the same old story [ja] AND THEN my mom's attitude now is just TO GET better.
 [45/1] THEY DON'T UNDERSTAND moodiness, or how you can, stupid things can worry you where, where it's nothing of consequence to them.

Where "they" don't, can't or shouldn't know me, "I" don't necessarily understand them or myself either:

- [5/1] I DON'T UNDERSTAND things people do and say, why they do them, what happens TO ME, why things happen TO ME [mmm] AND ... I tend TO BE over-sensitive AND I [mmm] take things ... too seriously, I DON'T KNOW.
 [8/1] Ja, it's it's I DON'T UNDERSTAND why. That's

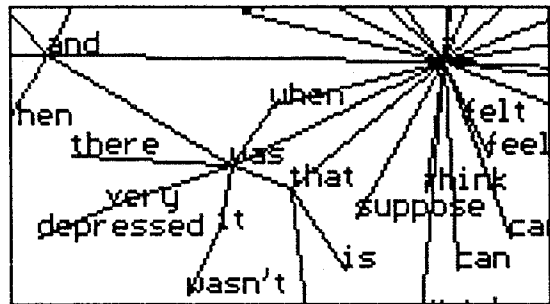
- the only thing I DON'T UNDERSTAND.
 [44/1] Uh AS FAR AS I UNDERSTAND it I suffer depression. I'M NOT sure whether it's endogenous or whether it's reactive.
 [48/1] I HAVE attempted to UNDERSTAND within myself ...I FEEL very very deeply

Thus what emerges from the epistemological tangle at the centre of the net (*you-know -I-don't-know-they-don't-understand-I-understand-they-understand*) is the modern (private) self, both colluding in and denying the intersubjective moment of mutual understanding (*you-know*), both wishing to be and resisting being understood - the sadly misunderstood, uncomprehending subject of truth:

- [1/1] I really DON'T KNOW, YOU KNOW. I really DON'T KNOW. I'm sure that's why I'm here. Because I'M NOT sure how to cope.

The blues

Growing under this canopy of general incomprehension are of course numerous more specific ailments, but the only one sufficiently common to be caught up in the lexical net was



the sequence *I-was-very-depressed*¹⁰. This sequence rarely appeared as such, but in many cases the *I was* pair occurred in relatively close proximity to *depressed*, *depression* or *very depressed*. As already mentioned, depression appears to be the preferred way, in this group of patients, of accounting for being admitted to a mental hospital. Even where other issues such

¹⁰ This is so even though the parts of interviews specifically relating to depression had been excluded.

as drug taking are mentioned, they tend to be subsumed under the depression label:

[1/1] uh I WAS drinking far too much, uh I WAS VERY
uh ... DEPRESSED

This was also sometimes the case even where the stereotypical *I was and very depressed*
pairs did not occur:

[11/1] I'm here because I'm depressed and I I'VE BEEN
taking cocaine.

[36/1] I smoked dope with him [mmm]. AND THEN, I
DON'T KNOW, I just, then I started getting
depressed again, I'm really depressed.

However, once again a subtext of resistance is audible behind the pat answers regarding
depression as the cause for hospital admission, frequently in association with knowledge-
withholding devices such as *I suppose* and *I dunno* discussed earlier:

[8/1] Uh, well its I DUNNO I I SUPPOSE I FEEL pretty
... depressed

[16/1] Uh, I DON'T really, I SUPPOSE depression.

[34/1] Ag I SUPPOSE I'm suffering from depression or
something, I DUNNO, I just DON'T FEEL well.

[49/1] I'M HERE for a depression I THINK. [You think?]
Ja [laughs]. I DON'T KNOW. I DON'T FEEL
depressed.

To further distance the self from this diagnosis, even while proclaiming it, the attribution of
depression is also often imputed to professional others:

[5/1] I DON'T KNOW ...UhI KNOW from WHAT THEY
SAY, from what psychiatrists have said TO ME,
uh ...THEY just SAY ...uh I suffer from
depression ...I DON'T KNOW

[52/1] Uh well I haven't been officially told but I
guess for depression.

[8/1] So they think that by coming here I'M GONNA I'M
GONNA come to the hospital. They gonna TELL ME
that I'm depressed and uh they gonna make me
all better. Well that's how they think it's
gonna happen [mmm]. YOU KNOW I DON'T THINK
THEY quite UNDERSTAND that it's ...I DON'T
UNDERSTAND it myself, but ...I DON'T KNOW, JA.
I DON'T KNOW what they think. I just ...I just

FEEL that they're doing this TO ME. THEY want ME TO be here, it's it's a good thing. I DON'T KNOW, it's strange.

Depression, it would appear, is something which is inherently difficult to recognise and diagnose correctly. Either it is hidden so deeply in the inner core of the subject that others fail to notice it, or professionals flounder around looking for the correct way of diagnosing and treating it:

- [11/1] To a person who doesn't understand depression, and never FELT it [yes] - they thought I WAS just plain lazy. And I wasn't - I WAS really feeling depressed [ja] and my job was starting to suffer cause I wasn't [inaudible]. My bosses were starting to get upset. That's basically it.
- [39/1] AND THEN I went for blood tests, AND THEN I went to my psychologist. And we were just talking, YOU KNOW. But I still couldn't get out of the depression. I WAS getting deeper into depression [yes]. And out, when people looked at me, I looked fine [ja, ja]. I looked fine.
- [46/1] Uh this time I'm here BECAUSE I WAS VERY suicidal and VERY destructive. I used TO GET VERY angry with A LOT OF things. Uh originally I WAS here for a major depression, but now it's a dysthymia something, I'M NOT sure what.

Thus depression, as the major symptom of a misunderstood and impossible to understand patient is itself mysterious:

- [17/1] I've obviously been DEPRESSED, VERY DEPRESSED about four months back, really depressed. But I, it's, it's, you see I DON'T UNDERSTAND BECAUSE I. Uh does depression uh encompass the feeling of, obviously the feelings of like [inaudible] and all that, but I actually force my mind not TO WANT TO care, not TO WANT TO think, not TO WANT TO do, not TO WANT TO BE. Is that depression?
- [20/1] Ja, uhm, when I WAS, it is funny like when I WAS really depressed, I, I DIDN'T really feel depressed. I WAS running all over the place getting anxious and, and doing crazy things.

AND THEN I took anti-depressants AND THEN I felt better. And now, afterwards, I'M just FEELING low. I'M NOT even being crazy, I'm just low [ja].

[44/1] Uh as far as I UNDERSTAND it I suffer depression. I'm not sure whether it's endogenous or whether it's reactive. I THINK it's A BIT OF both [ja], AND I become extremely suicidal. I DON'T HAVE a great love for life as it is [ja]. And that's basically why I'm here. And also to discover why YOU KNOW I FEEL the way I do about MY LIFE and my circumstances.

I was although associated with *very depressed* is also frequently used in other contexts.

Sometimes it is used to introduce long-standing problems ([10/1] it's been going on since I WAS a child) or more immediate precipitating conditions ([52/1] IT WAS JUST I JUST DIDN'T do anything I couldn't work), but most often it signals legitimization of the current admission in terms of previous psychiatric treatment:

[16/1] ja uh I WAS at X-clinic ... I actually overdosed after I WAS AT THE X
[28/1] I WAS in the X-hospital before I came HERE
[36/1] well I I WAS HERE in 1987 and I WAS HERE FOR 6 months
[39/1] uh I WAS HERE August September last year I'VE GOT temporal lobe epilepsy
[43/1] uhm the reason why i'm here WAS I WAS discharged from X-hospital
[46/1]] uh originally I WAS HERE FOR a major depression ... this time I'M HERE BECAUSE I WAS very suicidal

It is interesting that even in the context of a superficial attempt to explain the reasons for admission to a mental hospital, previous admissions to the same or other institutions should play such a conspicuous role. Many of these interviewees seemed clearly embedded in a discourse of perpetual patienthood, as is exemplified in the following extract:

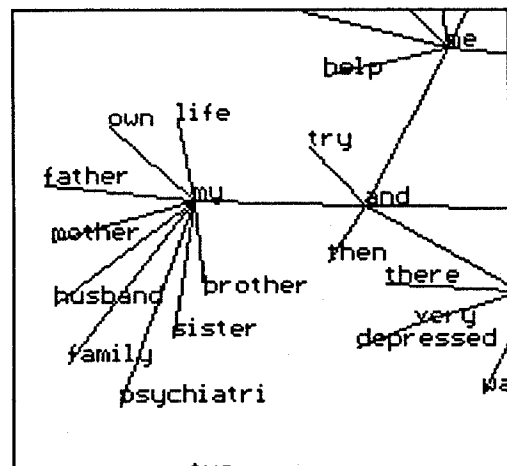
[10/1]
WELL uh I'M VERY DEPRESSED [mmm]. AND it's been GOING ON since I WAS a child [ja] and it's just over the years I'VE GOT to a point now where I MEAN I FEEL I need help

and they have TRIED TO treat ME over the years and nothing seems to help [really?]. ja.

In my experience many patients do more than merely drift along in a state of serial chronicity, but often, at the very least, express an awareness of the ironies of their condition. For example, I asked one patient in an informal conversation how long she had been at the hospital during her previous admission. Her response was: "The first time ... two months. The second time ... my whole life." Another patient told me a funny (and perhaps somewhat rehearsed) story about a party for ex-patients that he had attended. At 6 o'clock everybody suddenly became restless and the next moment wherever you looked the little yellow packets in which the hospital's outpatient department dispenses medication appeared.

Mommy daddy me

From the epistemological never-never land of *You-know-I-don't-know-they-don't-understand-I-don't-understand-that-I-was-very-depressed-here-before*, into which the psychologised self is perpetually both readmitting and discharging herself, it is a relief to turn (reading the lexical net



from left to right now) to the more clearly demarcated territory of the family (*my-mother-my-my-father-my-brother-my-sister-my-husband-my-family-and-me*). As we have been told so often, there is a 'stigma' attached to being admitted to a mental hospital, and in its first incarnation the family indeed appears in these interviews as actually or potentially scandalised, or as uncomprehending and sceptical:

- [23/1] Well ... Well the first time MY MOTHER, MY FATHER, and my mother's couple of friends knew about it ... Well most of my mother's friends knew about it, and my father's. But uh the second time I DON'T even THINK they wanted to tell their friends about it
- [24/1] So I've told them its something to do with my drugs and they've got TO just GET the drugs back into balance. So I lied TO my grandmother and my aunt. MY MOTHER I DON'T KNOW what she's thinking, she's in X. MY FATHER thinks it's like protective custody.
- [34/1] Like MY MOTHER, LIKE YOU KNOW if she comes out and I tell her I'm feeling sick, she says ah just forget about it, YOU KNOW, stop thinking about it, YOU won't feel LIKE it. I said I'M NOT thinking about it [ja]. Because I USED TO BE a very active person.

Not only does the patient present her illness as an embarrassment for the family, but also as an occasion for expressing concern (echoing recent professional concerns about the 'burden' mentally ill people place on their families) that she may be negatively influencing this otherwise healthy family:

- [5/1] I get VERY DEPRESSED and that, and upset [mmm]. And because they love me it affects them to ...a very great extent to ...YOU KNOW they get ...I just affect them A LOT and I'll land up pulling them down with me [mmm] which is not fair [mmm].
- [17/1] I've driven MY SISTER crazy, YOU KNOW. Because LIKE, instead of doing something constructive AND active AND positive, I DON'T. I dwell on it, YOU KNOW [ja].

There is also the older theme of the family, not as the victim, but as the cause of the mental illness, creating the conditions for all manner of psychological damage: Bereavement

([11/1] when I WAS little MY BROTHER DIED; [38/1] I WAS crazy about MY FATHER and he died), abuse ([43/1] MY HUSBAND can be very abusive and at times violent with me), family break-up ([23/1] MY MOTHER

and FATHER are divorced), and impoverishment ([17/1] MY FATHER and MY MOTHER, YOU KNOW, they have this very poor SORT OF background).

This is the Freudian family, generator of traumatic childhood memories (irrespective of the objective significance of what happened) that come flooding back and threaten to engulf the present:

[50/1] AND I CAN remember since I WAS small WE WERE living on a plot uh MY BROTHER actually said TO ME that, I WAS seven or five, I DUNNO I DIDN'T even start school yet, I WAS five, MY BROTHER said TO ME THAT I WAS sleeping with a little kaffir¹¹ ... I MEAN THAT hurts, YOU DON'T realise ... how much, it's a bottleneck, everything just goes in, and it hurts. It's hurting now, more, than I THINK it's hurt that time [ja].

However, far more prominent in the interviews than any of these stock images is that of the medicalised family:

[34/1] [What's your mother think of the, of the whole ...?] Ag she's also under the doctors [laughs]. She's, also been here. [Is it?] Ja. [You mean she's also got difficulties of her own?] Ja, ja. And MY other SISTER, and MY other SISTER. We all, basically, you know suffer with our nerves [ja]. All of us.

Even if not themselves patients, the families that emerge from these interviews approximate the ideal families of the psychiatric literature to a remarkable extent, working in close partnership with professional caregivers for the benefit of their errant members.

[5/1] Uh, I was just ...well I WAS I WAS staying down in X [mmm] and ...uh ...I DON'T KNOW ... just ...I lost my job and everything went wrong and ... uh my mom found out and she came down to X and fetched me and SAID it ... SHE thinks its time I should do something [mmm]. Between her and MY BROTHER they convinced me well to come

¹¹ Derogatory term for African.

back with them AND TO ... try AND GET professional help [mmm] AND ... I agreed TO COME back with them and I ... went to see some people and I'VE BEEN referred here.

[53/1] I THINK MY MOTHER has been helpful. She ... YOU KNOW she just organises things for me, she'll always phone doctors and she had SORT OF spoken to people and she's found out about a certain psychiatrist and got me into hospital and uh ... that KIND OF thing.

Not only do families assist patients to get connected up with the psychiatric system ([8/1]

Ja well uh, MY BROTHER phoned the crisis centre [mmm] and they sent us here), they also cooperate closely in the process of diagnosis, acting (although not always successfully) as interpreter between psychiatrist and patient:

[22/1] I KNOW they went to see ... a psychiatrist, MY BROTHER AND MY mom, just TO GET an idea of what it WAS, AND I CAN'T remember what the psychiatrist said. And they're still confused [mmm].

[36/1] No they, they, the psychiatrist at the X-hospital who saw me after I took my first overdose SAID that HE doesn't think, told MY MOTHER THAT he DIDN'T THINK I WAS schizophrenic, AND THAT they had actually made up a wrong diagnosis of me [ja], two years ago.

As before, patients also describe themselves as resisting, often passively, the process of physical and mental incarceration through which the medicalised family tries to guide them:

[17/1] I DIDN'T WANT TO COME HERE [ja]. Uh, when my family, MY BROTHER, tell me [inaudible] you're sick and you need some help [ja]. And didn't believe THAT myself, I WASN'T interested in helping myself AT ALL. So that's why I'm here [laughs]. I'll do whatever I HAVE TO, but I'M NOT REALLY into it.

[24/1] She made me phone MY FATHER. AND uh tell him, YOU KNOW, THAT I should be HERE. I MEAN she was very for me coming, more than I WAS [oh is it].

When cooperation is given, it may be reluctantly, and to achieve extrinsic rather than intrinsic

objectives:

[8/1] But uh ...I DUNNO, I DUNNO what they gonna do, I just. Look I'M GONNA give it a bash [ja] and if they, if the therapy starts helping. Because I'VE GOT to I'VE GOT to I'VE GOT to come right, YOU KNOW. I'M GOING overseas so, I'VE GOT TO GET my head together. And you see this is a condition. You see MY MOTHER will not send me overseas unless I get this whole thing done TO ME [oh]. So IF I, IF I pull out of HERE, I won't go.

At other times, the family itself comes to be presented as just another institution in the patient's listless migration from one facility to another:

[36/1] I DUNNO. Unless I CAN live off MY MOTHER for the rest of MY LIFE, but I DON'T THINK I CAN. Or else I could GO TO X-Hospital, and just. But you see I DON'T WANT TO GO TO X-Hospital either [ja]. I DON'T WANT TO do anything.

The final member of this extended family to rise to the level of visibility in the lexical net is of course the psychiatrist (*my psychiatrist*), and we would expect her to play an even more active role in getting the patient incarcerated than the rest. But instead we find her arguing, ineffectually, *against* entering or remaining in the hospital and having her ideas about the appropriate form of institutionalisation thwarted at every turn:

[16/1] And HE SAID OK Monday you must go [i.e., leave the hospital]. And I said no I'M NOT ready, Wednesday. And HE SAID uh OK. Wednesday I said no I'M NOT ready I'll go on Friday. HE SAID Friday that's it, finished. So Friday I went out. Uh, the weekend wasn't very good. An enjoyable Monday. The day was quite a good day. AND THEN the early hours of Tuesday morning, about half past two IN THE morning I took an overdose, about two hundred tablets. AND uh THEN I was in, YOU KNOW I woke up from a coma in X-hospital [ja], pipes coming out of me, all those machines on. AND THEN uh, the psychologist came, or psychiatrist, and SHE SAID uh Valhalla.

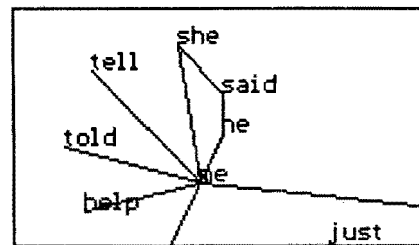
[19/1] I raised the idea of Valhalla in therapy. Over the last TWO WEEKS I raised WHAT my state was AT THE MOMENT, and if he thought IT WAS a good idea. And ultimately HE SAID, yes, but uh ...uh ...how CAN I express it, only in response to explicit questions.

[21/1] [What's the psychiatrist think of coming here?] He's very opposed to institutions.

[39/1] [So the work felt it would be a good thing to go to Valhalla?] Ja, MY PSYCHIATRIST didn't. [Is it?] Ja, because she thought I WAS doing fine. She sees me, but then the work see me every day.

The oracle speaks

With one exception, I found it impossible to ascribe more than syntactic functions to the remaining branches of the lexical net, i.e., the *they-say-what-do*



sequence, the *want-to* and *wanted-to* sequences, the *have-been* sequence, the *I'm-scared* and *I'm-going* sequences, and the independent sub-net around the *type-of-the* sequence. The exception is the *he-said-she-said-tell-me-told-me* pattern near the top left of the net. My expectation was that this would typically involve blow-by-blow accounts of arguments, and in a few cases this was so:

[11/1] AND I started accusing him of being with someone [mmm], of which the maid THE next DAY SAID that HE was. And HE SAID HE wasn't and that was basically the final straw.

Much more commonly, *he-said-she-said-told-me-tell-me* signalled a pronouncement by a professional or lay counsellor regarding the true nature of the patient's illness, often followed by a ritual endorsement by the patient.

[11/1] No, she, I told her about MY LIFE and SHE SAID could understand WHY I WAS DEPRESSED BECAUSE I HAD just come out OF A relationship where I HAD, where he, I found him in bed with somebody. And I freaked out because I was rejected [mmm].

[17/1] Uh, HE SORT OF SAID that uh ...Well HE, HE, HE SAID THAT I obviously haven't made any improvement or any, I've just got worse and worse. And uh thought that my environment has been ... constantly [inaudible] and reinforces the whole negativity in me [mmm]. And the fact THAT I WANT TO stay alone and keep myself isolated is not good. AND I I know he's right.

The ideal form of the oracular *he-said-she-said* pronouncement appears to be that of a deep insight (not necessarily by a professional) into the workings of the patient's mind:

[11/1] Ja, but this has been GOING ON like AS FAR AS I CAN remember. I remember an instance WHEN I WAS twelve years old AND ice skating AND I bought somebody some lip gloss. And SHE SAID you don't HAVE TO buy my friendship, YOU KNOW [mmm]. THAT I remember, THAT I remember as clear as daylight.

[28/1] YOU KNOW HE SAID TO me I KNOW exactly what's going through your mind, it's a place for the mad.

The pronouncement following *he-said-she-said-tell-me-told-me*, when it involves suggestions regarding treatment, seems almost invariably to elicit assent, but of a rather passive or even lukewarm variety:

[8/1] She TOLD ME that she's uh helped me enough now and I'VE GOT TO GET MY LIFE together, YOU KNOW. So I said cool, that was it.

[16/1] And SHE SAID no SHE recommended Valhalla, so I said OK, anything that'll make me better.

[34/1] Well SHE SAID they'll send me off for a few days TO GET treatment, and they at least can put me on the proper treatment [ja], YOU KNOW. Because IT'S getting worse, I DUNNO.

[39/1] So down I WANTED TO commit suicide, which I HAD

a blade, and I WAS contemplating. So I went AND told MY PSYCHIATRIST [ja], and uh ... SHE SAID I must hand the blade in, which I DIDN'T. I handed the blade in here, in case I might need it, YOU KNOW.

The *help-me* sequence, which is part of the same cluster on the net as *he-said-she-said-tell-me-told-me* is thematically also strongly related, often taking the form of a formulaic expression of hope that hospitalisation may be of some use:

- [01/1] [Is there anything good about being here?] Like I said, I SUPPOSE Valhalla being better equipped to HELP ME.
- [02/1] They're professional people and they ... can HELP ME more than what an outsider can.
- [04/1] They couldn't get.. uh.. what is really my, my illness [mmm] and uh ... that is why she had to TELL ME that day they they will bring me here at Valhalla [mmm] since I heard Valhalla is maybe more advanced in medication [mmm] to HELP ME with uh I [inaudible]

As with other psychological and discursive traps of this sort, interviewees were not necessarily unaware of the ambivalence of the position they were being spoken into. One interviewee, for example, spoke at length of how his mother would always help him ([05/1] She she also took ME to people for HELP, she never gave up ... right until she died she ... always TRIED TO get HELP for ME, YOU KNOW), while at the same time suggesting that:

- [05/1] Instead of helping us, she's always DONE everything FOR us [mmm], instead of helping us with it [mmm], YOU KNOW. IF I went to her with HELP, instead of helping ME, she would do it, and consequently I ... It comes to me going out on my own now, and I DON'T KNOW how to do it [mmm].

He also spoke wryly of how the same pattern would be repeated with a friend:

- [05/1] He would help me a lot ... You know where my mother left off he just carried on [mmm]. I told him not to. I said rather help me with something [ja], don't do things for me [ja,

ja].

At other times, interviewees complained bitterly that the form in which the help was being offered was not sufficiently directive:

- [02/1] THEY DON'T say much, YOU KNOW, THEY just ...
THEY DON'T TELL ME what to do, which doesn't
help much. I DON'T KNOW what to do myself.
- [08/1] She [a previous therapist] was, she was OK, but
she sort of betrayed my trust, which I won't go
into. [Did she go back to the family?] She SORT
OF she she helped me for like four years and
then she didn't she like stopped helping me.
She TOLD ME that she's uh helped me enough now
and I've got to get my life together, YOU KNOW.
So I said cool, that was it.

We are back, therefore, in the land of the singular individual, who cooperates, does not cooperate, half-heartedly cooperates, with sovereign power; the private self whose inner being may be glimpsed only in moments of intersubjective understanding and oracular revelation.

- [5/1] I DON'T KNOW what's wrong with myself. I'm
just hoping they can TELL ME [mmm]. And I'm
just hoping they can change it or TELL ME why
I'm doing, what's wrong [mmm].
- [54/1] And that's everybody, that's absolutely
everybody has TOLD ME that, YOU KNOW you've
been through therapy because your face is wet
[laughs]. So I'm A BIT apprehensive about
that.

Occasionally the ideal of the intense intersubjective moment is realised, when patient, therapist and official transcript (each in their allotted place in the hierarchy) all converge on the same truth, and the self is finally realised as a mobile form of chronicity:

- [43/1]
Well yesterday morning he spoke TO ME from about a
quarter to 10 to after 11 o'clock. Obviously he'd had my
file from the other hospital [ja], but he'd read it
thoroughly, because he was asking me questions, but HE
could TELL ME the months and the years. Where I could

maybe just say the year, and he could say yes THAT WAS October or September or whenever. So, I felt as if he ... he knew what was GOING ON. AND THEN immediately he pinpointed the three areas where I HAD HAD problems ... Uhm so I FELT that he was very aware of what was GOING ON.

Before and after

Admission to a mental hospital, like so many rituals of modern life, is an overtly interventionist step. Although the aims of hospitalisation are now often more modest than they once were - typically to stabilise medication, forestall suicide, or offer respite from unbearable circumstances rather than to embark on intensive therapy - the patient is nevertheless supposed to emerge a different, and hopefully a better, person. In getting a proposal to do this research project accepted by the hospital's management committee, I therefore found myself using phrases such as the "influence of hospitalisation on patients' speech patterns" and "the way in which hospitalisation affects patients' use of language". It is difficult not to slip into causal and uni-directional formulations of this sort when dealing with diachronic material, which may be one reason why non-positivist approaches such as discourse analysis are (with the notable exception of Foucaultian analysis) so rarely used to analyse changes over time (Levine, 1996).

Although the comparison between the way patients talk about the reasons for their admission shortly after being admitted, versus two weeks later, was meant to show how discursive patterns may have changed in that time, one should be careful not to ascribe this simply to the 'influence' of the hospital environment. The change or lack of change is also a function of the analytic technique of collocational analysis. While patients may have undergone profound changes at other levels, the stock collocations they draw on may in

many cases be typical of those that occur in all forms of informal talk and may therefore be impervious to rapid change; conversely, the technique may be particularly susceptible to rapid oscillations and any differences found may be unrelated to the two weeks of hospitalisation.

More important, however, than uncertainty about the stability of the technique used, is the probability that patients do not merely passively absorb influences and then betray the signs of these in their speech, but actively negotiate particular discursive positions to contend with changed circumstances at the beginning and some way into hospitalisation.

At the immediate level of their relationship with me, for example, the ostensibly standard stimulus to which interviewees were asked to respond (a request to explain why they were at the hospital) had a very different meaning on the first and second occasions. In both cases it was a fairly disrespectful question, although I of course attempted to soften this through my body language and the way in which I introduced the question. However, the question was disrespectful for different reasons on the two occasions. On the first occasion it was an intrusive question by a stranger relying on his position of relative power and expertise to oblige the interviewee to construct some form of reasonable response. On the second occasion the question was posed by someone with whom a degree of trust had been established, and who was thus even more strongly positioned to expect an answer. This was again demeaning to the interviewee - not so much because it was an overly intrusive question, but because asking a question that had already been answered implied that the interviewee was an experimental subject whose responses would not be taken at face value.

I therefore tried to bear in mind the pitfalls of an overly simplistic stimulus-response interpretation in comparing the two sets of responses, but will not discuss this in detail again, and in what follows apparently causative and uni-directional remarks should be read as being

made in the context of the above caveats.

Preliminary quantitative overview of the reason for admission corpora

Since they represent only those sections of the interviews dealing with the reason for admission, the corpora¹² used for the before-after comparison were much smaller than the first interview corpus thus far analysed, namely 1252 tokens and 1756 for the first and second corpora respectively. This is only 3.7% and 5.2% the size of the first interview corpus. The number of types used is also much smaller - 394 and 459 for the first and second corpora respectively, which is 14.4% and 16.8% of the first interview corpus. The type-token ratios are far larger - 1:3.17 and 1:3.83, as opposed to 1:12.33 for the first interview corpus - indicating greater vocabulary richness (i.e., more different words per number of running words). However, as discussed in Chapter 6, higher type-token ratios can also be a consequence of smaller corpus sizes.

The 20 most common types in the three corpora are shown in Table 7.6. As can be seen from the table, there is considerable stability among very high-frequency types such as *I*, *and*, *to* and *the*, irrespective of whether the whole interview or only the part dealing with reason for admission, and whether the first or second interview is considered. Of the 20 most common types in the first interview corpus only two do not occur among the first 30 types for the reason for admission corpora. This is an indication that much of the basic materials used to construct meaning in these interviews remain relatively invariant across different situations.

¹² I labeled these the first and second reason for admission corpora.

Table 7.6 Rank order of common types in the first interview as a whole and in sections of the first and second interviews dealing with reason for admission

Whole Interview		Reason for Admission	
First Interview		First Interview	Second Interview
1.	I	1	1
2.	and	2	2
3.	to	3	4
4.	the	5	5
5.	a	6	8
6.	that	9	10
7.	of	11	9
8.	it	10	7
9.	was	7	3
10.	you	22	30
11.	uh	4	6
12.	my	14	13
13.	know	24	15
14.	me	28	12
15.	in	18	29
16.	just	21	14
17.	I'm	8	19
18.	because	19	17
19.	but	26	31
20.	it's	16	33

Note. Numbers are ranked positions, with 1 being the most common type, 2 the second most common and so on.

Lexical types in the first reason for admission corpus (Table 7.7) also closely resemble those found in the larger first interview corpus (Table 7.4) of which it is a part, with similar clusters of depression-related types (*depression, depressed, suicide, commit*), diffuse problem-related types (*things, people, life, drugs*) and epistemological types (*know, think, suppose, mean, basically*). Because of the smaller corpus size there are also a number of unusual types (such as *poison*) that may have occurred in one or two interviews only. In common with the larger

first interview corpus of which it is a subset, types clearly related to anxiety or stress (with the possible exception of *handle*) is absent from the set of most frequent types.

Table 7.7 Forty most common lexical types in the first reason for admission corpus

depression	12	just	10	know	9	well	9
things	8	get	7	depressed	6	think	6
feel	5	time	5	people	5	life	5
find	4	sure	4	suppose	4	first	4
lot	4	scared	4	better	4	problem	4
said	3	take	3	way	3	bit	3
suicide	3	drugs	3	handle	3	search	3
mean	3	rationalise	3	tried	3	basically	3
took	3	got	3	commit	2	therapy	2
away	2	poison	2	come	2	Valhalla	2

Note Numbers indicate the frequency with which each type occurs.

The situation with regard to the second reason for admission corpus is somewhat different (Table 7.8). Although depression-related types (*depression, depressed, suicide*) are still very prominent, other forms of illness-talk is also evident, notably *anxiety* and a number of stress-related types (*cope, coping, and possibly pressure*), suggesting that depression may be rivalled by other discursive formulations after two weeks of hospitalisation. This is discussed in greater detail below. Perhaps not surprisingly, there is also evidence of more treatment-related talk (*therapy, medication, treatment*) as interviewees began to settle into the hospital routine. Epistemological types (*know, dunno, basically, actually, really*) remain prominent.

Table 7.8 Forty most common lexical types in the second reason for admission corpus

just	19	know	18	time	17	got	11
depression	11	again	9	lot	8	therapy	8
working	7	get	7	depressed	6	sort	6
medication	6	life	6	said	6	well	6
better	5	quite	5	pressure	5	work	5
treatment	5	back	5	dunno	5	last	5
cope	5	sent	4	basically	4	actually	4
suicide	4	anxiety	4	took	4	now	4
big	4	too	4	coping	4	really	4

Note Numbers indicate the frequency with which each type occurs.

As a further comparison between the first and second reason for admission corpora, the collocational information in Appendix 5 was used to draw up the lexical nets in Figures 7.2 and 7.3. From Appendix 5 and Figures 7.2 and 7.3 it is again clear that there is a considerable degree of robustness in the collocational patterns found, with many of those identified in the first interview corpus again evident in the first and second reason for admission corpora. Examples include the ubiquitous *you-know* and *I-don't-know* sequences (with some breaks in the link, possibly due to the smaller corpus sizes), the *I'm-here-because* sequence and the proliferation of links fanning out from the cardinal point *I*. There are also various unique features to each net. Due to the small corpus sizes, several of these proved, on investigation, to come from a single interview or from a small number of interviews. Examples include the *it's-the-search-for* pattern at the top of Figure 7.2 which comes from a single interview in which the interviewee repeated a phrase containing these words many times over ([48/1]), and the reference to *medication* in Figure 7.3, which comes from two interviews ([16/2] and [44/2]) in which the interviewees discussed issues of medication at length when asked about the reason for their being at Valhalla.

Figure 7.2 Lexical net of the first reason for admission corpus using a span of 8 and minimum collocation frequency of 5

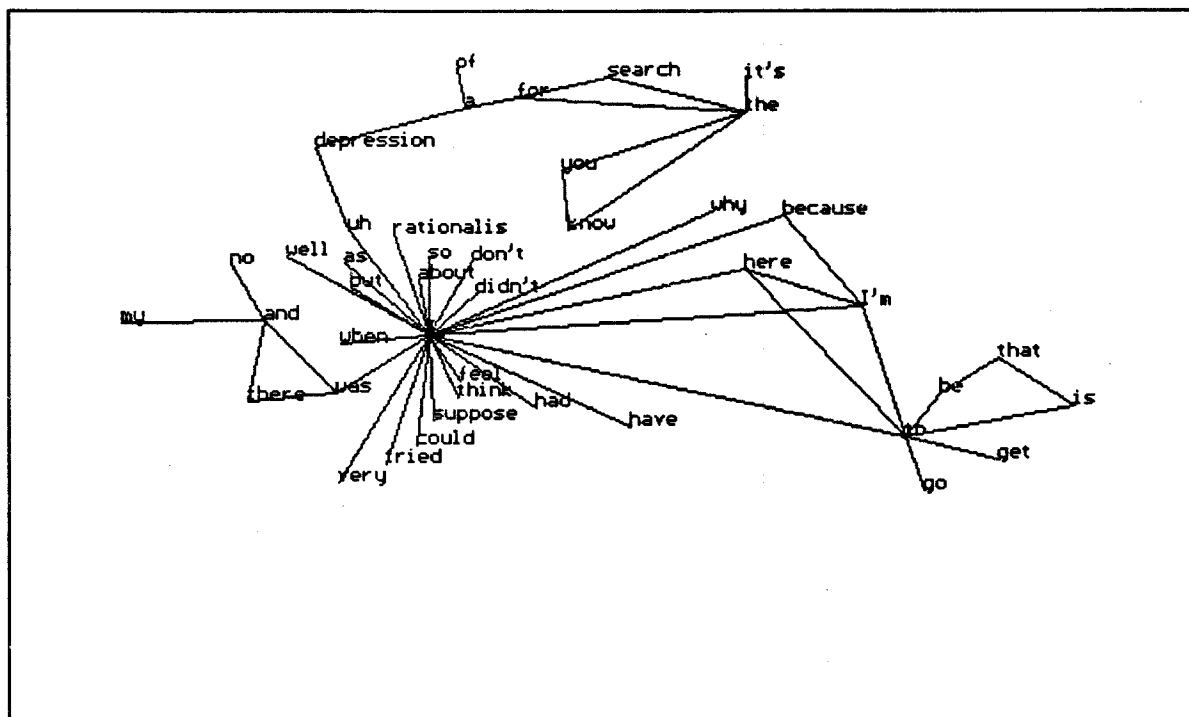
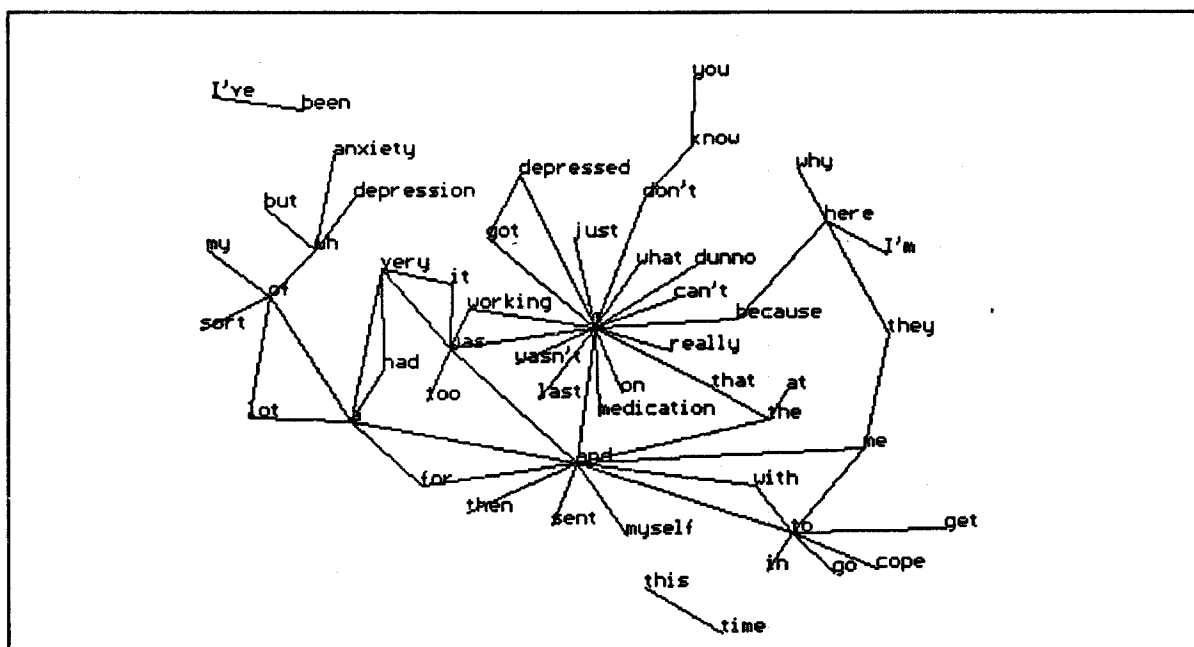


Figure 7.3 Lexical net of the second reason for admission corpus using a span of 8 and minimum collocation frequency of 5



Apart from such spurious variations, a number of differences between the first and second reason for admission corpora were identified which appear to be more substantial. These are discussed below.

Being there

One of the patterns in Figure 7.2 which is not present in Figure 7.3 is the *I-was-there-and* sequence at the bottom left of the figure. Almost without exception this sequence is employed in the first reason for admission corpus to talk about admissions immediately preceding the current one, often comparing the previous admission favourably or unfavourably with the current admission:

- [16/1] DEPRESSION - UH, feeling down, I had an overdose [is it?]. Ja, UH, I WAS at X-Clinic and uh there they just [inaudible] you with the drugs [ja]. AND uh, THERE WAS no therapy [ja], AND I actually overdosed after I WAS at the X-Clinic [really]. AND [inaudible] said, no, the drugs aren't gonna do you any good.
- [28/1] I WAS in the X-hospital before I came HERE, but it definitely wasn't the place for me TO BE, YOU KNOW. Because the patients there are different cases completely.
- [47/1] UH I'M HERE BECAUSE I first went to X Lodge, which is a centre for people that abuse alcohol and drugs, AND I WAS unsuccessful THERE BECAUSE I TRIED TO commit suicide and they decided [inaudible] to send me to Valhalla, which I sincerely doubt WAS, WAS the right alternative.

Only a single case could be found in the second reason for admission corpus which made use of the *I-was-there* pattern, again to talk about an admission immediately preceding the current one:

[44/2] I WAS encouraged TO GO AND see a psychiatrist, AND I WAS put on medication, which worked initially, AND THEN it petered, well I DUNNO what happened, but I got depressed again AND I attempted suicide, AND I WAS admitted to the Gen, AND I WAS THERE. AND after discharge I WAS on other medication AND I GOT DEPRESSED on that as well AND THEN I came here ...

That talk about institutions from which they had just been discharged should figure more prominently immediately on admission than two weeks later is perhaps understandable in that interviewees were still very much in the midst of the decision to be transferred to Valhalla. By the second interview they would perhaps have become more preoccupied with issues around the current hospitalisation rather than the series of events leading up to it. There is some evidence, however, that interviewees were still equally concerned with pre-admission events, but were talking about them differently. This is discussed below.

Working hard; stressed out

Where a typical pattern in the first interviews when responding to a question about the reason for admission is to invoke the *I-was-there* sequence in relation to immediately preceding admissions, by the second interviews, a broader perspective is attained by invoking the *I-was-working* sequence to talk about work pressures preceding admission. This sequence is quite common in the second reason for admission corpus, but completely absent from the first. Some examples:

[11/2] Ja, BECAUSE I couldn't handle my life, IT WAS a bit TOO heavy, I WAS WORKING, I WAS WORKING, I used to work in the X industry. And my workload WAS TOO much, AND in order to keep up WITH that I used to take cocaine - but it didn't, I in fact slowed down, to such an

- extent that I almost stopped, totally. That's it.
- [23/2] OK, I tried to commit suicide for my second time, and mostly because of work, pressure of, BECAUSE I WAS WORKING with a guy I didn't really like, he was giving me A LOT OF hassles and that
- [54/2] Oh ja, I'M HERE as the result OF A suicide attempt ... Uh ... ja ... under, under, I'VE BEEN under A LOT OF pressure. I'VE BEEN working under a LOT OF pressure for, for quite a while. Uh ... AND I, I, while I WAS WORKING I had been SORT OF very bad, severely mugged, AND I felt that my nerve had sort of snapped.

What is being drawn on here, of course, is what may be termed stress discourse, in which pressures are presented as building up inexorably until something snaps. Talk about stress is not completely absent from the first reason for admission corpus, twice surfacing in the vicinity of the *I-was-there* pattern (which, as discussed above, more commonly signals talk about preceding admissions):

- [24/1] I'M not quite sure. I SUPPOSE the main thing IS THAT everyone, all my support was going away, and THERE WAS no way that, I WAS not coping. I WAS also feeling very depressed.
- [52/1] THERE WAS just ... I just DIDN'T do anything. I couldn't work. I de-registered for my course at varsity ...

However, the prototypical stress-related type, *cope*, is completely absent, while similar types such as *coping* (N=1) and *stress* (N=2) are very rare. By contrast there appears to have been an infusion of stress-talk between the first and second interviews. Interviewees still refer to *depression* to explain why they have been admitted, but now very frequently do so in conjunction with stress, making use of the *I-wasn't* and *to-cope-with* sequences at the bottom right of Figure 7.3:

- [16/2] Uh to try and ... [interruption at door]. TO GET TO COPE WITH the DEPRESSION, or TO UH, or

- [08/2] TO maybe find ways of not having it at all.
Uh well, as I SORT OF mentioned before IT WAS DEPRESSION, UH YOU KNOW I JUST lost control, ja. I DON'T want to go into detail, it's JUST repeating everything I said, BUT UH, BECAUSE I feel a lot better about a LOT OF things, BUT UH ja IT WAS just VERY severe depression, just losing control OF MY OF MY MY entire thoughts, ja, and my ability TO COPE in life.
- [19/2] UH ... well, DEPRESSION UH ... inability TO COPE WITH therapy AND conduct a day-to-day life, uh periodic SORT OF ... intermittent periods OF of intensity. Uh, a desire to SORT OF engage in A process of therapy full time [mmm]. [inaudible]
- [46/2] Uh ... THIS TIME I'm at Valhalla, it's the fifth time I'VE BEEN HERE, is BECAUSE I WAS VERY suicidal AND I WASN'T coping with anything at home. Everything WAS like TOO big AND too, I DUNNO, everything was just beyond me, AND I WASN'T coping WITH anything ... Uh so my psychologist decided IT WAS time for me to come back again ... Uh I DUNNO.
- [28/2] UH, a bit of DEPRESSION, the majority of it stress. After the car accident - final touch to basically five years OF A build-up: separation, divorce ...uh pressure from family side ... So I DUNNO ...I, I DUNNO, I REALLY DON'T KNOW. I'm going have TO just COPE WITH it, that's all.

It is remarkable that stress discourse as described by Young (1980) and Pollock (1988) could appear with such vigour where it had been almost completely absent two weeks previously, and doubly remarkable that it should almost invariably be used in the same breath as talk about depression. Where patients arrived at Valhalla talking about depression and suicide when asked about their reason for being there, two weeks later this talk had become hybridised to include coping with the pressures of life, therapy and depression itself.

Some of the dynamics which may have contributed to this process are the following: Firstly, stress as an explanatory construct and stress management techniques were explicitly taught in groups run by occupational therapists and social workers at the time of the study, and several patients are likely to have picked up the jargon from this source. Secondly

therapy, although very highly valued in the ward, was (often without this being made explicit to patients) of a 'supportive' nature, and warnings were continually issued to inexperienced therapists to avoid doing any 'uncovering' work in the hospital milieu (the phrase often used was to 'keep the lid on'). This kind of support is of course in many ways seen as a temporary replacement for the 'social support' which the patient is presumed to lack - and from social support it is a short discursive journey to the idea of stress. Thirdly, at the root of the official censure of 'uncovering' therapy is a fear that patients may 'disintegrate' and become unsuitable for early discharge. Much of the acrimony between patients and staff, and among staff, thus centred around the issue of readiness firstly for weekend leave and then for discharge. *Is the patient still too fragile to cope with being out of the ward? Will there be enough social support at home?* These were the questions which concerned staff on a daily basis, and which inevitably impacted on patients' perceptions of the nature of their difficulties.

I find it impossible to say whether sinking into depression or drowning in stress is preferable, nor even if rapid discursive shifts from the one predicament to the other is harmful or beneficial. It is likely, however, that both kinds of discourse fulfil similar functions and are merely inflections of a more fundamental form of speech which invokes causal and psychological language to both give an account of oneself, and resist (at many different levels simultaneously) being held accountable for oneself:

[34/2]

M: Uh first thing is if you could just sort of for the record again summarise why you're here.

I: Why I WAS here? [laughs] O God.

M: Can't remember?

I: No! [laughs] Ja, I DON'T KNOW. I SUPPOSE I JUST got sick. My nerves cracked in or something [both laugh]. Whatever. I DON'T KNOW. Pressure, I DON'T KNOW. Something like that.

M: OK. I can't remember what you said last time.

I: I know [laughs]. My doctor sent me here.

Breaking free

If, as Rose (1990) and others have argued, the purpose of psychotherapy and other forms of moral orthopaedics is to "restore to individuals the capacity to function as autonomous beings in the contractual society of the self" (p. 227-228), it is clear why an individual such as interviewee number 34 quoted above should be thought to be in need of help. Even after two weeks of psychiatric hospitalisation the patients I spoke to continued to resist imperatives to be accountable, both in the immediacies of an interview with me and (it would appear) in the larger context to which the interview referred. Had I again conducted interviews with the same patients shortly before discharge, a more purposeful and optimistic discourse may have started to become evident. In each of the five cases where I did have an opportunity to speak to patients a third time, there seemed to be an expression of greater optimism, willingness to take responsibility and an eagerness, as Rose (1990) puts it, to "make a project of our biography [and] narrativize our lives in a vocabulary of interiority" (p. 254):

[16/3]

M: Could you maybe expand a bit on that. You know I'm not quite sure how it helped you.

I: Ja [inaudible] actually a lot better, about myself uh, in certain situations. I mean take for example over the weekends [ja]. I mean I hadn't spoken to [my sister] for a long time. And uh, I just, I feel a lot better, and uh I, I can actually cope with most of the problems that I come up with [yes]. Maybe now and again I'll feel a little bit - stressed about it, but it doesn't get into a serious depression [ja].

However, even as these individuals took on the shackles of freedom, they maintained a connection to the institution:

[51/03]

Ja. The therapy at Valhalla has been useful, especially with the nurse therapist who is my age and has been through similar experiences. I think it's basically up to you to do something about it. It's true, I mean most of us cause it ourselves. Uh at the moment I'm on an aggression management course learning to deal with problems as soon as I can instead of bottling it up. I hope to leave here with a more positive outlook and able to deal with the emotions I'm going through ... I expect to start working from here and to move into my own flat.

Whether it is partial hospitalisation, attendance at an outpatients' clinic, rehospitalisation, seeing a private therapist, or simply keeping an eye on one's self, the former psychiatric patient, like the rest of us, is well advised to work at being a better person, while always maintaining contact with the therapeutic system in case of failure:

[20/03]

M: OK uh is there anything more that you want to say sort of in ... making things clear to me?

P: Uh I think it's very important to keep having therapy, and keep in contact with, with people who know about it and can help you [ja]. Because, a lot has to do with your attitude [ja]. And, and even when you, when you're better you, you've got to still work at it. I think you've got to try harder than most people to, to keep yourself up.

M: Ja, so it can easily happen that you just let it go if you don't have therapy and keep contact.

I: Ja, you've always got to try and be optimistic uh and uh keep a positive attitude [ja].

As Rose (1990) puts it:

It [psychotherapeutics] promises to make it possible for us all to make a project of our biography, create a style for our lives, shape our everyday existence in terms of an ethic of autonomy. Yet the norm of autonomy secretes, as its inevitable accompaniment, a constant and intense self-scrutiny, a continual evaluation of our personal experiences, emotions, and feelings in relation to images of satisfaction, the necessity to narrativize our lives in a vocabulary of interiority. The self that is

liberated is obliged to live its life tied to the project of its own identity (p. 254).

Conclusion: No looking back

To claim, as I have done in this chapter, that psychiatric patients use particular forms of speech recurrently is at once to invite comparison with the language-use of 'ordinary' people, and from there to ask whether psychiatric patients' peculiar speech is somehow implicated in causing or maintaining their recidivist tendencies. Following such a line of enquiry one might argue that the analysis demonstrates (although tentatively, as there was no non-psychiatric control group) that patients appear to be at the mercy of their language in the same way as they are at the mercy of their illness, being sucked, again and again, into self-defeating linguistic patterns just as they are sucked into repeated hospitalisation.

However, language-use of necessity entails drawing on a system of conventions such as a common lexicon and syntax, idiomatic phrases, stock images, culturally recognised storylines, scripts, discourses, and so on, so that psychiatric patients can hardly be thought of as unique in this regard. One would have to prove that psychiatric patients, and particularly recidivist patients, are particularly stereotypical (or perhaps erratic) in how they apply the building blocks of language - or, more crudely, that they tend to use different building blocks (a peculiarly biased vocabulary, aberrant semantic forms) entirely. One may even propose new kinds of therapy in which individuals are supported and accompanied as they become differentially subjectified by psychiatric discourses, moving perhaps from robotic repetition to 'ownership' and elaboration, and finally to reflection and deconstruction.

This kind of thinking is seductive, but tangential to the purposes of this dissertation. The challenge is not to discover variables, however subtly-defined, that differentiate

recidivists from non-recidivists - the sane from the mad - but briefly to disrupt the circuitry of power and knowledge of which this text is one relay, and to do it in such a way that the fluencies of what goes without saying take on a more staccato and machine-like quality. To present what passed between myself and the people I interviewed as part of a strictly regulated production line is not, however, to imply either that we were coerced by the power of psychiatry or that it would be possible to draw up a blueprint of the truth-factory in which we were labouring. Power and knowledge do not radiate formally from the centre, but seep back from the extremities of social interaction - a physical examination, a psychometric test, an interview.

At the furthest end-points of these capillaries of power are perhaps those moments when linguistic redundancies such as those I have recorded here are passed between individuals to bring about the appearance of a common understanding. As Foucault (1967) recognised, there is no escape from these commonplaces of expression, as we now no longer have access to "all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made" (p. xii-xiii). What is more, these micro regimes of true discourse are continually subsumed, as in Whorf's vision, into ever larger patterns of social intercourse, so that all of the social world of mental illness may at times be reflected in everyday phrases such as *you-know*, *I-suppose*, *I-was-there*. Just as it is no longer useful to speak of being outside the institution, there is also now no outside to the language of psychiatry.

As Sophie, "a 27-year-old former office secretary" six weeks into her first admission at Valhalla, recently confided to a journalist:

I believe there's a light at the end of the tunnel ... I know I have a very low self-esteem and lack of confidence. The point of me being here is to get better so that I

never come back (Weekly Mail & Guardian, 1997).

Chapter 8

'Apparently a known schizophrenic':

From confession to surveillance

For the relations of words are in pairs first.

For the relations of words are according to their distance from the pair.

- Christopher Smart, *Jubilate Agno*, c1760¹

In the previous chapter I analysed texts cast in the form of spontaneous confidences shared between troubled individuals and an interested listener. In this chapter the focus moves from such confessions to the other side of Foucault's disciplinary diagram - that of surveillance.

At this level it is no longer the individual subject which is re-inscribed as truth by discourse under the guise of agentic and unpremeditated speech, but the individual subject created through a system of scientific visibility that enumerates, classifies and defines her in relation to other individuals.

The material I use comes from a psychiatric ward of a general hospital in the same city as Valhalla hospital, and consists of case records entered on a computer data base over a 5 year period in the late 1980s and early 1990s. Not only does this source represent an exemplar of the rapidly proliferating forms of textual data now available in electronic form, as discussed in Chapter 6, but it is also representative of the form of superpanopticism predicted by Poster (1990), in which the technical limitations of Bentham's panopticon are

¹ Written while in Mr Potter's madhouse in Bethnal Green (quoted in Ingram, 1991, p. 171-172).

overcome and surveillance becomes truly omnipresent.

The hospital (which I shall refer to as 'Milfield') is a large general hospital in the greater Johannesburg area. I was given access to the records of the psychiatric ward for research purposes by the psychiatrist in charge of the ward, and for some months spent one day per week at the ward working on various research projects for the psychiatrist and some of his colleagues. Unlike at Valhalla, however, I did not attend ward rounds or conduct interviews with patients.

Milfield, like Valhalla, is a state hospital and an academic training facility located in a former white suburb in Gauteng. However, it is very much larger than Valhalla, and the psychiatric ward is a small part of the hospital. Many of the patients accepted into the ward are 'acute' cases, hospitalised in the wake of a suicide attempt, because they had caused a public disturbance, or had suddenly become unmanageable to their families. Patients were also occasionally transferred from other wards in the hospital when their physical ailments were found to be due to or accompanied by psychiatric difficulties. There is no segregation into different classes of mental illness as at Valhalla, and the emphasis is on relatively short-term crisis intervention followed either by discharge or by transfer to medium-term facilities such as Valhalla, private drug and alcohol rehabilitation centres, and the like. In some cases, particularly where there have been several previous admissions, patients are transferred to long-term institutions where they are involuntarily committed.

'Subjects and sampling'

As in the previous two chapters, there is limited utility in thinking of the material used in this chapter in terms of individual subjects or cases, since subjects are the product as much as the

source of discourse. Some empirical data on subjects are nevertheless presented to help contextualise the linguistic material analysed. Two groups of individuals could qualify as subjects for the present study: The psychiatric registrars who composed the case histories and the patients about whom the histories were written.

*Registrars*². In all, 63 registrars contributed case histories, with a mean of 29.84 histories written by each registrar (SD=25.35) and a range of 1 to 129 histories per registrar. Unfortunately no further data are available on the registrars as the database was of course set up with the view that patients rather than medical personnel constitute cases to be studied. From my observations at Milfield it appeared that the registrars were a diverse group in terms of age, gender and cultural background, but that nearly all were white. A list of the registrars' surnames includes one Indian but no African surnames. During their training registrars were placed for periods of six months at a time at various hospitals and clinics forming part of the academic system in and around the city. Placement centres included Valhalla, Milfield, an inner-city outpatients' clinic, a township day clinic and the psychiatric ward at a large township hospital.

Patients. The case histories used for analysis refer to all 1883 psychiatric admissions at Milfield over a 5 year period in the late 1980s and early 1990s. The first 435 of these admissions were fully coded on the computer database, but after this it was apparently decided to code only certain variables. Descriptive statistics for both fully and partially coded biographical variables are presented in Table 8.1 and Table 8.2. These show that patients were typically somewhat older than those at Valhalla, typically spent only about two weeks

² Registrars are medical doctors assigned to a psychiatric hospital (or a psychiatric ward in a general hospital) as part of their practical training to qualify as psychiatrists. Registrars make diagnoses, prescribe medication and do psychotherapy under the supervision of a qualified psychiatrist.

in the hospital, and were (at the time) overwhelmingly white. As at Valhalla, the majority were female.

Table 8.1 Age at admission and days spent in the psychiatric ward at Milfield Hospital

Variable	N	Mean	SD	Min	Max
Age	1858	42.13	17.10	12	85
Days in ward	1859	14.31	16.36	1	241

Table 8.2 Gender and race distribution of patients in the psychiatric ward at Milfield Hospital

		N	%
Gender	Female	247	58.53
	Male	175	41.47
	Total	422	100
Race	White	416	95.63
	Black	11	2.53
	Coloured	4	0.92
	Indian	4	0.92
	Total	435	100

Of the first 422 patients in the database 33% (143) were coded as having had previous admissions, and 73.56% were recorded (Table 8.3) as having previously had psychiatric medication or electroconvulsive therapy (ECT) prescribed to them. The kinds of medications prescribed to patients are also listed in Table 8.3. No details regarding prior psychotherapeutic treatments were recorded.

Table 8.3 Somatic treatments given to patients in the psychiatric ward at Milfield Hospital prior to admission

Treatment	N	%
Benzodiazepines	254	58.39
Antidepressants	191	43.91
Antipsychotics	173	39.77
ECT	64	14.71
No somatic treatment	115	26.44
One type of treatment	94	21.61
Two types of treatment	126	28.97
Three types of treatment	64	14.70
Four types of treatment	36	8.28
Total	435	100

Analytic strategy

As in the previous chapter I started with a quantitative overview of the corpus, and moved from there to qualitative analysis. The quantitative techniques used are the same as for Chapter 7. Also as in the previous chapter, the qualitative analysis proceeded by first locating extracts containing collocational patterns identified from the lexical net, determining how these patterns function in the extracts and then presenting this interpretation together with illustrative extracts. The analysis in some cases continued on to issues thematically but not statistically related to the collocational patterns found.

Getting into the text

The case records in the computer database duplicated some of the information contained in patient files. These files are used at various points during a patient's stay at the hospital, for example by registrars prior to presenting the patient's case to a ward round, by psychotherapists for background information on the patient, to check on the patient's medication history where changes in medication are being considered, and when decisions are being made regarding home leave, transfer or discharge. In each of these cases existing information in the file is scanned and new data added. In cases of readmission old files are retrieved and placed inside the new file.

The most intensive period of activity around the file occurs shortly after admission when an official 'history' is taken from each patient (supplemented by 'collateral' information from family, friends and other medical staff), usually by a psychiatric registrar. This history includes a description of the events leading up to the patient's admission, information about

her current symptoms, biographical information and various other psychiatric indispensibilities such as the results of a brief 'mental status examination'. In this analysis I focus in particular on an open ended section of each patient's record headed "EVALUATION/ INITIAL HISTORY: LEADING UP TO THIS ADMISSION" which contains a brief description of the presenting complaint, similar to the following (all case material in this chapter has been edited to ensure anonymity):

[121]³ 29 year old unmarried female, no children, staying with parents in X-city, presenting in a psychotic state with tactile hallucinations, sexual delusions and delusions of misinterpretation, delusions of influence, that started 1 m ago and got progressively worse over last week. Delusions are directed towards father. Father is transmitting his "lust" to her. Hypomanic features. Marked conduct disorder with substance abuse as child. 4 previous admissions - Weskoppies, Magaliesoord, Phoenix House and Milfield. Defaulted meds.

While the ostensible purpose of a vignette such as this is informational, it is also, as discussed in Chapter 5, a linguistic ritual in which the beliefs and values of the medical world are reinscribed. For example, at least five epistemological strands, explanatory schemas, discourses, can be reconstructed from the short vignette quoted above:

1. *The old maid discourse*: Having violated the 'normal' developmental path for a woman (getting married and having children), the patient is now sexually frustrated and projects her frustration onto the nearest male figure.
2. *The rotten apple discourse*. Even as a child the patient was a delinquent who took drugs. Maybe she's fried her brains.
3. *The noncompliant patient discourse*. She stopped taking her medication. That's why she's gone off the rails again.
4. *The schizophrenia discourse*. She is deluded and has hallucinations. If I'm pressed

³ Numbers in square brackets refer to patient numbers in the database.

for a diagnosis I'd say schizophrenia. But then on the other hand maybe it's mania.

5. *The recidivist discourse.* She's been here four times before. Are you surprised she's back?

While it is easy to imagine a similar analysis of 10 or even 100 such vignettes, it obviously becomes increasingly difficult to sustain as the numbers increase. Given that the data available to me, which I shall call the initial history corpus, consisted of 1880 vignettes (68 939 tokens or 212 pages of single-spaced typescript), the idea of some form of preliminary quantitative parsing seemed even more appealing than for the interview transcripts used in the previous chapter.

Preliminary quantitative overview

As an initial step the corpus was spell-checked and 783 spurious types removed. There were numerous uncommon types, such as medical terms (*surmontil, ativan, emdalin*), abbreviations (*LOA, ICU, IQ, psych*), numerical indicators of various sorts (*1, 2, 3, 1st, 25mg, 50mg*) and unusual constructions (*RHT'd, function++*, *4/5*). I left these unchanged so as to preserve the tenor of the case histories. Individuals' first names and surnames were replaced with *X*.

The corpus consisted of 68 939 tokens and 5 916 types, giving a type-token ratio of 1:11.65, which is comparable to the 1:12.33 ratio found for the interview transcripts. However, the initial history corpus is approximately twice as long as the first interview corpus, and (as discussed in Chapter 6) vocabulary richness tends to be lower for longer texts. Taking only the first 33 644 tokens in the initial history corpus (the same length as the first interview corpus), 3753 types were found, giving a type-token ratio of 1:8.96. This

higher vocabulary richness is probably in part due to the telegraphic style of the case histories, which in many cases dispense with high frequency grammatical tokens such as *a* and *the*. Table 8.4, which lists the 60 most common types in the initial history text, confirms this interpretation, with lexical types such as *history*, *patient* and *admitted* among the most frequently used types, outranking even *the*, usually the most frequent type in written or spoken English.

The corpus contains 5768 lexical types and has a lexical density of 69.1%, almost twice that of the first interview corpus. This can again be ascribed to the abbreviated style used in the case histories and to the numerous unusual types mentioned at the start of this section.

Table 8.4 Sixty most common types in the initial history corpus

and	2194	of	2015	to	1589	with	1232
in	1127	for	977	history		866	patient 786
a	732	on	605	was	587	depression	585
year	521	has	499	at	489	admitted	460
had	437	from	432	her	430	2	401
old	398	by	398	no	379	the	366
she	364	years	360	admission	345	previous	345
not	323	suicidal	317	3	316	abuse	305
known	304	depressed	299	been	285	months	284
alcohol	279	he	279	after	268	poor	265
is	260	ago	256	weeks	241	suicide	237
as	235	family	231	very	231	OD	228
behaviour	226	paranoid	225	problems	223	features	220
his	220	disorder	219	treated 211	Valhalla	208	
well	208	since	207	ward	202	also	191

Note. Frequencies are to the right of each word type.

Not surprisingly, the two most common lexical types in the initial history corpus (Table 8.5) are *history* and *patient*. The remaining types can tentatively be divided into a number of clusters. As with the interview corpus, *depression* and depression-related words (*suicidal*, *depressed*, *suicide*, *OD*) are particularly prominent, mirroring the frequency with which patients invoke depression to account for their hospitalisation. However, another finding from the interview corpus, that patients make some use of the discourse of social stress to explain their circumstances, at first glance appears to be absent from this corpus, with no

clearly stress-related types included in the table. Types such as *cope* (N=34), *stress* (N=34) and *stressful* (N=88) do occur in the full list of types, but with relatively low frequency.

Other kinds of reference to psychiatric signs, symptoms and diagnoses are however plentiful (e.g., *paranoid, disorder, hallucinations, ideation, bipolar, psychotic, aggressive, vegetative, and manic*) reflecting the more scientific and objective tenor of the histories.

Table 8.5 Sixty most common lexical types in the initial history corpus

history	866	patient	786	depression	585	year	521
admitted	460	2	401	old	398	years	360
previous	345	admission	345	suicidal	317	3	316
abuse	305	known	304	depressed	299	months	284
alcohol	279	poor	265	ago	256	weeks	241
suicide	237	family	231	OD	228	behaviour	226
paranoid	225	problems	223	features	220	disorder	219
treated 211	well	208	Valhalla	208	ward	202	
hallucinations	187	delusions	177	ideation	177	admissions	173
bipolar	173	presented	172	psychotic	171	1	159
past	158	4	157	last	155	week	155
previously	154	referred	150	aggressive	147	prior	147
appetite	142	sleep	142	X	141	vegetative	136
6	134	month	133	hospital	132	manic	131
psych	130	treatment	130	auditory	126	home	125

Note. Frequencies are to the right of each word type.

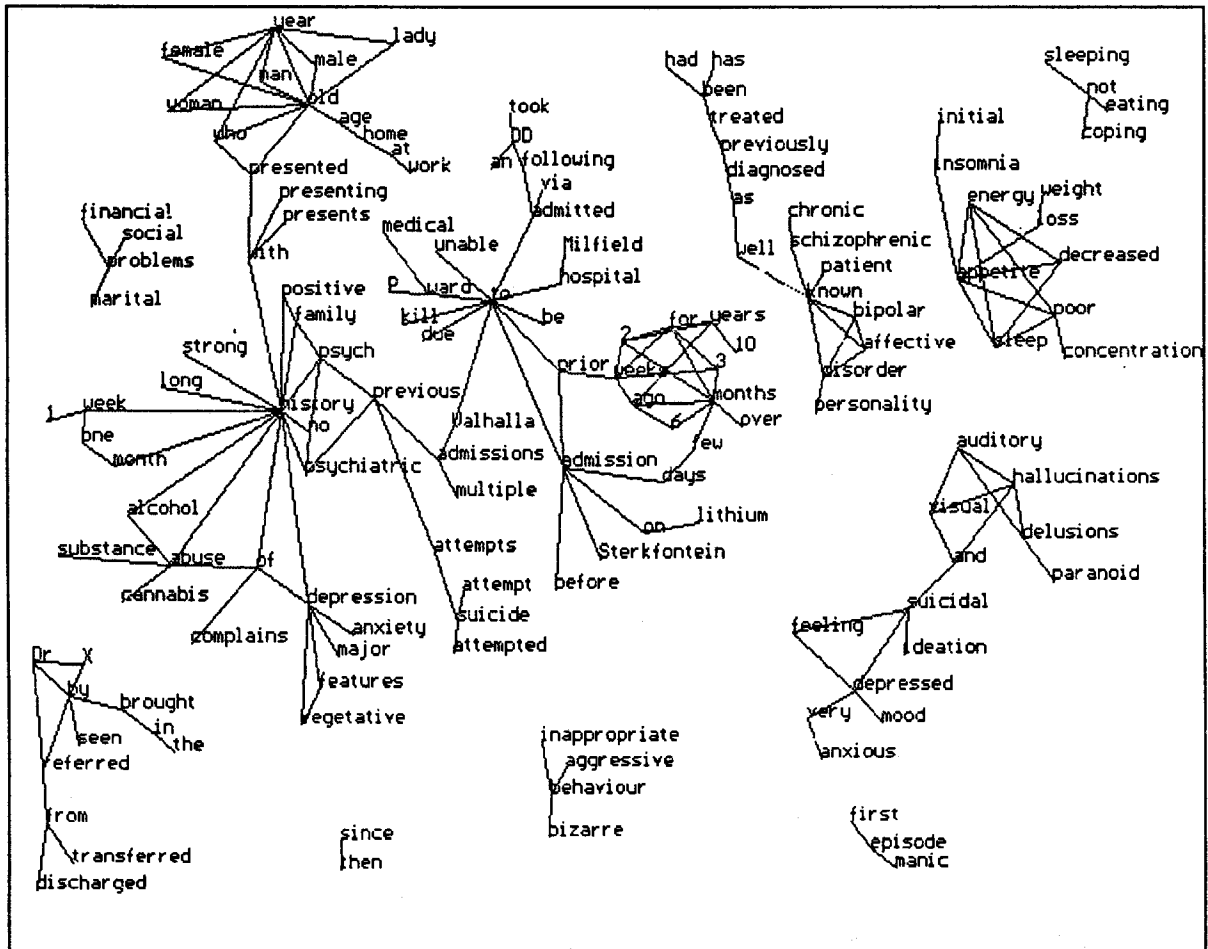
The epistemological types prominent in the interview corpus are absent here, with the

exception of the word *known* - which will be discussed later. In the place of these types there is an array of numerals (1 - 6), again indicative of the more unequivocal and objective genre within which the case histories operate. There are also many time indicators, such as *year, years, previous, months, ago, weeks, past, week, previously, prior* and *month*, marking the corpus as a set of psychiatric *histories*. A final group of words, which may be related to the time cluster, appear to refer to the process of entering psychiatric care - *admitted, admission, Valhalla* and *admissions*.

As previously discussed, frequency counts such as that in Table 8.5 provide an indication of the lexical content of texts, but are somewhat limited in their usefulness. As an example, one of the more prominent lexical items, *abuse*, is a case of homonymy and could (among other possibilities) refer either to substance/alcohol abuse perpetrated by the patient or to child/sexual abuse perpetrated upon the patient.

In order to move beyond such ambiguities, collocation counts were therefore again computed for each pair of types in the text (reproduced in Appendix 5), and a lexical net drawn using this data (Figure 8.1). As before, the z-scores on which the net is based were calculated using a span of 4 words on either side of each target word (truncated at vignette boundaries), but given the large size of the corpus, a larger minimum collocational frequency of 20 was used. The most prominent collocations were plotted down to a z-score of 18, at which point the resultant lexical net threatened to become too unwieldy.

Figure 8.1 Lexical net of the initial history corpus



'Presenting problems'

Reading the lexical net from the top left, one finds a sub-net of terms relating to gender and age (*man, woman, lady, year, age* and so on). This reflects a stereotypical opening sentence used in many of the histories, as in the following short extracts:

- [4] 61 YEAR OLD Jewish divorced MAN
- [5] 43 YEAR OLD WOMAN WHO PRESENTED WITH nine MONTH HISTORY
- [11] 63 YEAR OLD widow for last 15 years
- [720] A 39 YEAR OLD LADY WHO teaches at ... school

[898] 60 YEAR OLD prisoner WHO PRESENTED WITH dehydration
[900] 52 YEAR OLD woman with poor social circumstances

These simple biographical statements appear unremarkable, but clearly have more than an information-giving function. Basic data such as age and gender are strictly superfluous as they are prominently recorded in the patient file and the computer database anyway. Rather, one could argue that they are an effective opening gambit for a history of which it is required that it should appear parsimonious, objective and factual. There are of course variations in the degree to which objective scientific language (*male vs man, female vs woman/lady*) is considered necessary, and how much additional information is immediately introduced (a *Jewish man, an unmarried woman*), but what is ubiquitous is the need to signal from the outset that what is being dealt with here is a 'case' - an entity which is in principle knowable and susceptible to being summarised in a few lines.

Reading further downwards along the lexical net, it is evident that many of the vignettes proceed from an initial statement of biographical information to refer to the difficulty that the patient presented with. This 'presenting problem' can take many different forms:

- [34] 49 YEAR OLD LADY, divorced two YEARS AGO after 28 YEARS of marriage. PRESENTED WITH symptoms of adjustment disorder with depression.
[74] 54 YEAR OLD Jewish WOMAN WHO PRESENTED WITH depression, poor response to Ludiomil with side-effects and medical problems.
[1169] A 33 YEAR OLD MAN WHO PRESENTED WITH pseudoamnesia after having disappeared from his parents' home.
[1862] 19 YEAR OLD MALE PRESENTED mute WITH intermittent tearfulness.

As is the case with listing biographical information, describing a patient as 'presenting with' a set of problems, symptoms or a diagnosis draws on the idea that she or he can be objectively known as a case. The presenting problem is discursively marked as uncontroversial 'raw

data', literally or metaphorically visible to the physician's eye, while at the same time it is signalled that these are preliminary observations and that further investigation may yield further data and more sophisticated interpretations.

In the first instance psychiatric patients thus appear in these vignettes as humanist critiques of psychiatry might have predicted they would - objectified, dehumanised and subjected to a regime of scientific visibility. Where they are 'given voice', it is only in the context of professional scepticism, so that they are for example said to *complain of* various ailments (bottom left of Figure 8.1) rather than to be in any position to diagnose:

[912] COMPLAINS OF slurring, dry tongue, glassy eyes.
[1380] Self referred after several non-suicidal overdoses.
COMPLAINS OF a loss of identity.

Other professional distance markers such as *claims, denied, unreliable* and the use of scare quotes also occur in the corpus, although not with sufficient frequency to be included in the net. Some typical examples:

[174] Has felt a "power" within her which makes her pray and perform religious rituals. Also claims that her husband is confusing her by saying strange things to her.
[798] Burnt all his belongings outside a hotel. Assessed as being psychotic in casualty. Unreliable historian ++. Query history of substance abuse.
[803] Patient denied recollection of interview.

The psychiatric mode of dealing with its subjects, as revealed once again in the opening lines of many of the vignettes, continues to be something of a scandal in the modern, humanised world. However, one should not therefore assume that psychiatric patients are somehow being denied their full individuality. The kind of power that psychiatry now holds (or more accurately - is both a product and a relay of) does not suppress, but fabricates and reinscribes the uniqueness of individuals. Just as the lexical net and similar devices produce the

language of psychiatry as a particular kind of discourse, so that discourse is no more and no less than a grid for bringing into visibility the objects *it* produces - a never-ending series of individual subjects. In Foucault's words:

In a system of discipline (such as that of modernity) the child is more individualized than the adult, the patient more than the healthy man, the madman and the delinquent more than the normal and the non-delinquent. In each case, it is towards the first of these pairs that all the individualising mechanisms are turned in our civilization; and when one wishes to individualise the healthy, normal and law abiding adult, it is by asking him how much of the child he has in him, what secret madness lies within him, what fundamental crime he has dreamt of committing (1979, p. 193).

Histories of the present

The objects created by the discourse of psychiatry, are specifically *psychiatric* subjects, and part of psychiatry's discursive work in vignettes such as those analysed here is to claim them, with due reference to signs, symptoms and histories, as its own. As can be seen from Figure 8.1, symptoms, problems and diagnoses are most often not introduced directly after the *presented/presenting/presents-with* construction, but are accessed via the intervening key word *history*. Not only is this the most frequent lexical type in the corpus (Table 8.5), but it is also at the centre of a web of signification. Patients are portrayed as having a history of *anxiety* or *depression* (to the bottom of *history*), a *family* history of psychiatric illness (top right), a history of *substance, cannabis* or *alcohol abuse* (bottom left) or a history of *previous suicide attempts* and *admissions* (bottom right).

In some cases, vignettes run the full sequence from biographical variables and the

presenting with construction, via *history of* to a diagnostic statement, as in the following

extracts:

- [5] 43 YEAR OLD WOMAN WHO PRESENTED WITH nine MONTH HISTORY OF DEPRESSION
- [12] 48 YEAR OLD white FEMALE WHO PRESENTED on 10th Feb WITH HISTORY OF ONE week's manic symptoms
- [61] 24 YEAR OLD married WOMAN WHO PRESENTED WITH 6 MONTH HISTORY OF DEPRESSION and changes in her behaviour.
- [81] 46 YEAR OLD MAN WHO PRESENTED in casualty WITH 6 m HISTORY OF DEPRESSION

More typically, however, *history of* is used interchangeably (rather than in conjunction with) *presenting with*, and appears to have much the same function - to locate initial observations of the patient in the realm of objective fact. Thus patients are said to have a history of *deteriorating function* [106], *depression* [164], *poor concentration* [430], or *substance abuse* [432]. To further 'factualise' the situation, the time frame of the history is sometimes quantified, as in a *one month* or *one week* history (middle left of Figure 8.1). Patients are also sometimes said to have a *strong history* of one or the other kind:

- [117] STRONG FAMILY HISTORY OF AFFECTIVE DISORDER.
- [394] Past STRONG ALCOHOL HISTORY WITH antisocial personality.
- [837] STRONG schizophrenic FAMILY HISTORY.
- [976] STRONG HISTORY OF excessive intake of ALCOHOL.
- [1424] Recurrent depression...STRONG FAMILY HISTORY.

The kind of warrant being offered here goes a little further than the 'neutral facts' placed on the table by means of biographical variables, the *presenting with* sequence and some forms of the *history of* sequence. What is being alluded to is mental illness as hereditary ([117], [837] and [1424] above) and as a recurrent chronic condition ([394] and [976]). Ironically, the *strong history* construction at the same time somewhat weakens the force of invoking historical data as it implies that history is not simply a matter of fact, but is open to evaluation.

Long, like *strong*, also functions to intensify *history*, but has a less obvious element of subjective evaluation and this may be why *long history* is a more popular construction (see Appendix 5). *Long* is used like *strong* to indicate chronicity ([93] Has had a LONG PSYCHIATRIC HISTORY [515]; [1019] LONG HISTORY OF CANNABIS ABUSE; [1603] Patient WITH a LONG HISTORY OF chronic depression), but interestingly is not once used with *family* to invoke hereditary factors. Family histories, it would appear are per definition long and need no further embellishment along that dimension. Instead, family histories are frequently elaborated on with reference to various diagnoses that family members have had, and as frequently the family is rather vaguely said to have a (*positive*) *psych* or *psychiatric* history, in which case further explanation appears to be optional:

[62] FAMILY PSYCH HISTORY - mother depressed.
[71] Patient has POSITIVE FAMILY HISTORY.
[145] FAMILY PSYCH HISTORY POSITIVE for alcoholism.
[672] Strong paternal FAMILY PSYCHIATRIC HISTORY.
[794] POSITIVE FAMILY PSYCH HISTORY.
[1124] POSITIVE FAMILY HISTORY - brother diagnosed as schizophrenic, currently functioning well.

It is also thought necessary in some cases to indicate that in fact there appears to be no such history ([957] No family psych history; [1111] No family psychiatric history; [1138] Family history nil), with occasionally comical results:

[1155] He denies a FAMILY HISTORY, SUBSTANCE ABUSE or homosexuality.

In a few cases *long* and *strong* history is used in tandem to help qualify the nature of the patient's problems:

[37] Patient PRESENTED WITH PARANOID DELUSIONS, concerning

black men who wanted TO KILL her. At time of admission was agitated and reported AUDITORY HALLUCINATIONS. LONG prior PSYCHIATRIC HISTORY OF similar problem, STRONG HISTORY OF ALCOHOL ABUSE for 15 years, but had stopped drinking one month previously.

Various of the sub-nets in Figure 8.1 appear to operate in much the same way as a long/strong/family history, namely as a kind of mental crossing off of items on an imaginary checklist. An example is the 'social stressors' sub-net (top left):

[678] Multiple SOCIAL PROBLEMS.
[755] FEELING DEPRESSED for 11 months. FINANCIAL and MARITAL PROBLEMS. Treated with Eglonyl and Lexotan. No improvement.

Another example is the schizophrenic symptoms sub-net, which is connected to a suicide risk sub-net (bottom right):

[3] marked DELUSIONS, AUDITORY AND VISUAL HALLUCINATIONS
[492] Feeling VERY DEPRESSED AND SUICIDAL
[908] Recently broke up with girlfriend AND expressed SUICIDAL IDEATION.
[1396] Five day HISTORY OF paranoid ideation and VISUAL HALLUCINATIONS

Perhaps most remarkable for its extreme enmeshment is the sub-net near the top right of Figure 8.1, which can be thought of as a vegetative features net. If the initial history is like a pinball game, the vegetative features net represents an area where the ball bounces rapidly from side to side, setting lights flashing and bells ringing, before finally resuming a more linear, but not necessarily related, trajectory:

[726] Depression for about ONE MONTH after stepson moved into home. UNABLE TO handle situation. Feels neglected and ignored. Feels stepson is encroaching the previous family life pattern. Doesn't see solution to problem of stepson. Also - increased SLEEP pattern. No ENERGY or libido. Bulimic. No WEIGHT LOSS.

To the top right of the vegetative features sub-net is an unconnected sub-net relating to

similar information, but couched in everyday language. These constructions (e.g. *not eating*, *not sleeping*) are sometimes used interchangeably with the more formal terminology of the vegetative features sub-net, typically in the context of reporting on information supplied by a third party. The term *vegetative features* itself is not connected to the sub-net, but to the *history of depression* sequence (bottom left of Figure 8.1), indicating that a global reference to the presence or absence of vegetative features obviates the necessity of referring to individual signs and symptoms. The 'ordinary language' vegetative features sub-net also contains the only reference in Figure 8.1 to the discourse of coping, which is otherwise (as noted earlier) not prominent in the corpus.

By discursively calling on these various sub-nets a sufficient initial case can be made to explain a patient's admission into the psychiatric system. In theory each history should refer to each possible sub-net just as a checklist would indicate the presence or absence of each possible complaint or symptom. However, in practice there appears to be a complex (and no doubt inconsistently applied) hierarchy in which for example mention of a 'strong family history' together with 'alcohol abuse' and 'financial problems' obviates the need for referring to the presence or absence of 'vegetative features'.

Histories of the past

History is not only used to 'place' the individual as exhibiting a certain subset of psychiatric signs and symptoms (i.e., to *account for* the patient's illness) but also to give an *account of* the circumstances which led up to admission. Much of this has to do with the disturbed and disturbing behaviour for which hospitalisation is often seen as a (temporary) solution. In places this information still functions as a psychiatric checklist, but elsewhere it starts to

operate as a narrative, as for example in the 'behavioural' sub-net at the bottom of Figure 8.1 :

- [201] Chronic HISTORY OF BIZARRE BEHAVIOUR and functional decline.
- [632] Change in personality according to husband, including LOSS of WEIGHT (15 kg last year). Apparently neglecting house, INAPPROPRIATE BEHAVIOUR.
- [1251] AGGRESSIVE and BIZARRE BEHAVIOUR at a friend's house. Threatened 18 YEAR OLD girl with rape. Became abusive and stripped down to his underpants.

Attempted suicide (to the bottom right of *history*) and drug overdoses (top right) also sometimes function as checklist items (e.g., [995] Several SUICIDE ATTEMPTS in past. DEPRESSED AND SUICIDAL), but as with the behavioural sub-net a slightly richer history of events leading up to the hospitalisation starts in many cases to emerge:

- [412] OD previous evening at 8pm of 20 Dormicum tablets. Following minor MVA at 7pm. He had had 2 double brandies PRIOR TO MVA. Spur of moment decision to take OD, because of cost of repair to car, inability to take children on holiday until car repair. No suicide notes. PREVIOUS SUICIDE ATTEMPT 2 and a half YEARS AGO.
- [1204] Referred to psychiatry by plastic surgeon following SUICIDE ATTEMPT by slashing his wrists and inhaling organophosphates. He was very delusional, blaming all problems on a pinched nerve in his neck for past 35 years.

Thus even though the grid of what is psychiatrically important and knowable (as reflected in the lexical net) reduces the variability in people's lived experience to a smaller subset of stereotypical possibilities, it at the same time causes individual trials and tribulations to stand out with even greater poignancy:

- [888] Brought in to casualty by colleagues. Had gone into Soweto to martyr himself for the black people. Friends report gradual decline in functioning over last few months. NO PREVIOUS PSYCHIATRIC HISTORY.
- [1540] COMPLAINS OF DEPRESSION and ANXIETY FOR 3 MONTHS. Had witnessed husband's murder in 1986. Never allowed herself to grieve. Bringing up 4 kids on own, living in poor downtown flat. Recently started recalling husband's death. Sometimes thinks she hears him calling her.

Familiar to the system

An important theme in a great many of the vignettes has to do with the path traced by each patient through the psychiatric system. This is reflected in the net in the sections to the right of *history* dealing with being *admitted to Milfield Hospital*, to (or via) a *medical ward*, to *ward P* (the psychiatric ward at Milfield Hospital) and having experienced an *admission* or *admissions* to *Valhalla* or *Sterkfontein* (a psychiatric institution for long-term patients). It is related (via the word *admission*) to a *prior to admission* sub-net which makes extensive use of quantified time constructions such as *for 3 months* and *2 weeks prior to*. This sub-net is typically invoked to describe the patient's condition in the period immediately before the current admission ([449] HAD not BEEN talking FOR 2 MONTHS PRIOR TO ADMISSION) or ([1234] physically assaulted by 2 men FEW DAYS PRIOR TO ADMISSION). However, in most cases (*multiple*) *prior/previous admissions* and related constructs to the right of *history* are used not for purposes of story-telling, but to invoke a discourse of chronicity:

- [166] 33 YEAR OLD unmarried young MAN WITH a LONG HISTORY OF PSYCHIATRIC problems. Previously admitted at MILFIELD HOSPITAL, Valhalla, Weskoppies, Sterkfontein. PRESENTED WITH unconvincing religious delusions.
- [382] Two ADMISSIONS TO VALHALLA 1986/1988. WARD P - 1988. Admission X-Hospital 1987. DIAGNOSED AS a psychotic depression.
- [1306] Previous OD 1 MONTH PRIOR ADMISSION, admitted X-Hospital. MULTIPLE ADMISSIONS VALHALLA, last in 1986 with depression.

There is a ritualistic quality about many aspects of the vignettes, but it is particularly evident in the almost ceremonial reference made to previous admissions, with phrases such as the following being very common:

[12] 8 PREVIOUS ADMISSIONS for Bipolar Affective Disorder
[35] MULTIPLE ADMISSIONS to nearly all hospitals in
Witwatersrand, Cape Town, Pretoria etc.
[464] HISTORY OF 3 PREVIOUS ADMISSIONS to Sterkfontein
[1121] PREVIOUS ADMISSIONS for depression and ATTEMPTED
SUICIDE

These admission histories are typically very sparse, and seem to require little further elaboration. The idea that previous encounters with psychiatry explain her or his current status is quite central to making a case for why any particular person qualifies as a true patient. Reference to previous admissions frequently occur in the middle of vignettes where they appear to play a pivotal role in lending credibility to accounts:

[44] 38 YEAR OLD WOMAN WITH 3 WEEKS HISTORY OF manic symptoms WITH disinhibition, promiscuity and grandiose delusions. MULTIPLE PREVIOUS ADMISSIONS to other psychiatric hospitals and DIAGNOSED AS rapid cycler BIPOLAR DISORDER. SUBSTANCE ABUSE - poppers, CANNABIS, ALCOHOL. Stressors - bad relationship with boyfriend, moved to X, new job, financial, divorce, parents deaths, infertility.
[188] WELL KNOWN BIPOLAR lady admitted from Casualty in a manic state. Not compliant on meds. MULTIPLE ADMISSIONS TO VALHALLA and STERKFONTEIN since 1966. No stressors.

This emphasis on previous encounters with authority is reminiscent of Spencer's (1988) studies of probation officers' reports, in which previous criminal convictions (analogous to previous brushes with institutional psychiatry) are always carefully reported, although much else may be selectively left out.

Another form in which a previous psychiatric history is invoked is by means of the sub-net at the bottom-left of Figure 8.1. The constructions in this sub-net allow for reference to the role of other psychiatric staff earlier in the patient's career. Thus a patient may have been *referred by* or *brought in by Dr X* (all surnames were replaced with X), or may previously have been *seen by him or her* (another similar construction - *under Dr X* - occurs with some frequency in the corpus, but not sufficiently so as to be included in the net):

[28] HAS BEEN SEEN BY DR X regularly at OPD, treated for depression.
[242] Had phoned DR X twice and was REFERRED by him TO the HOSPITAL.
[650] REFERRED BY DR X after OD of hypnotics.
[1423] SEEN IN the past BY DR X AND DR X.

Interestingly the *brought in* sequence, although connected to the *Dr X* construction, does not refer to psychiatric staff, but to a range of other groups and individuals: the police, family, brothers, sisters, parents, work colleagues. Medical personnel 'see' patients and then 'refer' them, lay people simply 'bring them in'. Patients are also frequently (to the bottom of the sub-net) *transferred* from other hospitals and wards or *discharged* from such places before being admitted to the psychiatric ward at Milfield.

The only sub-net not yet discussed, at the top right of Figure 8.1 represents another method of accounting for the patient's current situation by positioning it as just another incident in a long psychiatric career. In terms of this sub-net (which is linked by sharing the word *disorder* to the commonly used phrase *personality disorder*), patients are said to have been *previously diagnosed* as having one or the other condition, to be a *chronic schizophrenic* or a *known patient*, *known schizophrenic* or *known sufferer from bipolar affective disorder*. Significantly, terms usually associated with schizophrenia such as *delusions*, *hallucinations* and *inappropriate behaviour*, are not statistically linked to *schizophrenic*, suggesting that if a person is already *well known* as a *schizophrenic*, further evidence regarding schizophrenic symptoms are considered superfluous, as in the following vignette:

[77] Patient REFERRED FROM X-Clinic, where he HAS BEEN for three and a half years - apparently a KNOWN SCHIZOPHRENIC. Sent to Milfield hospital for treatment and management of aggression which is not possible at X-Clinic.

By contrast, details of symptomatology are required where it is impossible to state

categorically that the patient is already known to the medical authorities as a schizophrenic or some other category of mental illness:

[476] Sudden onset, AUDITORY HALLUCINATIONS, PARANOID DELUSIONS, DELUSIONS of control. Inappropriate, disinhibition, insomnia. According to husband she gets these episodes up to three times a year. Includes BIZARRE BEHAVIOUR and disorganised speech.

Again, the language is reminiscent of the criminal justice system, where offenders' accounts and those of their families have to be treated with studied scepticism, while previous convictions instantly qualify a person as a "known house breaker", a "well known child molester" and so on. The contrast between the scepticism accorded lay accounts on the one hand and the certainty provided by previous diagnosis on the other is illustrated in the phrases culled from randomly-selected vignettes in Table 8.6.

Table 8.6 Lay accounts versus previous diagnoses in the initial history text

Lay account	Previous diagnosis
According to wife patient has had aggressive outbursts	Well known bipolar disorder
According to wife, alcoholic habits in past	Known alcoholic
According to parents patient has been totally irrational	Well known bipolar patient
Change in personality according to husband	Well known schizophrenic

The *known patient* sequence and related constructs also form an interesting contrast with the

epistemological tangle at the centre of the lexical net of the interview corpus (Chapter 7).

The uncertainties and equivocations of that net are here replaced with the fixed confidence of something that is already known.

Conclusion: The timeless trajectory

As a distillation of the initial history corpus, the lexical net in Figure 8.1 can be read in many different ways - as a map of the pathways open to the (recidivist) psychiatric patient, as a table of accounting practices used by psychiatric registrars to confirm the patient status of those they have been asked to treat, and so on. However, whatever reading is imposed on the net it is hard to escape the impression that what is shown is a peculiar kind of self-referential epistemology: A patient is a patient because s/he is a patient (has been previously treated/diagnosed/admitted) or because members of her/his family have previously attained patient status. What is revealed is a Kafkaesque world, governed by an insane circularity forever predicated upon itself, where admission explains readmission, where categories of madness are always already known, and where well-rehearsed symptom-checklists are recited over and over again as they ceaselessly confirm the actuality of the objects that are the effects of this psychiatric surveillance technology.

To present the case history as a kind of machine, much as one-on-one interviews were in the previous chapter said to be machine-like, is not however to claim that they are 'great satanic mills' which close upon the primordial innocence of psychiatric patients. Instead psychiatry labours, perhaps often 'in good faith', and always under difficult circumstances, to achieve what would count as a proper understanding of its subject:

The impossibility of getting precise information arises in most instances from the

insuperable difficulties under which we are of knowing a person's character and history fully, intimately and exactly. We cannot go through the complex and often tangled web of his whole life, following the manifold changes of it, and seizing the single threads out of which its texture has been woven, unravel the pattern of it (Maudsley, 1899, p. 139).

Although Maudsley's terms are perhaps now somewhat archaic, it applies equally to the difficulties of 'writing up' a case history today. 'Character' (or what we might term 'individuality') is somehow immanent (although difficult to uncover) in the tangled web of epistemological labour, so that the quest for objective apprehension conceals the play of productive discipline at work as it manipulates 'character' as its object and effect.

Chapter 9

Conclusion: The prison house of language

- One difficulty, said Stephen, in aesthetic discussion is to know whether words are being used according to the literary tradition or according to the tradition of the marketplace. I remember a sentence of Newman's in which he says of the Blessed Virgin that she was detained in the full company of the saints. The use of the word in the marketplace is quite different. *I hope I am not detaining you.*

- Not in the least, said the dean politely.

- No, no, said Stephen, smiling, I mean...

- Yes, yes: I see, said the dean quickly, I quite catch the point: detain.

- James Joyce, *A portrait of the artist as a young man*

Squire (1990) suggests that different forms of social psychology can be understood as operating in terms of three kinds of popular narrative: Detective story, autobiography, and science fiction. Traditional empirical social psychology, intent on discovering the hard facts about individual and society, is structured as a detective story; alternative social psychology, of the sort which wishes subjects to express their views in their own words and engages in informal and participant forms of data-gathering, models itself after autobiography; while discourse-oriented social psychology, which is interested in collective as much as individual patterns of meaning, classes itself as science fiction.

Discourse psychology is science fiction not only because of its still marginal position in academia, but also because its professed interest in deconstructing and re-constructing the

technologies of its parent discipline - and in grafting foreign apparatuses (borrowed from philosophy, sociology, linguistics, literary studies) onto the existing machinery for social-psychological knowledge production - often serves as a pretext for extra-scientific commentary on society and subjectivity.

In this dissertation I have taken apart various knowledge machines which have been, or could be, deployed in relation to the question of mental illness - quantitative and individualising empirical enquiry (Chapter 2), Whig history (Chapters 3 and 4), biopsychiatry (Chapter 5), and discourse analysis itself (Chapter 6) - and have used the parts to fashion fanciful new technologies of my own. Concurrently, I have presented a commentary on the form of subjectivity implied by recidivism, arguing with Foucault that the sporadic physical incarceration and liberation of the 'mentally disturbed' person occurs in the context of discourses of modernity which normalise and accommodate aberrant behaviour.

Like the rest of us, except perhaps more so, the recidivist is made the subject of an implacable scientific determinism while at the same time having agency thrust upon her. Thus her oscillation between freedom and incarceration is merely one instance of the fundamental duality which is constitutive of modernity. I have tried to demonstrate this duality historically, in the disciplinary texts of modern psychiatry, in the moment-by-moment vacillations of the confessionals and in psychiatry's technologies for discursive surveillance. Thus I have followed Foucault (1967) in claiming that "language is the first and last structure of madness, its constituent form; on language are based all the cycles in which madness articulates its nature" (p. 8).

As with science fiction, however, the danger with the kind of text I have put together to warrant this claim is that it will end up "too far from conventional representations of reality to be taken seriously as an alternative to them, but also close enough to these

representations in some ways, to be co-opted into them" (Squire, 1990, p. 44). In particular a text such as this dissertation may become co-opted by what Michael (1991) refers to as the modern axis of clarification-stabilisation-practicality. In other words it may start using words as currency in the academic marketplace to answer questions such as: How can we understand readmission and its relationship to mental illness? How can we use this knowledge as a basis for further research? How can we practically intervene to make things better? I have tried not to engage with such questions, instead addressing the prior question on the status of the knowledge-making procedures used to constitute the objects on which modernist discourses fasten. Although I have also tried throughout to speak of my own procedures, even while allowing them to operate, some further reflection is required.

Methodological commentary

The techniques I have used in this dissertation could all broadly be classed as forms of discourse analysis. In earlier chapters I constructed a reading of the history of psychiatry designed to show how the twin projects of scientific progress and humanist reform are accompanied, as modernist projects are, by an extension of disciplinary power into, and from, the furthest recesses of the social world. I tried to show how psychiatry, which speaks continually of objective knowledge and of liberation from the distorting effects of power, stands mocked by the figure of the recidivist patient, who can never finally be grasped by or uncoupled from the system of knowledge and power of which it is an effect.

In moving from historical material to contemporary texts, I have continued with the same kind of analysis, namely to bring into visibility the discursive structures presumed to underlie the surface appearances of psychiatric practices - in this case the personal interview

and the psychiatric case history.

Inevitably, the structuralist approach yielded the sorts of objects it is intended to, namely repetitive patterns of psychiatric writing and speech. These include depictions of patients as liberated into a 'community' which increasingly resembles the institution (Chapter 3); preemptive appeals to imminent scientific breakthroughs (Chapter 4); and ultimately circular references to previous encounters with institutional psychiatry to account for the current hospitalisation (Chapters 7 and 8). When such structures are made visible it is easy to start believing that they operate to reduce diversity and to limit the scope of what it is possible to say and do, while in fact they are *productive* of diversity and are precisely the kinds of mechanisms through which it becomes possible to say and do anything at all.

In that the analysis itself operates in and through language (although it also draws on an artificial language of statistical conjunctions), it can only point to those features of language which are already in the process of being supplanted by more nuanced formulations, much as humanist critiques of psychiatry are forever doomed to fasten onto a few remnants of its scandalous past rather than the productive realities of its present.

Thus a structuralist approach must, to recall Cox's (1989) words quoted earlier, result in 'salt-flats of abstraction' from which all the 'beautiful specifics of culture' have been stripped. So with reference to the psychiatric case histories, for example, we are left with no way of knowing that patient #378 has in the past three weeks shown a tendency to fall over his own feet, that patient #1018 believes that Satan has taken over her boyfriend's personality, or that patient #1465 is a political detainee who suffers from echolalia and suicidal thoughts and has been tearing holes in his clothes. It may be that meaning is contained not in frequent words and stereotypical formulations, but in everything that is infrequent, atypical and silent.

I have tried to show how the structuralist scaffolding on which for example psychiatric case histories appear to be built also forms a surface of visibility against which such singularities stand out all the more clearly, but in giving an account of the material for even minimally 'scientific' purposes it is impracticable to show more than a handful of such instances. Ironically, the case histories themselves appear to be caught in exactly the same tension, attempting in one gesture to give an *account of* patient histories and to *account for* them - to tell extraordinary stories while simultaneously showing how they should be understood.

The numerical techniques developed to assist with the task of structuralist analysis, while certainly not providing an escape from this impasse, do offer possibilities for further experimentation. I have, for example, in the analyses presented in this dissertation consistently used the strongest sets of connections among words. This amounts to following an aggressively structuralist strategy. It would be instructive for future projects of the same kind to work with the kinds of semantic units that are produced when less powerful (but still statistically significant) connections among lexical items are plotted. Another possibility would be to exclude sequences of immediately adjacent words from the lexical nets so that longer-range connections become more prominent.

Lexical nets are the result of a statistical projection of word distances in a one-dimensional string to a presumed many-dimensional discursive space (as reflected in the collocation matrix) and back to a two-dimensional printed page. For the first projection I used z-scores, while the second projection is done manually. In both cases, other approaches would be worth considering, for example using the mutual information statistic to form the collocation matrix and multi-dimensional scaling to collapse this multidimensional space back to two dimensions.

One of the justifications offered for the use of quantitative indices (Chapter 6) is that they offer a backdrop against which the relative importance of particular discursive features can be assessed, unlike many discourse analytic studies which fail to show how prominent identified features are. Although frequency counts, lexical nets and the like did prove useful for this purpose, it is important to maintain a critical distance from the idea of such contextualisation. The nets did show how certain linguistic features fit into patterns found in the text as a whole, but the choice of what is defined as a 'whole' text remains that of the analyst. Thus in future analyses it may be useful to see if it is possible to draw up a combined net for interview transcripts and case histories together, or perhaps to combine these with similar material from other hospitals, or with standard psychiatric texts. Conversely it may be worth segmenting the texts in terms, for example, of admitting physician, sex, or diagnostic category and constructing separate nets for each cell.

Some would argue that such experimentation would be pointless, as lexical nets and similar devices are simply overly literal interpretations of the idea of *repetitive patterns* (of which discourse analysts speak so repetitively), displaying as they do connections between mere words, while it seems more probable that God would have stocked our linguistic aquaria with larger, more shadowy creatures (phrases, sentences, natural meaning units), and that it is in the elaborate mating rituals which occur between these higher-level elements that we may witness the spawning of human subjectivity. Lexical nets, one might argue, are too fine-grained and too flimsy to catch anything bigger than the amorphous plankton of the discursive ocean.

However, while it seems evident that no mechanical device could be used to 'understand' all the levels of meaning encoded in language, the analyses in Chapters 7 and 8 suggest that there may be some utility in employing such a device to assist with the initial

scanning of texts. Although, in truth, there may be nothing special about the little snatches of repetitive talk and writing identified in Chapters 7 and 8, and any connection between such micro events and larger systems of meaning and power may be entirely coincidental, it is also true, as Zipf (1935) observed, that:

In concluding this introduction to a field of possible scientific enquiry, we may well be reminded that the actual speech-gestures, together with their meanings and patterns, are but accidents when compared to the close-knit relationships of the stream of events in the total universe of behavior (biological, psychological, sociological) in which these accidents occur. Yet, in their *recurrences*, these accidental speech-gestures have found acceptable use by human groups as time-saving representants of the larger universe of experience. A record of the recurrence of these gestures constitutes in fact the chief and almost the only record of human experience available for empirical study (p. 309, original emphasis).

Afterword

While writing this dissertation I received a copy of a letter from a certified psychiatric patient at one of the facilities catering for such people in the Gauteng area. The letter was addressed to heads of government, legal authorities, international organisations, and similar possessors of sovereign power, asking them to intervene on the patient's behalf as he was being held against his will by callous and uncomprehending psychiatrists despite being of sound mind. As evidence of his sanity, the patient attached a photographic brochure of extremely finely wrought furniture which he had manufactured before being detained. After asking for advice from friends and colleagues I turned the letter over to a group of mental health workers

concerned with human rights issues in psychiatry.

They addressed several letters to the superintendent of the hospital and to officials in the department of health, but by the time they received a reply the patient (who had been hospitalised on several previous occasions) had already been released.

It is in any case doubtful if the postmodern alternative (Michael's, 1991, transgression-accelerated turnover-consumption of spectacle axis) doomed to some form of coherence, however much stammered and colourless green ideas sleep furiously, however much pastiche, flagrant plagiarism, as again in Finnegans case, doubtful if any escape is possible, whether voluntary or o dedi a dada orzoura detention house-arrest in the prison ich bin confus (see).

My wud! The warped floor of the lair and soundconducting walls thereof, to say nothing of the uprights and imposts, were persianly literatured with bursts loveletters, telltale stories, stickyback snaps, alphybettyformed verbiage, ahems and ahahs, imeffible tries at speech unsyllabled, you owe mes, eyoldhymms, fluefoul smut, fallen lucifers, counterfeit franks, best intentions, curried notes, upset latten tintacks, painful digests, once current puns, quoshed quotatoes, messes of mottage, unquestionable issue papers, seedy ejaculations, to which, if one has the stomach to add the breakages, upheavals, distortions, inversions of all this ch. nbermaid music one stands, given a grain of goodwill, a fair chance of actually seeing the whirling dervish, Tumult, son of Thunder, self exiled in upon his ego, a nightlong a shaking betwixtween white or reddr hawtors, noondayterrorised to skin and bone by an ineluctable phantom (may the Shaper have mercy on him!) writing the mystery of himsel in furniture.

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APPENDIX 1

Interview consent form

I _____ (full name)

hereby agree to taking part in a research project about the language used to describe emotional and mental difficulties. I understand that the project will involve being interviewed for short periods on two occasions during my stay in hospital. The interviews will be audiotaped and the tapes will be used only by the researcher. Nothing that I may divulge in the course of the interviews will be passed on to anybody in such a manner as to compromise my right to anonymity. The research will have no bearing whatsoever on my treatment.

Signed: _____

Date: _____

Witness: _____

Date: _____

Appendix 2

Choice of parameters in drawing up a lexical net

In this appendix a short extract from one of the interview transcripts from Chapter 7 is used to illustrate the consequences of using different numerical parameters when drawing up a lexical net and to explain how particular parameters were decided on for the main analysis. The extract is from the first interview with interviewee number 44, a 21 year-old woman in her second admission to the hospital. The extract is from a part of the interview dealing with reasons for admission and has been annotated using the COCOA format:

<topic why>

<p M> The first sort of standard question that I ask people is if you could tell me why you're here - you know the obvious thing.

<p P> Uh as far as I understand it I suffer depression. I'm not sure whether it's endogenous or whether it's reactive. I think it's a bit of both [ja], and I become extremely suicidal. I don't have a great love for life as it is [ja]. And that's basically why I'm here. And also to discover why you know I feel the way I do about my life and my circumstances.

<p M> What uh sort of form might that discovery take, do you think?

<p P> Uh...I have a lot of trouble expressing myself, especially my emotions, and it causes a lot of anger within me, and causes me to isolate myself from other people. It affects my life outside. And what I'm hoping to achieve here through therapy is to learn to express these emotions so that uh I can function

normally, outside and not find myself hiding away [yes], and find myself acceptable to those outside.

<p M> But so you feel it's probably a kind of psychological thing really then.

<p P> I'm inclined to think it's more psychological, personally yes.

<topic preadmit>

<p M> Uh to change the topic slightly, I'd like to come back to this later, if you could just kind of tell me what happened in the two three weeks prior to coming in this time.

<p P> I was actually at X hospital before I came here [is it?]. I was there for five and a half weeks. What happened was...I started getting very suicidal and I decided to actually do something [yes]. And I happened to talk to a friend of mine who eventually had me certified and sent to X hospital.

<p M> Certified?

<p P> Ja [gmmm]. Where I, I was locked up there for four weeks, and then I went to an open ward for a week and a half, and then I managed, I requested transfer here, because I find this environment more therapeutic.

<p M> Much better, I'm sure...Uh how did you feel about this certify business, were you sort of [interruption at door]?

<p P> It was a shock, it really was a shock [is it]. I had been threatened with it before, uh, but I had never sort of really thought I'd actually end up there, and it was, it was very difficult. I was very angry in the beginning [mmm]. But uh, that subsided. I don't hold it against my friend for certifying me. I would have, I would have done the same for her. She was worried.

<p M> And it was the only way to kind of force you to come.

<p P> Ja [gmmm].

<topic helpprof>

<p M> OK ja, then I'd like to sort of hear the opinions of, or the opinion of some professional person that's, you feel has been helpful to you in the past. Uh or that you have felt close to, such as a psychologist, psychiatrist, social worker, whatever. Uh if you could say who the person is, maybe not by name, and uh how he or she defines your problem.

<p P> ...One professional person?

<p M> Preferably, but if you like, you could -

<p P> I've been seeing one of the psychologists here, a female psychologist, and...she's seen me in my, my good states, my bad states [ja] and it, it makes it easier to discuss things with her because she knows ME, for what I am, without a mask I'm inclined to put on. And it's helpful that she's there to listen. She understands, she doesn't judge you. She's objective, she's not subjective. And...you know they're able to read, sometimes read between the lines so to say [ja]. So that you find yourself, something you can't express [yes], with their prompting and their aid, it makes it easier to express things, and it increases an awareness within one. Sometimes one gets a bit tired of talking and talking and talking, but you know one gets to realise that it's got to come from you [yes]. Although you sometimes feel frustrated, because you'd like them to give the answer, you know right there, and say look this is what you must do [yes]. You do realise that they're there to help you, and it's got to come from you, yourself [ja]. And it, it's sometimes difficult to talk about things, but it helps knowing that they're not going to judge you, they're not

going to hold it against you, it's not going to go further than the professional team working here. And that in itself makes you feel a bit more comfortable, because sometimes things get a bit personal.

<p M> Yes but it's kind of, they're not part of your friends circle or something.

<p P> Ja, it's not as though you need worry about people finding out what you said, or how you feel about things [ja, ja]. And that, that in itself makes things a lot easier.

<topic helplay>

<p M> What about a non-professional, uh like family or an acquaintance or something. If you could sort of pick on some person whose been helpful to you there.

<p P>[sighs] I have a friend, who is also an X with me, and

<p M> Are you an X?

<p P> Ja. And she has been through much the same experience herself - she's actually the one that certified me - and I find that we're able to talk to one another quite freely, knowing that that person's not going to spread it, you know, around the whole group or whatever [ja]. And having been there herself, she's very understanding. And it's not of a case where she's trying to give advice. She might discuss her experience and one can learn from that. And it's, you know, it's helpful that you know the person and you feel comfortable with them. And they, OK it's subjective, but they know where you're coming from, they know what type of person you are, what lifestyle you lead, you know things like that, they know your background a bit better [ja, OK].

A conventional qualitative analysis of this extract could focus on a variety of different themes, such as: The nature of the interaction between the interviewer and interviewee (which appears to be structured to allow for maximal talking by the latter, while the former presents himself as an empathetic listener despite the sometimes brutal topic changes); the interviewee's easy familiarity with (sometimes outdated) clinical jargon such as 'expressed emotion' and 'endogenous' versus 'reactive' depression; the ostensible high regard shown by the interviewee for others' opinions about her situation; or the interviewee's acquiescence with and resistance to various forms and degrees of incarceration.

An analysis making use of a lexical net, by contrast, would start by identifying repetitive linguistic patterns (such as for example, the repetitive use of the "and...and...and" structure in the last paragraph of the interview transcript) as a starting point for further qualitative analysis and interpretation. Lexical nets provide an automated, objective means of identifying patterns that depend on the repeated co-occurrence of words. The following parameters affect what is counted as a significant co-occurrence:

Span: The number of words on either side of a target word which are counted as co-occurring with the target word.

Minimum collocation size:

The minimum strength of collocation (as calculated using the z-score) which is accepted as significant. Although all collocations with a z-score of above 2.57 are statistically significant at the 5% level, in a large text inordinately many collocations reach significance and different (usually more stringent) cut-offs have to be set.

Minimum collocation frequency:

In cases where words occur together consistently the statistical procedure will flag them as collocates even if they are used quite infrequently in a text. To prevent such rare words from becoming too prominent in a lexical net it is therefore necessary to exclude words that co-occur less frequently than a certain cut-off.

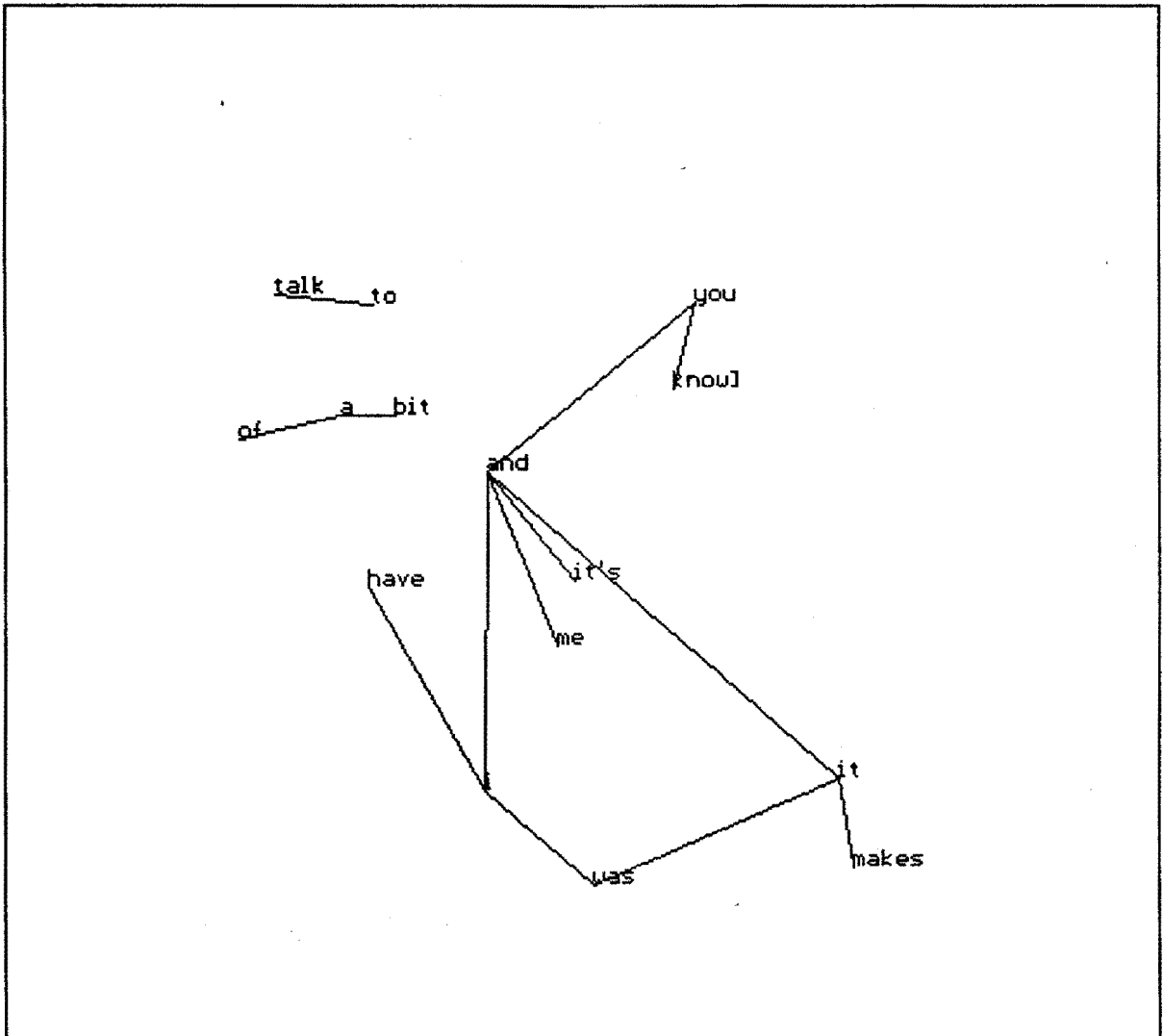
These three parameters are interdependent, such that a larger span will result in more statistically significant collocates and a consequent need to set more stringent cut-offs with regard to minimum collocation size and frequency. In addition, the number of statistically significant collocates also depend on the size of the text, with more significant co-occurrences identified as the length of the text increases. At present there is no objective method of deciding on the minimum collocation size and frequency, and a pragmatic approach aimed at keeping the lexical net within reasonable levels of complexity has to be followed.

The situation with regard to the first parameter, the collocation span, is somewhat different. In theory, a small span will result in the identification of lexical redundancies at the level of frequently used word-pairs and phrases, while a large span will result in the identification of co-occurrences which occur when words are frequently used in the same general context, but not necessarily next to each other or as part of the same stock phrase. As a general rule, a small span can therefore be expected to throw syntactic relationships between words into relief, while a larger span will tend towards the identification of semantic contingencies.

To illustrate this, three different lexical nets derived from the extract are presented below. The net in Figure 1 is based on a span of four words (two on either side of the target word), which (as discussed above) can be expected to highlight stylistic redundancies such as

word pairs or short phrases. Figure 2, by contrast, uses a span of 40 words, which can be expected to show patterns of co-occurrence of words not necessarily in close proximity.

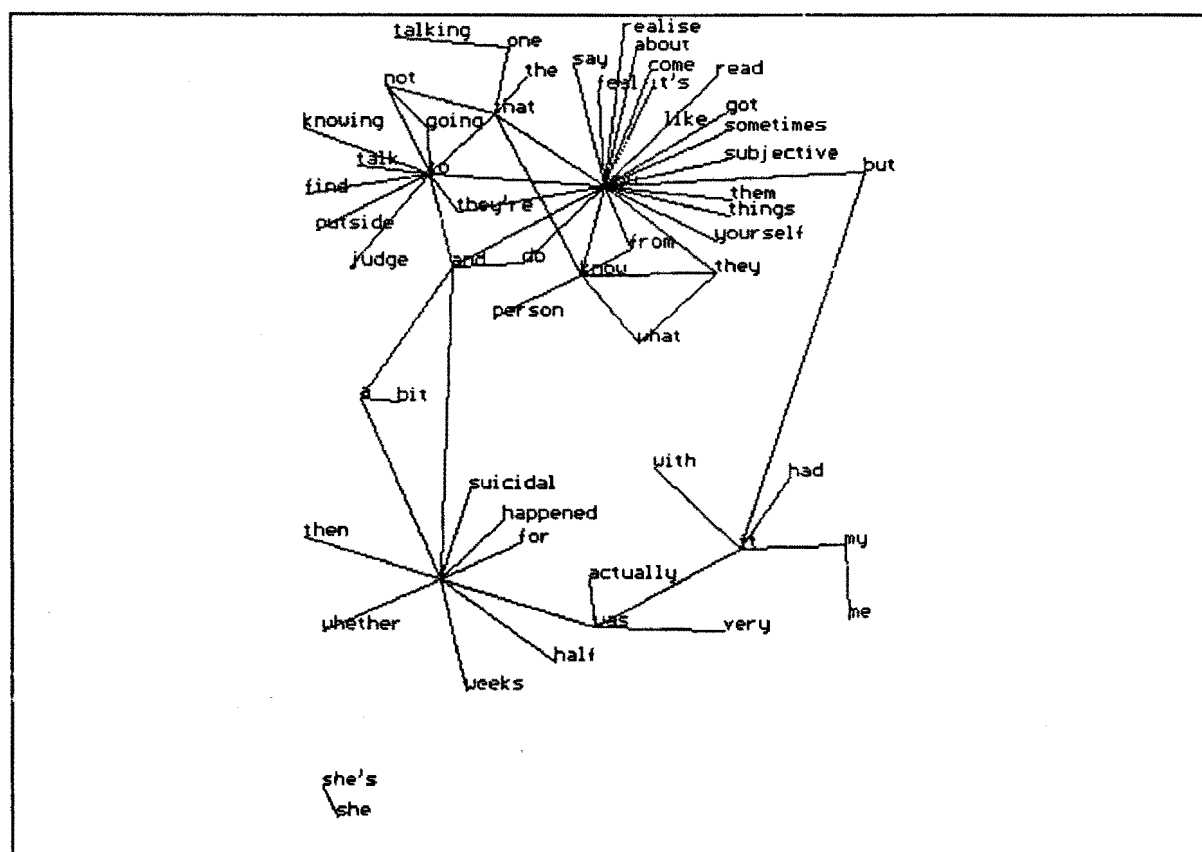
Figure 1. Net for a span of 4, minimum frequency of 5 and minimum size of 1.64



As can be seen from Figure 1, the shorter span does indeed reveal word pairs and phrases such as 'you know' (which occurs no fewer than 8 times) and a pairing between 'I' and 'have' which occurs 6 times in short phrases such as 'I have', 'I don't have' and 'I would have'.

An extreme view would be that using a very short span simply leads to the rediscovery of grammatical rules at the syntactic level. (For example, 'I' and 'has', being a grammatical mismatch, are unlikely to be significant collocates for any text when the span is set to two.) Nevertheless, the collocational patterns found when a small span is used will not be the same for all texts and do reveal something of the stylistic 'signature' of a particular text. The 'you know' locution shown in Figure 1, for example, rarely occurs in written texts.

Figure 2. Net for a span of 40, minimum frequency of 8 and minimum size of 5.07



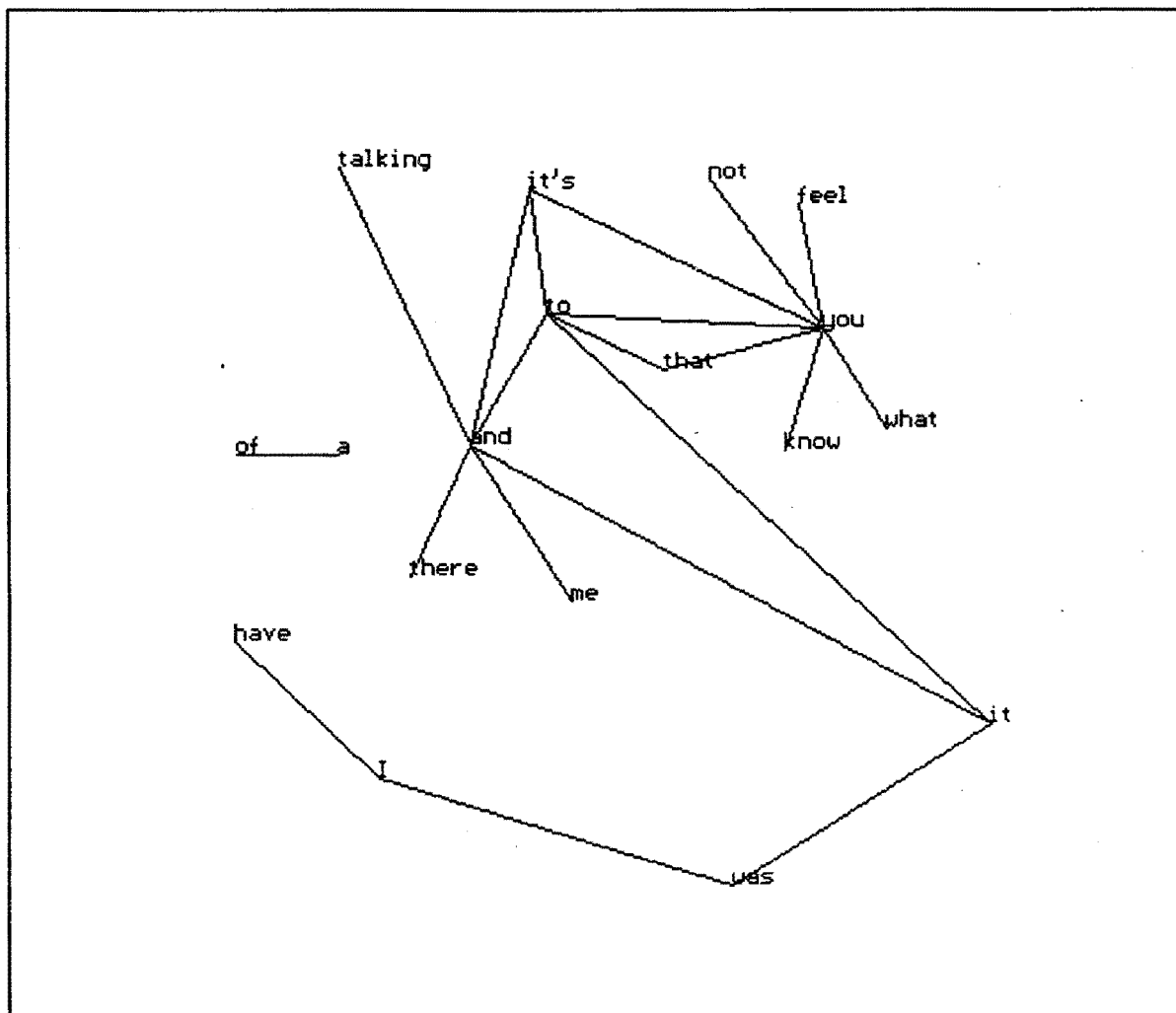
At the other extreme from the lexical net based on a very short span shown in Figure 1, is the net in Figure 2, which is based on a span of 20 words on either side of the target word. Thus, for Figure 2, words are taken to be in the same general area of the text if they occur within 40 words of each other. The first consequence of this, as is evident from Figure

2, is that many more word pairs are considered to be statistically related, despite the fact that far more stringent cut-offs have been set, with a minimum collocation size of 5 and a minimum collocation frequency of 8. As can be seen, some of the stronger short-range (or syntactic) collocations such as 'I-was' and 'you-know' have been preserved in this net, to which have been added a profusion of longer-range collocations with a somewhat more semantic flavour. For example, we can see that the word 'suicidal' tends to occur with statistically significant regularity in the vicinity of 'I', even though the two words do not form part of a stock phrase.

Another effect of using a very large span is that high frequency words (such as in this case 'you', 'I' and 'to') are shown as high-frequency collocates of a large number of words that rarely co-occur with one another. Thus a word such as 'you' will tend to occupy a central position in a net, with a large number of collocations radiating out from it. Taken to extremes, very large word spans could thus result in lexical nets that do little more than reproduce the word frequency table for a text.

Figure 3, with a span of 8 and frequency cut-offs somewhere between those for Figures 1 and 2, represents a middle position. Strong short-range collocations such as 'I-was' and 'you-know' present in both the other figures are reflected here as well, as are some present in one of the figures only. The phenomenon of high-frequency words such as 'you' and 'and' occurring at the centre of a collocational web can also be observed, but is much less marked than in Figure 2.

Figure 3. Net for a span of 7, minimum frequency of 6 and minimum size of 2.57



None of the three lexical nets is a more accurate reflection of the text than the others, but each presents a somewhat different view of the text. Which view is more useful depends on the analytic purposes for which the net is being used. If the purpose is to know which words co-occur in the same broad areas of text, a large span is indicated. An example of this may be where the text has been segmented into a number of 'cases' and the analyst wishes to know which words tend to cluster together in the same case. A large span will ensure that all words in a case are counted as collocates, while words in different cases will not be counted as collocates (since case boundaries are not crossed). Different sections of the net will

therefore tend to represent different types of cases, each with its characteristic pattern of collocation. Although some of the collocations may be short-range locutions such as repetitively used word pairs, many will be long-range and possibly have a more semantic flavour.

If, on the other hand the purpose is to identify typical turns of phrase in a text, a shorter word span is indicated. If the purpose is to identify a mix of stock phrases and longer range 'semantic' contingencies, a word span of intermediate-length is indicated. From the three lexical nets presented here it is in any case clear that the nets are reasonably robust and that at least some of the more prominent features of the lexical interdependencies in a text are identified despite wide variations in the parameters used.

For the purposes of the analysis presented in Chapters 8 and 9 it was decided to use a word span of intermediate length. The data used for Chapter 8 consisted of a relatively small number of cases each containing a large number of words, thus precluding a case-wise analysis since even a very long word span would not have covered each case. Chapter 9, by contrast, made use of a large number of relatively short cases and using a longer word span to cover each case would have been feasible. However, the purpose was not to find clusters of similar cases (correlated, perhaps, with psychiatric diagnosis or with the registrars making the diagnosis), but to highlight typical forms of expression occurring in the text taken as a whole. A very short word span was also considered inadvisable as many of the relations among words identified in this manner would be likely to be of a trivial semantic nature.

Finally, it should be borne in mind that, whatever the parameters used, lexical nets are not intended as an end in themselves, but as a starting point for further qualitative analysis. As a concise overview of a text, a lexical net can serve as a contextual backdrop for whatever analysis is performed with the text.

Appendix 3

Significant collocates in first interview transcripts

Type (a)	N(a)	Type (b)	N(b)	C	z
you	512	know	458	339	62.13
time	109	long	30	23	37.94
two	58	weeks	33	15	34.75
years	42	ago	20	10	34.75
know	458	don't	260	132	33.16
we	70	were	31	17	33.05
i've	214	got	141	64	32.64
of	522	sort	55	62	32.22
i've	214	been	158	67	32.01
at	202	moment	26	23	31.27
i	2227	don't	60	312	31.05
a	643	lot	69	71	29.89
in	380	terms	20	27	28.01
i	2227	was	514	442	27.52
a	643	bit	41	49	26.84
my	503	mother	27	35	26.71
as	107	far	26	15	26.14
i'm	300	not	206	75	26.06
i'm	300	scared	16	20	26.04
to	988	want	60	67	23.61
don't	260	understand	33	23	22.59
my	503	brother	12	19	22.46
and	1257	then	153	127	22.26
of	522	kind	33	33	22.17
of	522	lot	69	48	22.10
i	2227	think	166	181	21.95
it	519	was	514	149	21.75
that's	108	why	44	16	21.36
a	643	of	522	167	20.95
to	988	me	439	188	20.28
me	439	she	244	82	20.16
i've	214	always	51	24	20.14
i'm	300	gonna	30	21	19.56
to	988	go	119	84	19.55
i	2227	know	458	314	19.10
people	93	other	61	16	18.86
my	503	life	44	31	18.45
me	439	they	273	81	18.43
what	175	do	136	32	18.28
for	217	long	30	16	18.10
my	503	sister	16	18	18.04
of	522	type	17	19	17.90
the	774	of	522	165	17.71
to	988	used	40	42	17.61
the	774	time	109	62	17.26
of	522	terms	20	20	17.23
i'm	300	here	134	39	17.00
i	2227	to	988	514	16.91
of	522	course	21	20	16.76
i	2227	dunno	37	60	16.70
the	774	in	380	129	16.61
no	155	no	155	29	16.59

i	2227	feel	75	89	16.41
my	503	husband	13	15	16.40
a	643	long	30	26	16.32
the	774	at	202	85	16.26
at	202	look	34	15	16.21
to	988	able	22	28	16.17
i	2227	had	169	148	15.99
the	774	moment	26	24	15.56
the	774	last	54	38	15.55
for	217	years	42	16	15.43
i	2227	when	100	103	15.40
on	161	going	80	20	15.37
my	503	own	21	18	15.36
i	2227	didn't	93	98	15.33
they	273	don't	260	51	15.23
my	503	father	21	18	15.20
i	2227	that	623	343	15.10
to	988	get	127	71	15.08
he	165	said	86	21	15.04
i've	214	never	56	19	15.02
to	988	talk	35	33	14.83
as	107	as	107	18	14.71
to	988	be	127	69	14.60
i	2227	mean	61	72	14.57
to	988	do	136	70	14.46
me	439	told	33	20	14.30
well	154	as	107	21	14.04
don't	260	want	60	20	13.94
to	988	come	68	45	13.86
they	273	understand	33	15	13.81
you	512	like	242	65	13.71
i	2227	can't	70	74	13.67
was	514	very	182	55	13.66
it's	273	not	206	40	13.60
i	2227	and	1257	564	13.55
that	623	is	214	67	13.54
i	2227	because	286	189	13.52
was	514	there	116	42	13.46
but	274	not	206	40	13.45
he	165	he	165	27	13.34
what	175	say	88	19	13.27
of	522	out	110	40	13.26
the	774	thing	100	47	13.21
i	2227	just	307	194	13.15
to	988	trying	17	20	13.09
you	512	it's	273	67	13.03
and	1257	my	503	182	12.97
i	2227	suppose	25	39	12.92
i	2227	have	163	124	12.91
you	512	are	50	25	12.91
me	439	help	59	24	12.79
i	2227	if	112	97	12.78
i	2227	want	60	64	12.77
my	503	psychiatrist	31	18	12.75
to	988	have	163	72	12.62
know	458	like	242	56	12.52
a	643	for	217	65	12.51
i	2227	felt	29	41	12.35
very	182	depressed	64	15	12.34
they	273	say	88	23	12.34
i'm	300	going	80	23	12.29
know	458	what	175	45	12.28
my	503	family	26	16	12.28

i'm	300	feeling	37	15	12.27
i	2227	here	134	99	12.27
have	163	been	158	24	12.27
she	244	she	244	39	12.22
at	202	all	139	24	12.05
the	774	first	27	21	11.98
i	2227	what	175	122	11.93
me	439	he	165	42	11.82
to	988	going	80	44	11.81
to	988	myself	90	46	11.81
to	988	wanted	21	20	11.80
the	774	same	19	17	11.76
and	1257	was	514	175	11.73
it	519	but	274	63	11.70
me	439	tell	31	16	11.70
and	1257	to	988	280	11.68
and	1257	me	439	153	11.58
was	514	when	100	34	11.53
that	623	was	514	105	11.53
not	206	really	115	21	11.47
have	163	would	75	15	11.44
to	988	tried	25	22	11.43
they	273	are	50	16	11.42
the	774	day	54	29	11.40
the	774	way	47	27	11.39
it	519	wasn't	45	21	11.36
she	244	said	86	20	11.26
all	139	time	109	16	11.25
that	623	thing	100	36	11.23
i	2227	can	106	84	11.15
and	1257	try	19	21	11.09
you	512	do	136	38	11.04
and	1257	on	161	76	11.04

Note. N(a) and N(b) are the frequencies of the corresponding types. C is the collocational frequency of the two types. z is the z-score. A span of 8 words (4 at either side of the target word) and a minimum collocational frequency of 15 was used. The first 218 significant word pairs (to a minimum z-score of 11) are shown.

Significant collocates in first reason for admission corpus

Type (a)	N(a)	Type (b)	N(b)	C	z
for	14	search	3	5	13.74
you	9	know	9	6	12.63
the	32	search	3	7	12.50

i'm	23	here	14	11	10.00
i	113	don't	9	17	8.32
a	27	of	16	10	7.51
the	32	you	9	7	6.92
to	38	be	7	7	6.80
i	113	feel	5	10	6.67
that	22	be	7	5	6.61
to	38	go	4	5	6.60
i	113	suppose	4	9	6.48
i'm	23	because	10	6	6.25
i	113	was	25	26	5.99
the	32	for	14	8	5.97
i	113	but	9	13	5.59
was	25	there	8	5	5.56
and	47	my	13	9	5.54
the	32	it's	12	7	5.53
and	47	was	25	13	4.98
i	113	rationalise	3	6	4.87
i	113	could	3	6	4.87
the	32	know	9	5	4.85
to	38	get	7	5	4.85
i	113	think	6	9	4.79
that	22	is	12	5	4.74
i	113	because	10	12	4.56
i	113	very	6	8	4.34
i	113	have	4	6	4.26
i	113	as	10	11	4.07
to	38	is	12	6	3.92
to	38	i'm	23	9	3.88
i	113	when	3	5	3.88
i	113	tried	3	5	3.88
a	27	for	14	5	3.68
and	47	no	8	5	3.68
i	113	here	14	13	3.66
uh	34	depression	12	5	3.58
i	113	to	38	26	3.56
and	47	there	8	5	3.54
i	113	so	6	7	3.46
i	113	uh	34	23	3.30
uh	34	a	27	8	3.10
i	113	didn't	4	5	3.05
i	113	well	9	8	2.98
i	113	had	7	7	2.91
i	113	i'm	23	16	2.85
i	113	about	6	6	2.76

Note. N(a) and N(b) are the frequencies of the corresponding types. C is the collocational frequency of the two types. z is the z-score. A span of 8 words (4 at either side of the target word) and a minimum collocational frequency of 5 was used. All significant word pairs to a minimum z-score of 2.76 are shown.

Significant collocates in second reason for admission corpus

Type (a)	N(a)	Type (b)	N(b)	C	z
here	23	why	4	6	14.10
know	18	you	10	9	13.52
been	8	i've	8	5	12.74
time	17	this	9	7	12.58
got	11	depressed	6	5	12.54
know	18	don't	8	7	11.74
uh	38	anxiety	4	7	11.62
a	37	lot	8	9	10.27
me	23	they	14	9	10.17
very	13	had	8	5	9.92
here	23	i'm	16	9	9.83
to	48	cope	5	7	9.55
of	37	sort	6	7	9.50
i	148	was	52	54	9.17
i	148	dunno	5	12	8.84
a	37	of	37	18	8.66
was	52	working	7	8	7.99
and	81	myself	4	6	6.86
was	52	too	4	5	6.67
of	37	lot	8	6	6.58
and	81	to	48	27	6.46
i	148	that	26	25	6.04
here	23	because	17	6	6.00
it	38	very	13	7	5.86
i	148	don't	8	12	5.86
i	148	because	17	19	5.83
the	40	at	7	5	5.79
to	48	with	17	9	5.53
uh	38	depression	11	6	5.52
here	23	they	14	5	5.50
i	148	what	9	12	5.46
i	148	wasn't	12	14	5.45
a	37	had	8	5	5.34
to	48	get	7	5	5.32
was	52	it	38	15	5.30
and	81	sent	4	5	5.29
and	81	me	23	14	5.18
i	148	working	7	10	5.14
i	148	really	4	7	5.03
and	81	then	11	9	5.00
i	148	got	11	13	5.00
to	48	go	7	5	4.98
i	148	and	81	51	4.87
and	81	was	52	24	4.86
uh	38	but	10	5	4.72
the	40	that	26	9	4.65
uh	38	of	37	11	4.61
was	52	very	13	7	4.54
i	148	medication	6	8	4.35
i	148	depressed	6	8	4.35
a	37	for	15	6	4.33
i	148	on	10	10	4.31
of	37	my	20	7	4.24
i	148	can't	4	6	4.14

and	81	the	40	18	4.14
and	81	for	15	9	3.90
a	37	very	13	5	3.84
to	48	me	23	8	3.83
i	148	last	5	6	3.70
to	48	in	11	5	3.68
and	81	a	37	16	3.67
i	148	just	19	15	3.63
and	81	with	17	9	3.50

Note. N(a) and N(b) are the frequencies of the corresponding types. C is the collocational frequency of the two types. z is the z-score. A span of 8 words (4 at either side of the target word) and a minimum collocational frequency of 5 was used. All significant word pairs to a minimum z-score of 3.5 are shown.

Appendix 4

Sample interview

[13/12/89b - first interview]

<case 23>

<diagn adjustment>

<admit 01>

<intno 01>

<sex m>

<age 20>

<topic why>

<p M> OK, the obvious question that I always start off with is if you can just tell me why you're here.

<p P> Uh...because I committed [suici], I tried to commit suicide two times in two weeks, from the first one I did. Like the first time I did it, they let me out because I had to go and get my stomach pumped.

<p M> Out from here?

<p P> Uh.....

<p M> Gen, JG_Strijdom?

<topic preadmit>

<p P> Uh, no.....The South, I had my stomach pumped out at the South_Rand hospital. Uh, they put me on a drip. Then Thursday they let me home. Then two weeks later I did it again, but this time I did it even more amount...of pills [ja]. It was 31, no the second time I did it was 31 lithium carbonate, and there was 11 calmettes and 5 sleeping pills. And the first time I had my stomach pumped out it wasn't, wasn't so bad because I was mostly unconscious, but the second time it was very painful because I was mostly awake [shit]. I kept on trying to puke, and uh...nothing came out. And afterwards I just sat up and I, it just all came out [gmm].

<p M> It doesn't sound pleasant in the least.

<p P> No, it doesn't [laughs]. It's not very nice.

<p M> ...Could you maybe fill me in on the sort of details a bit more, you know, apart from the suicides? What, what brought it on and so on, over the past two, three weeks.

<p P> Uh, OK I was at College in X, because I was studying a X course, because my work sent me there. OK, and I was under a lot of pressure from that. I think that was one of, one of the reasons why I did it. And then I went back to, work, and then a guy that I was working with, they fired him, because he asked for a raise. He was a Black. And they put me with

this Portuguese guy who uh didn't suit me so good. I didn't really like him. And...they still put me with him after the first time I did it [back again!]. And that even made me worse. And I even said to myself, here we go again. I couldn't handle it. Two days, and the third day again I cracked, I couldn't handle it. I went home, and took a overdose of pills, tried to kill myself.

<topic other>

<p M> ...Who have you been seeing, if anybody, like a psychiatrist or psychologist?

<p P> Uh, it's a Dr C, it's a female doctor...She's not, I don't think she's here, but she's got something to do with Valhalla.

<p M> Some connection with Valhalla.

<p P> Ja, she, she pulled some strings. Her and this other doctor, my house doctor Dr V.

<p M> I see. Uh, how long have you been seeing her?

<p P> Well I only went there the first time I did it, I went there on a Thursday after I left the hospital, I went to see her. And they drew some blood from me, to see how my blood is, and...they said I've probably got hepatitis, so [inaudible] a week. So she said to me I must come back on Thursday to check if I've properly got it. I went back. Uh...I, I had the symptoms of it, but I didn't have it [I see]. Because my eyes were all yellow, swollen up a bit, and all that. So I went there on a Thursday. So I've only seen her twice...And it wasn't really, how would you say...they didn't really get it all out at that time [ja], the first time, and the second time I went to her.

<topic profess>

<p M> What does she think of your difficulties, how does she sort of make sense of it?

<p P> Uh, I wouldn't really know, because I didn't. Like I gave to her the main pointers, like I was under a lot of pressure from, from college, I was coming back and worried about my marks. And uh worried about work, especially this guy. [inaudible] Black was fine [inaudible] otherwise. And uh, and I was under a lot of pressure because I had just bought a new car...and the payments, when I was at X the payments got a bit, like I was supposed to be saving, but I wasn't, because it was so boring, eventually you'd just spend your money. When I came back I was under a lot of pressure. Like I was about a week away from my...my date of having to pay and I only had [inaudible] rand in the bank. And it was over R260 I had to pay back for the car, you know? That was also bugging me. And...[inaudible] also because my mother and father are divorced...for the second, for the second time. Like the first time you think ah this is the pits man I haven't got a father man, I don't see him so often. You can't do the things you would like to do, you know [ja]. And uh...then they got married again, and I thought great I've got him back [ja]. And you just starting to get, like I used to do cycling with him [mmm], I got into that, you know and broke up again, and got divorced [mmm]. And uh...it started all over again. I think that's also one of the reasons [ja]. That's it, that I can think of.

<topic treat>

<p M> What do you hope, if anything, to get from being here? How do you think will it help you to be here?

<p P> Well, put it this way, I didn't want to come here. For one I heard from a patient at JG Strijdom who said this place was all barbed wires and guard dogs around it, and all that. Which I saw for myself is not, it's...But I'd still rather be at home because I could, because I have to just finish something on my car which hasn't been finished. I must finish that. I would just like to get out, just get freedom you know [ja]. Like I'm not allow to, got to swim under supervision. Like if I swim I just swim you know, I'm a good swimmer. Uh...I'd like to go out, go to disco, movies...socialise with my friends quite a lot. Like all of them are in the motor trade [mmm]. One is a panel beater, one does, you know, piston what do you call it...he like grinds the pistons, different valves and that...

<p M> So over here you're kind of right out of that - away from everybody.

<p P> Ja. I'd still prefer to be home. Be able to do what I want.

<p M> If, if they do help you, how do you think will it happen?

<p P> How do I think it would happen? I think the only way it would happen is if I co-operate, and that's the only way I'm gonna get discharged from here quickly [ja]. So I'd rather co-operate.

<topic treatprof>

<p M> [laughs] Ja. What does uh the psychiatrist that you spoke to, what has she got in mind for you being here?

<p P> I dunno...I dunno. For one she must think I'm mad because I committed suicide, tried to commit suicide. I must seem a bit of a loony...And, I dunno...I dunno what she was thinking. I don't even know if she, I don't even think she knows I'm here. So...

<topic lay>

<p M> What about your folks. How do they make sense of what's happened to you?

<p P> ...Uh, how do you mean?

<p M> How would they explain it?

<p P> To me?

<p M> Or to somebody else maybe.

<p P> Well...Well the first time my mother, my father, and my mother's couple of friends knew about it...Well most of my mother's friends knew about it, and my father's. But uh the second time I don't even think they wanted to tell their friends about it [inaudible]. And...I think that's more-or-less it...

<p M> Are they in favour of your being here?

<p P> They're in favour but I'm not.

<topic other>

<p M> Ja. Uh, would you say that you have, or experienced depression.

<p P> Yes, definitely. Uh...because of work, changes, like... going back, like at College we started at seven and finish off at two, and you relax the rest of the day, or study...And then coming back to work is. You know like in a way going to College was like a holiday for me. And weekends we had free, didn't have to do, most of the week after College was free, except if we were studying. And then to go back to work, in a way made me so...angry, being back. Like when I was at, when I was at College like sometimes I wished I was back at work. When I'm at, when I'm at College I wish I was at, you know at work. And at College, and vice versa, or versa visa.

<topic define>

<p M> [laughs] Whichever. The story of one's life [ja]. Uh could you perhaps describe to me what depression is like, maybe pretending that I, I really have no idea.

<p P> ...Mmm...OK, uh, it's when, it's when, when all your...all your thoughts about what happened in the past, and maybe about what's gonna happen in the future, like come together, and they start working, like uh, making like, how would you say, like energy [ja]. And then, then you can't get rid of this energy and then working, and you, people moaning at you, that's going in also [ja]

[interruption for tea]

<p M> Uh, I don't know if you could sort of pick up the thread. You were sort of describing depression to me.

<p P> OK, it's when all like the energy builds up inside, inside your mind...And then you start to...you start to uh...You start to wonder what to do with yourself, because you've got so much in your mind...And you just eventually do something drastic, or, or you just walk out on the job, or you try to commit suicide like I did [mmm]. And it's...especially if you don't have anybody to talk to, it even gets worse [ja], it stays in [ja], you know. Then you can't get it out, let your feelings...go out [ja]. That's what I think depression is [laughs].

<p M> Uh, very often people mention depression as at least one of the things that bother them and uh just about everybody has got their, their own version of depression, you know. Uh, I'm sure there are some official versions, but I'm not very clued up on that [inaudible] what people say themselves [inaudible] unofficial versions as well.

<p P> Ja.

<p M> Uh when do you get depressed, when does this build-up start?

<p P> Uh...say when you've had a hard day at work, or you.....or something tragic has happened in you family, like say someone died, or even an animal that you, that you loved, you know?...

<topic measles>

<p M> Uh...OK, maybe I could ask you the sort of two gimmicky questions I have. The one is if you could tell me what's in your view, in what ways is depression the same as an illness like measles, and in what ways is it different?

<p P> Uh...Different to measles. OK, well measles is...uh, kind of, well it's a disease that most children get...And it's, you've just got to like lay [sic] down and relax, and depression is different because you've got all this energy building up, and you want to get it out, and you want to talk to somebody...Like when you've got measles, like everybody knows you're sick [ja], you've got measles and they come and visit you and, you know, but depression nobody knows you've got it [ja]. Nobody knows you're say depressed. That's what I think the difference is.

<topic weight>

<p M> OK, the second gimmicky thing is basically the same question, but to do with a chronic weight problem.

<p P> [laughs] Uh...well, for me that wouldn't be a problem, because I'm not fat, so.....OK...depression, the difference between fat?

<p M> Ja, and the ways in which it might be the same.

<p P> OK well, OK, OK say, say I'm fat, right? And I'm trying to lose all this weight, but I know it's going to be hard, so it's starting to worry me. So, and then uh...in trying to lose it, I see shucks I haven't lost a kilo yet. And you keep on trying, and you still aren't losing, it's making you even angrier, and it's still building up inside of you, and, and you just want to, like, scream!, because you're trying to lose all this weight... and you're so, and you're starting to get depressed. So I'd say it's more or less, the same [ja]. Because you're trying to lose weight and the harder you're losing weight, you worried about losing weight also. And when you start to worry, you start to get depressed.

<topic purpose>

<p M> Uh, is there any point in being depressed? Can anything good come from it?

<p P> Uh.....I'd say yes, it can be good points, and there could be bad points. Because a good point is you can talk to somebody and get that information out. And you feel [shwwwwww], that's a relief to get that out [ja, I see]. Then, a bad point of it is, if you don't, if you don't get it out, you don't talk to somebody, then you get more depressed, and more information goes into your brain. And if someone moans at you, you feel stuff them. Maybe they're right moaning at you. You know it, but you don't...want to take it, take that person's advice [mmm].

<p M> So you're sort of saying that the goodness of depression might be that it forces you to bring things out which you otherwise wouldn't have?

<p P> Ja, if you didn't have it.

<topic other>

<p M> OK, well uh the last thing is, if I see you again in two weeks

<p P> If I stay here

<topic prognosis>

<p M> Ja [laughs]. Uh, how do you predict will things have changed for you by then?

<p P> Well, as I'm not here out of my own will, uh I've got to try my best, I can only gain something, I can't lose anything [ja]. So I can only gain something, and go out, and give the world another bash, you know [ja]. See how it goes. Maybe, maybe this place would have helped me, and maybe I don't tell them anything.

<p M> How do you mean by that?

<p P> Maybe I don't want to tell them. Maybe, maybe it's too... personal for me to tell.

<p M> Right. I don't know to what extent they'll try and dig it out of you.

<p P> Maybe they haven't got a spade! [laughs]

Appendix 5

Significant collocates in the initial history corpus

Type (a)	N(a)	Type (b)	N(b)	C	z
hallucinations	187	auditory	126	123	110.16
features	220	vegetative	136	134	105.69
year	521	old	398	350	98.57
x	141	dr	124	90	91.54
suicidal	317	ideation	177	145	85.64
hallucinations	187	visual	54	55	75.31
loss	92	weight	44	35	74.39
abuse	305	substance	111	99	74.22
disorder	219	affective	80	70	71.79
admission	345	prior	147	117	70.49
bipolar	173	affective	80	59	66.55
insomnia	94	initial	28	25	65.37
abuse	305	alcohol	279	135	63.20
disorder	219	bipolar	173	92	62.90
of	2015	history	866	699	62.22
auditory	126	visual	54	36	58.93
suicide	237	attempts	95	62	56.27
has	499	been	285	164	54.92
problems	223	financial	62	46	54.82
known	304	bipolar	173	94	52.59
poor	265	concentration	61	49	52.41
suicide	237	attempt	86	55	51.96
as	235	diagnosed	109	61	50.15
paranoid	225	delusions	177	74	50.11
sleep	142	decreased	95	43	48.90
ward	202	487	119	55	47.96
previous	345	admissions	173	90	47.70
years	360	ago	256	109	47.22
appetite	142	energy	101	41	46.71
old	398	woman	67	59	46.38
behaviour	226	bizarre	59	39	46.17
old	398	female	57	54	46.11
appetite	142	decreased	95	40	45.88
appetite	142	sleep	142	47	43.99
by	398	brought	118	74	43.92
suicide	237	attempted	48	35	43.62
old	398	male	59	52	43.56
appetite	142	loss	92	37	43.29
presented	172	who	163	56	42.80
problems	223	marital	39	29	42.66
episode	119	first	64	28	42.62
disorder	219	personality	101	47	42.59
poor	265	appetite	142	61	41.74
by	398	dr	124	71	41.44
home	125	age	66	27	40.46
year	521	woman	67	59	40.35
year	521	male	59	55	40.16

year	521	female	57	54	40.14
hospital	132	Milfield	53	25	40.09
depression	585	features	220	109	39.88
appetite	142	insomnia	94	34	39.67
schizophrenic	107	chronic	99	31	39.55
known	304	well	208	78	39.48
not	323	coping	31	29	38.63
energy	101	decreased	95	28	38.53
od	228	took	80	40	38.42
abuse	305	cannabis	54	36	38.33
depression	585	vegetative	136	81	37.48
known	304	schizophrenic	107	52	36.93
2	401	weeks	241	87	35.45
history	866	family	231	126	35.35
behaviour	226	inappropriate	43	25	35.12
to	1589	prior	147	137	35.11
with	1232	presented	172	131	34.47
admissions	173	multiple	80	31	34.38
poor	265	sleep	142	51	34.31
by	398	referred	150	66	34.29
depression	585	major	79	56	34.20
days	119	few	88	26	33.98
not	323	sleeping	70	39	33.88
treated	211	previously	154	47	33.67
poor	265	energy	101	41	33.62
old	398	man	53	38	33.55
family	231	psych	130	44	33.45
old	398	who	163	68	33.35
months	284	ago	256	69	33.33
at	489	home	125	63	33.33
not	323	eating	53	33	33.24
manic	131	episode	119	31	33.16
ward	202	medical	78	31	32.72
from	432	discharged	79	47	32.61
admissions	173	sterkfontein	117	35	32.52
old	398	lady	33	29	32.48
of	2015	depression	585	316	32.28
to	1589	due	75	88	32.05
one	139	month	133	33	31.32
sleep	142	energy	101	28	31.31
year	521	lady	33	32	31.28
depressed	299	feeling	94	41	31.27
hallucinations	187	delusions	177	42	31.14
for	977	years	360	153	30.79
history	866	week	155	91	30.64
for	977	months	284	133	30.60
history	866	long	97	70	30.23
at	489	work	95	49	30.20
to	1589	be	85	89	29.99
history	866	psych	130	80	29.64
year	521	who	163	69	29.19
year	521	man	53	38	29.13
known	304	disorder	219	59	29.11
3	316	weeks	241	64	29.09
very	231	anxious	72	28	28.99
as	235	well	208	50	28.89
since	207	then	81	29	28.83
family	231	positive	68	27	28.83

to	1589	admission	345	182	28.83
of	2015	loss	92	101	28.77
admission	345	before	91	37	28.46
admitted	460	via	31	26	28.14
in	1127	brought	118	84	28.13
by	398	x	141	51	27.48
referred	150	dr	124	29	27.45
history	866	abuse	305	115	27.37
known	304	affective	80	33	27.18
to	1589	unable	58	66	26.96
no	379	psychiatric	113	42	26.55
week	155	one	139	30	26.23
3	316	months	284	63	26.22
problems	223	social	96	28	26.20
history	866	psychiatric	113	65	26.15
on	605	admission	345	97	26.15
to	1589	487	119	92	25.99
by	398	seen	70	34	25.89
from	432	transferred	74	36	25.60
Valhalla	208	admissions	173	37	25.15
previously	154	diagnosed	109	25	25.00
behaviour	226	aggressive	147	34	24.97
old	398	presented	172	53	24.73
on	605	lithium	78	41	24.19
had	437	been	285	71	23.95
months	284	few	88	29	23.75
previous	345	attempts	95	33	23.64
months	284	6	134	36	23.51
1	159	week	155	29	23.38
suicidal	317	depressed	299	57	23.19
history	866	month	133	65	23.10
old	398	age	66	29	22.88
from	432	referred	150	47	22.77
2	401	years	360	71	22.53
od	228	following	103	27	22.28
with	1232	history	866	228	22.09
delusions	177	auditory	126	25	22.02
weeks	241	prior	147	32	21.68
of	2015	abuse	305	153	21.64
patient	786	known	304	93	21.48
ago	256	weeks	241	42	21.34
of	2015	complains	38	48	21.33
for	977	weeks	241	89	21.27
od	228	an	140	30	21.19
2	401	months	284	58	20.86
history	866	strong	41	31	20.83
suicidal	317	feeling	94	28	20.77
previous	345	psychiatric	113	32	20.70
history	866	depression	585	134	20.61
in	1127	the	366	120	20.59
with	1232	presents	44	39	20.56
with	1232	presenting	33	33	20.37
for	977	3	316	100	20.08
admission	345	days	119	31	20.00
depressed	299	mood	123	30	19.85
and	2194	visual	54	56	19.79
depression	585	anxiety	84	34	19.77

depressed	299	very	231	42	19.67
history	866	positive	68	38	19.52
history	866	no	379	99	19.35
and	2194	hallucinations	187	110	19.34
for	977	2	401	111	19.33
history	866	alcohol	279	82	19.30
no	379	psych	130	34	19.21
months	284	over	98	25	19.02
admitted	460	following	103	34	18.99
to	1589	kill	31	33	18.97
to	1589	admitted	460	161	18.94
been	285	treated	211	38	18.76
years	360	10	86	26	18.73
to	1589	Valhalla	208	96	18.72
and	2194	suicidal	317	148	18.61
to	1589	hospital	132	73	18.52
ago	256	6	134	27	18.46
previous	345	psych	130	31	18.11
to	1589	tried	37	36	18.08

Note. N(a) and N(b) are the frequencies of the corresponding types. C is the collocational frequency of the two types. z is the z-score. A span of 8 words (4 at either side of the target word) and a minimum collocational frequency of 5 was used. All significant word pairs to a minimum z-score of 18.08 are shown.