Introduction

This book is about the practice of emergency psychiatry in an American city. I am concerned with how the staff of an inner-city inpatient emergency ward—charged with “managing” and “placing” the acutely distressed people who emerge from this environment—experience their work.

The nine-bed Acute Psychiatry Unit*—called the APU by its staff—and the Frederick Douglass Community Mental Health Center of which it was a part had come into being in the mid-1970s as a response to the deinstitutionalization of psychiatric patients. The intent of its founders was to provide short-term psychiatric care tailored to the immediate needs of the residents of Midway City. The psychiatrists, social workers, nurses, and aides who staffed the emergency ward were, however, in a difficult position. They worked in an environment of diminished resources and uncertain community and found themselves at the intersection of the urgent and often conflicting needs of the patients, the patients’ families, the hospital, and the city.

Three aspects of the unit’s work particularly captured my attention. The first was the contradictory nature of the task: the staff described themselves as having an “impossible mandate” that required that they discharge patients quickly and yet treat them adequately. The second was the way the staff lived with this contradiction: they dealt with it in strategies for action and in outrageous and ironic verbal display. Finally, I was fascinated by the self-consciousness of the staff: in their talk with me and with each other they reflected on their problematic responsibilities and on the nature of the contextual and specific knowledge they had acquired.

*The names of the people and places in this book are pseudonyms. Identifying features of people and places have also been changed. In addition, I have purposely omitted reference to the dates of the events described.
I was introduced to the unit through the clinical director of the hospital, Anthony Giuliani, who hired me to work part time in his institution. He thought that there were certain "puzzles" about the hospital that an anthropologist might be able to make sense of and that these puzzles were particularly evident in the functioning of the emergency unit. One area that concerned him was "aftercare"; he wondered whether there was some way to persuade more patients to return for outpatient appointments after they were discharged. Another puzzle was the efficiency of the emergency unit in discharging patients quickly; how, he wondered, did staff accomplish this while maintaining a generally cheerful attitude?

When I met with Sam Wishinski, the director of the emergency psychiatric unit, and Ben Caldwell, who directed the hospital's emergency services department, they seemed pleased to talk with an anthropologist. Both had spent time in other countries and had no difficulty imagining that anthropology might be a suitable perspective from which to explore the work they were doing. The first thing they told me was that their service was "opposite in all ways" to "regular" psychiatry which, in their view, "denied a whole segment of the population." Their unit operated, they said, in the "unconscious" of psychiatry. They compared themselves to the "aberrant villager" who is the first to approach the anthropologist and who, out of his alienation, is able to reveal the underside of the normal life of the village.

This was the beginning of a two-year association in which I explored with Sam, Ben, and the rest of the APU staff the relationship between the puzzles Giuliani had given me and their position in what they perceived to be psychiatry's unconscious. Eventually I realized that the puzzles could be compared to the symptoms of the "presenting patient" in a family; they were not entities amenable to objective analysis, but rather complex representations of contradictions in the situation of the hospital and its patients. These contradictions were not discrete problems that might perhaps be solved if the right social scientist could be found, but were inseparable from the active practice of those on the front line of the emergency service. The staff incorporated me into this practice, not to help them take care of their patients but to listen as they conveyed their understanding of what they were doing. Their understanding was not expressed in terms of any single or integrated meaning to be found in the work, but rather as an ongoing confrontation with ambiguity and contradiction.

Most of the material presented in this account comes from meetings of the emergency unit staff, from interviews with the staff, and from attendance on the unit, where I listened in on interviews with patients and conversations among staff members. I also met regularly with An-
Anthony Giuliani, and I visited other parts of the system in which the unit was embedded.¹ The drawings that illustrate the text were gathered by asking the staff to “draw a picture of the unit.”² During my study of the APU I was also involved in teaching medical students at the university with which the hospital was affiliated, an experience that contributed to my interest in the unit’s training of medical students and residents.

Although I am not a clinician and was, in that sense, an outsider in relation to the activity of the unit, I participated in its practice in a way similar to that described by Jeanne Favret-Saada in her study of witchcraft in the Bocage (1980). She describes her experience of incorporation into the world of the French peasants who were her informants and notes that it was impossible to learn about witchcraft from an “outside” position, a position from which her informants’ lives would appear to be a “continuous surface without holes.” Instead, she had to be vulnerable herself to the “holes” in their experience that constituted the matrix in which witchcraft could make sense.

My experience of working on the APU was similar in that I understood the position of the staff through the ways in which I fell into the “holes,” the vulnerable spots, in their experience. One of these was my position as an employee. I too was dependent on the hospital and administration and shared with the staff of the APU the experience of being embedded in cross-cutting and contradictory expectations. I found that I shared their perception that there was “no non-guilty position” on which to stand. For example, certain practices on the APU were questionable and perhaps illegal when seen from an outside perspective. Was my responsibility to the administration (as an employee owing allegiance to the institution and its reputation), to the staff (as an anthropologist bound to protect their confidentiality), or to the patients (as an outside observer who might be able to affect their situation)? I chose the second path (though not without considerable confusion and discomfort), waiting, listening, and trying to understand the context that made such practices, if not defensible, at least comprehensible.

My tendency to listen, to understand through silence or through shared storytelling, constitutes another “hole,” a way in which my style matched that of the staff and drew me into their world. Toward the end of my study, one staff member commented:

You are the listener. People use you as a bridge, to feel connected to each other... we [each] have something to say [to you] which is part of the puzzle.

I listened to the staff as they argued, planned, disclaimed, joked, and raged, taking as my center those who most intensely articulated their in-
volvement with the unit. Their talk did not form a coherent “picture” of their work, and in fact they constantly warned me away from picture metaphors and overly neat conclusions. What held them together as workers was the necessity for action in the face of contradiction, and their talk reflected the discontinuity and intensity attendant on this task.

Thus, though I left the unit assuming that my task was to “connect” where the staff had not, to solve the “puzzle” by “making sense” of the unit’s contradictions, I eventually realized that the contradictions were the sense of the unit. Many current and competing approaches to problems in mental health care “spoke” and were embedded in the voices and events I had recorded. The staff of the APU were bricoleurs of psychiatric and social theory, using what was available according to whether it would fit a particular context, drawing upon what Ingleby calls the “bewildering array of theoretical approaches” (1983:142) to fit their pragmatic orientation. At any moment, and sometimes all in the same moment, a staff member might be a biological empiricist, a Freudian, or a Laingian antipsychiatrist. The unit was, as a friend of mine put it, a place of “patches without a quilt” where immediate problems could be seen in any number of ways, none of which added up to a frame that would bring the whole into coherence. I have not used any particular theory from within psychiatry or social psychiatry to discuss the situation I describe. Rather, I hope that the unit will function for the reader, as it has for me, to reveal multiple and contradictory perspectives. I have tried to convey the unit’s polyphonic and concrete interplay of voices, along with my own sensation of immersion in it as a listener and co-speaker.

One way of looking at psychiatry emphasizes the patients it treats; the questions center on what is wrong with them (and this can be framed in many ways, from biological to psychodynamic to familial theories of causation), what should be done for them, and what effect they have on those treating them. From this perspective, though the problems may be numerous and intractable, the issue of agency is fairly straightforward; those who treat psychiatric patients/problems are trying to help them to attain lives of greater functioning and ease. Much of the literature generated by psychiatry itself assumes this perspective and treats many of the problems of psychiatric settings (for example, the emotional negativity therapists may feel toward patients, or the entanglement of psychiatry with the legal system) as interfering with their basic mission. The question is how to overcome these obstacles in the interest of the patient.

Another perspective, often considered antagonistic to the first, considers psychiatrists and other practitioners as “agents of social control”
whose primary role is to contain deviance and preserve the social order. David Ingleby sums up this perspective thus:

[The] “critical view” argues that “mental illness” is to a large extent socially caused, or even socially constructed; that the goal of treatment has to do with the maintenance of social order, . . . and that the domination of the medical profession is neither warranted nor desirable. (1983:143)

Views on the ways in which illness is socially constructed and on the nature of medical domination vary widely within this perspective, but there is general agreement that psychiatric professionals are the agents of forces that are not, at bottom, in the interests of the patient. The “treatment agent” is to some extent an actor (consciously or unconsciously) in the interests of a larger system, whether it be professional practice (Light 1980; Scull 1979) political economy (Scull 1979; Warner 1985) or “society,” rather vaguely conceived as an agglomeration of controlling individuals (Szaz 1961; Scheff 1966). Therapy may be represented as a medical or humanitarian necessity, but its real function is to control, contain, or remove from society those who threaten or overburden it.

Both the therapeutic and the social control perspective are useful; the first draws attention to the complexity of subjective experience, whereas the second makes us aware of the larger social context in which subjectivity takes shape. But both take on a different coloring when approached from within a psychiatric institution. Many writers on institutional settings have found that the world of patients and staff defies explanation in terms of either mental illness or society. Young psychiatrists are inaugurated into work that is full of ambiguity and mystification (Light 1980; Coser 1979) and patients are caught between resistance and collusion (Caudill 1957; Estroff 1981; Goffman 1961; Reynolds 1977). The institution reveals itself to be constituted of “binds”—ambiguous relationships between form and content, constraint and opportunity—to which practitioners respond in pragmatic and strategic ways. From the perspective of those who work in institutions, the tension between context and agency is ongoing and irresolvable; it emerges continually in action and is resolved in actions that, in turn, bring further tension. Resistance and acquiescence are perpetually in balance (cf. Comaroff 1985; Ortnier 1984).

The work of Michel Foucault has been important in my thinking about these aspects of institutional life. Foucault writes about institutions not merely as places that reflect or contain larger societal problems, but as “figures” (Lentricchia 1988:84) for the fundamental ways in which society and institution mirror and shape one another. In his studies of
the asylum, the hospital, and the prison, Foucault shows that in the late eighteenth and early nineteenth century the inner space of these institutions developed a configuration that provided for the development of the peculiarly modern relationship between subject and object; through the manipulation and management of the body, the inmate became an object of knowledge and a subject of discipline (1973; 1979).

My intention in this book is not to provide an analysis or critique of the work of Foucault. Rather, I want to use Foucault’s notions of disciplinary space, power/knowledge, and subjectivity to illuminate the work of the APU. The similarities I found between the talk of the staff and the writings of Foucault are surely not accidental; the APU staff speak from the center of the kind of disciplinary space Foucault describes and describe themselves enmeshed in precisely the ambiguous relationship between subject and object that such a space produces. Thus I see the APU as a “field” in a larger sense than that usually implied in the notion of anthropological “field” work (though Foucault suggests historical kinship between the terms). The APU is a field of power in Foucault’s sense, where certain fundamental “mechanisms” of our society are visible. It is precisely these mechanisms that remain opaque if the psychiatric hospital is considered a “small society” (Caudill 1957) operating according to principles of social organization incorporated from sociology or psychology.

In allowing Foucault and the APU staff to serve as commentaries for one another, my emphasis is not only on the patients constructed as objects by the staff but also on the ways in which the staff themselves were made subjects of discipline. The notion that the staff were enmeshed in a space in which they were both watchers and watched, disciplining and disciplined, helps us to see the complex and paradoxical nature of their situation.

Part of the paradox lies in the nature of the staff’s power. Power, as Foucault shows, does not rest in the hands of individuals or groups; rather it is fluid and diffuse, operating in a net-like grid of relationships. This analogy to a net or web corresponds to my observation of the way the unit worked. The staff did not employ a single kind of power (as, for example, the power to label patients as mentally ill, or, conversely, the power to make them well), nor did they use their powers in a clear, unidirectional way. Moreover, the patients were not passive in the face of power. Rather, administrators, staff, and patients were engaged in a situation of shifting, reciprocal, and multidirectional power relations. I do not mean by this that the unit’s staff did not exercise more power than the patients; they did. But in order to understand the nature of clinical practice on the unit, we cannot depend for explanation on a “power-over” arrow that points only from the staff to the patients or,
for that matter, from the the state or the economy to the staff. Rather, staff, patients, administrators, and other institutions have to be seen as bound together in the same disciplinary space, one in which all, to varying degrees, are subjects of power.

The staff of the APU did not accede passively to their enmeshment in a system of power. “Where there is power there is resistance” (Foucault 1978:95) and they found ways to resist, through strategy, humor, and subversion of discipline. The resistance of the staff was covert, ephemeral, and oblique; it served to throw into relief, at every turn, ways in which the work constantly threatened to become absurd. Many of the “techniques for making useful individuals” that pervaded the hospital—from the patient interview to the writing of charts—had the potential to be subverted or mocked. This subversion was not peripheral to the “real” work of clinical practice, something that would end were the institution to be retooled to more perfectly meet the needs of its constituents. It was part and parcel of the work itself, and to the extent that the work had meaning to the staff it was because they made something tangible out of their experience of disjunction, contradiction, and absurdity. Novels and popular accounts of clinical work sometimes make this point indirectly, as when, in *The House of God* (Shem 1978) the intern/antihero is asked by those outside the hospital how he can laugh about what he is doing. The APU staff pointed out that the same dynamic is at work in television shows that exploit the paradoxical and absurd character of institutional work.

Like the protagonists of these books and comedy shows, the APU staff felt that their workplace was special and unique, set apart from an outside world that could not understand or respond to it. In their view the practice required a collusion and deviousness that concealed the particular and pragmatic character of their understanding from those who would incorporate it into normal institutional mechanisms. Elizabeth Traube mentions that during her fieldwork in a remote part of the island of Timor she believed, with her informants, that they were presenting her with a special knowledge that alone would enable her to make sense of their history (1986:243). Later she realized that their very insistence on the specialness of their knowledge was part of that history. Similarly, I felt while I was on the APU that I was being asked to attend to a peculiar and unusual way of thinking about the world of clinical work. Now, however, I believe that this impression was a result of the staff’s attempt to convey an understanding rooted in local and specific circumstances—what Foucault calls “subjugated knowledge”—and to contrast this with the standardized knowledge produced by objectification within disciplinary space. The local knowledge of the staff was highly contextual, strategic, and personal. It contrasted with (and made
strategic use of) the knowledge of diagnosis, treatment, administration, law, and management that constituted the more visible aspects of the institution. The difference between these kinds of knowledge—often brought out as a contrast between what could be said and what had to be written—lies behind many episodes of conflict or resistance described in this book.

Foucault insists that his task is not to provide intellectual comfort in the face of discomfiting social realities. Rather than offering a specific critique based on the idea that it is possible to reject “all possible solutions except for the one valid one,” he suggests that we approach social problems in a spirit of “problematization” that leaves the door open for original, unconventional, or radical understanding. He says,

[my attitude is] more on the order of “problematization”—which is to say, the development of a domain of acts, practices, and thoughts that seem to me to pose problems for politics. For example, I don’t think that in regard to madness and mental illness there is any “politics” that can contain the just and definitive solution. But I think that in madness, in derangement, in behavior problems, there are reasons for questioning politics. (1984:385)

Perhaps more important for this account than any particular insight of Foucault into the nature of institutions is this insistence on the need for problematization. It seems to me that when the staff of the APU recognized the potentially subversive nature of my writing—the fact that my notebook recorded their speech—and yet continued to encourage it, they wanted me to attend to their problematization of their situation. They insisted that I not foreclose on what they were doing, that I not assume that even the theories they were fond of could provide solutions to their dilemmas. I have tried to retain this spirit of problematization, keeping to the sense of ambiguity and lack of closure that was vividly expressed to me.

I want to point out three areas in particular that are deliberately problematized in this account. First, and most important, are the patients. The voices of the unit’s patients appear here only as they were heard by, and in relation to, the unit’s staff. I do not pretend to represent the patients “as they were”—that would require a different book—but rather as they appeared to the staff. At times the patients were objects to be sorted, held, and then disposed of. At other times particular patients became symbolic of specific dilemmas in the unit’s operation. Some patients came to be representations of, and repositories for, emotions of anger, disgust, compassion, or love. And occasionally the staff arrived at what seemed an almost existential acceptance of the patients as representative, in their very poverty and craziness, of the human con-
dition. Estroff says of the outpatients she worked with that “it is too easy to avoid or to oversimplify [their] human, often tragic dimension . . . And it is persuasively simplistic to stress the tragedy and to overlook the essentially bittersweet, paradoxical nature of these lives” (1985:198). In reproducing the multiple, inconsistent, and self-conscious ways in which APU staff responded to patients, and in allowing the patients to appear in this book in the same partial and incomplete way that they appeared on the unit, I too hope that the bittersweet of their lives shows through.

Second, I problematize psychiatry. Psychiatry is not the subject of this book, but rather one of its protagonists. Psychiatry appears in the form of goals, diagnoses, medications, and explanations, but these do not add up to a picture that represents or distorts some ideal type of psychiatric practice. Perhaps a useful analogy is the difference, in complex societies like India, between the great and the little traditions. In the context of work on the APU, psychiatry and psychoanalysis are great traditions that provide the rules, vocabulary, and mythology from which the little tradition draws (cf. Marriott 1955). Of course, in fact, the great tradition itself is changeable and historically situated. But the point here is that the little tradition is not a direct reflection of a great tradition; rather, it takes from the great tradition what is useful, and often uses it in local, context-specific ways. This could be seen on the APU in the way diagnoses, taken from the “sacred text” of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (APA 1980), were put to strategic uses entirely bound up with the immediate needs of the unit. It could also be seen in the ways the vocabulary of psychoanalysis was called into service for the description of emotion, providing a way to place emotion where it could best be dealt with at any given moment. In portraying the psychiatric side of the APU’s practice I have tried to remain as much as possible within the little tradition perspective of the unit itself; psychiatry constituted some of the stuff with which the quilt patches of the unit’s work were constructed, but not a larger explanatory focus that would provide a whole quilt to put them in. In Reflection in Action Schön suggests that many settings for professional work are like swamps in which practitioners must find their own path, using an intuitive, reflective approach to practice that may be guided by, but cannot directly match, the profession’s texts and traditions (1983). The APU was such a swamp; in what one staff member called the unit’s “moral murk,” psychiatry was refracted and fragmented, and the fragments were then used to illuminate the path.

Finally, this account problematizes issues of agency and subjectivity and, in the process, Foucault’s description of totalizing institutions. In disciplinary space as it is described in Discipline and Punish it seems that subjectivity is entirely shaped, imprinted, and normalized (1979; cf.
Lentricchia 1988). Historical and subjective agency is a delusion; the mechanisms that give institutions their distinctive character as loci of power relations shape the inner life of individuals, who find themselves in “an iron cage worse than any Weber ever dreamed of” (Berman 1982:35). But it seems to me that in giving us a figure that images power as both pervasive and fluid and that insists on the intrinsic character of resistance, Foucault also suggests that disciplinary space has chinks and crannies in which we can, if we will, recover the possibility of agency. In a later interview he says that his intent is to show “the arbitrariness of institutions and . . . which space of freedom we can still enjoy and how many changes can still be made” (Martin et al. 1988:11).

Mary Pratt points out that in contrast to the objective seeing of science, “subjective experience . . . is spoken from a moving position already within or down in the middle of things, looking and being looked at, talking and being talked at” (1986:32). The APU staff and patients were “within and down in the middle” of their work, as was I when I studied them, and their subjectivity is expressed throughout this book. This is particularly evident in the emotional tone of much of what is recorded here; the anger, humor, and frustration voiced by the staff should not be reduced to easy formulas (e.g., stress or denial) but allowed to stand as expressions of fundamental dilemmas in their position (cf. Hahn 1985:56). Similarly, the centrality of particular individuals in this account—funny, difficult, and inconsistent as they are—suggests the way the staff tried to make a mark on their environment. What is problematic is whether this agency mattered. Was it, as Foucault said of the writing of early psychiatric reformers, “so much incidental music” (1973), swallowed up by the disciplinary agenda of the institution? Or was the expressive life of the staff, flowering in whatever chinks it found, somehow providing the ground for a new kind of criticism? Throughout this study, I have tried to convey the way the issue remained in balance.