Inside Looking Out (The Value of Patient Insight in the Realm of Psychiatry)

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"The medical gaze, whose powers were beginning to be recognized, had not yet been given its technological structure in the clinical organization"

~Michel Foucault, "The Birth of the Clinic" (1)

When discussing insight and how it relates to mental health, the lowly psychiatric patient's feedback and 'mad experience narrative' is often overlooked while the imposing and prominent 'therapeutic machine' takes priority. In this essay, we will examine this dissymmetrical relationship while supporting a patient's integrity and struggles vis-a-vis the chemical empire maintaining its dominance through its use of self-glorifying false narratives and tactical barriers cleverly masked by subjectivity problems.

Within the mental health system, the mad body or psychiatric vessel is dwarfed by an intimidating pharmaceutical authority which takes the shape of what I have termed a chemical empire. This empire selfishly sustains its control through imposed chemical barriers which are sold and advertised as medications such as "antipsychotics" or "anti-depressants". Through psychiatric labelling and through medical systems of diagnostic categorization (i.e. the DSM), these same chemical barriers are coercively maintained and repeatedly applied to the blood system of the mad body under the guise that they are suppressing or controlling the manifestation and symptomology of madness while their overall effects are really to impose chemical control through neuroleptic enslavement. This disproportionate dynamic of power—where the pharmaceutical entity is of the scale of a machine-like behemoth and the patient entity is nothing more than a miniature soldier—confers an obvious disadvantage for the tiny challenger, whose image and resources have already been compromised by a court-system or legal-judiciary apparatus. This apparatus is bent on prolonging a stay in a mental health facility through imposing image degradation and false representation. While many would argue that the current mental health model no longer resembles the "total institutions" described by Erving Goffman, forensic hospitals tied to the jail system still meet the Canadian sociologist's criteria of "place[s] of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable length of time, together lead an enclosed, formally administered round of life." (2) For those who have been conditionally discharged from inpatient care and diverted to outpatient status, I prefer to use the term "partial institutionalization" to characterize a state of "partial" freedom and/or "partial" confinement. While no physical barriers such as walls or gated boundaries appear to restrain this outpatient entity, the myth of full autonomy and liberty is often advertised while constant chemical follow-up continues to be imposed by the well-dissimulated chemical empire taking on a new shape or form as a medication dispenser (i.e. pharmacy) and as the driving force behind a specialized medical monitoring program

(ex. schizophrenia program). Such a program is used by this chemical empire to periodically reestablish its control over the mad entity through its use of a complicit psychiatric practitioner encouraged and often pressured to adhere to certain rules and guidelines concerning the promotion and advertising of the particular label or brand of pharma products being administered to their patient on a daily basis. The chemicals barriers which are administered as a daily requirement for psychiatric patients have cleverly coded names, again to maintain the power dynamic of an authoritarian chemical empire over its weaker and more diminutive mad counterpart. For example, using the chemical Lysergic Acid Diethylamide (LSD) illustrate this point, Sandoz Laboratories first introduced the hallucinogenic narcotic under the cleverly coded trade-name Delysid in 1947. (3) Such a replacement of the original chemical name LSD-25 (or $C_{20}H_{25}N_3O$) is what I have termed the use of a "cryptography of names". Such a method of masking real chemical nomenclature through deceptive packaging and labelling again strengthens the commercial aspect of the drug in question and fortifies the immutable and imposing foundations of the chemical empire in power over the smaller psychiatric patient bastion.

While chemical empires rely on substance enslavement to maintain and further their corporate supremacy, research generated to justify and model these new forms of indiscernible barriers rely on a mythology of scientific progress involving code-breaking and puzzle-solving. In order to promote research within psychiatric monitoring programs (such as schizophrenia program), an ongoing search for an elusive panacea for complex mental illnesses is advertised through the pharmaceutical entity's promise of developing the next wonder pill or miracle drug cure. Such an El Dorado quest depends on the skewing of research into the cryptic realm of genomics, where a genomic secret or link becomes the ultimate goal in the search for a ground-breaking chemical treatment wielding the powers to somehow alter a defective or disabled brain and sway it to normality. Alternate causes of mental illness—resulting from external stimuli such as noxious destabilizing chemical barriers—are given lower priority while remaining hidden away in overlooked phlebotomy samples. Research that follows these false genomic pathways runs the risk of entering into the realm of eugenics which was prevalent in the first half of the 20th century and which still exists in well-disguised forms nowadays. Through the careful use of scientific jargon and manipulative statistical toolsets, modern psychiatric research of such a sort might in reality regress back to the days of psychiatrists such as Dr. Franz Josef Kallmann, who was an early pioneer in research related to heredity and mental illness. Such a direction inevitably leads to avenues of discrimination and even of sterilization. (4) Perhaps one should differentiate between opposing forms of knowledge in order to better understand the paths that should (or should not) be followed in order to improve the treatment of mental illness. The word "knowledge" itself can have both negative and positive connotations depending on the moral grounding of the scientific research in question. For instance, research supporting the series of steps to elaborate or synthesize an illicit compound (such as LSD-25) qualifies as a form knowledge although its use as a therapeutic drug would be detrimental to human mental health. On the contrary, research studies

involving external factors such as social interaction and financial barriers might prove to be a wiser form of knowledge to pursue given its potential egalitarian focus on healing and recovery.

While the quest for better treatments of mental illness usually involve false or illusive cures through the relentless pursuit of pharmaceutical progress, the realm of insight as it relates to patient recovery and chemical adherence needs to be clarified. While 20th century psychiatrist Karl Jaspers once stated that the mentally ill with schizophrenia lacked insight into their own illness, a system was eventually put into place to impose a biomedical model leading to forced adherence to neuroleptic drugs. In a discussion on insight relating to the Japanese psychiatric system, "[s]ome of the confusion found […] c[ould] be explained as a result of confounding some of the different dimensions: for example, the absence of differentiation between the awareness of psychosis and that of treatment need, resulting in the superficial use of the Jaspers' notion of lack of insight as an excuse for involuntary admission." (5) For instance, admission psychiatrists are frequently pressured or led into the act of forcing chemical adherence under the guise that such a lack of insight into mental illness thus justifies this so-called chemical solution. Many patients undergoing such a (skipped) step in their admission and psychiatric stay, feel that their rights have been taken away while they fall victim to a system of displacement, chemical restraints and even brainwashing. Brainwashing occurs through continued observation and interrogation with conditional discharge privileges for those who become chemically compliant and seclusion or extended confinement as the punishment for non-compliance or the insistence on absolute discharge.

While the use of chemical confinement in subjects with a history of mental illness is often attributed or justified by what is deemed to be a higher risk of violent behaviors, perhaps the substances found in phlebotomy samples of patients upon admission represent the true causal agent when a psychiatrist rules that they pose a threat to themselves or others. In a study on violent behaviors and drug addiction, "39.68% of the sample [of addicted patients] had experienced problems related to violence control. These problems were closely associated with drug consumption and were mainly directed at family, friends, and drug-abuse partners or executed to obtain money for buying drugs." (6) While illicit substances clearly play a role in cases of psychiatric relapse through the re-surfacing of a triggered chemical imbalance (or drug-induced psychosis), a large proportion of patients in such a state are prone to refuse medication treatments and be non-compliant. In a study on rural patients in China, this state of non-compliance was attributed to certain barriers "including lack of self-insight, inadequate family support, treatment duration and side-effects of drugs, economic burden, and the perceived stigma of illness." (7) While these barriers of adherence to medication explain some forms of non-compliance, one is left to wonder once again if such profit-driven chemical entities are even effective at suppressing the psychosis of a patient consumer who inevitably feels that their negative feedback is overlooked in a

world where powerful chemical shares or stocks (with little therapeutic value) are constantly advertised and elaborately endorsed in global markets.

While the biomedical model of mental illness appears to be supported by “expert” statistical evidence and “objective” case histories, a problem of subjectivity arises every time an admission psychiatrist diagnoses a newly-admitted psychiatric patient or when a patient in outpatient care is interviewed through repeated mandatory psychiatric follow-up. According to Foucault scholars, a patient in the psychiatric system plays a dual role both as an “object of psychiatry” and as “the subject of its treatments”. (7) Such a dual role presents an epistemic contradiction: on the one hand, a patient is a “moral object simultaneously constituted by an emerging medical and moral discourse” while also being a “lacking subject in need of reformation and cure”. (8)

This problem of subjectivity is further summed up in a ground-breaking study entitled “On Being Sane in Insane Places” published in the journal Science in 1973.

"From Bleuler, through Kretchmer, through the formulators of the recently revised Diagnostic and Statistical Manual of the American Psychiatric Association, the belief has been strong that patients present symptoms, that those symptoms can be categorized, and, implicitly, that the sane are distinguishable from the insane. More recently, however, this belief has been questioned. Based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of observers and are not valid summaries of characteristics displayed by the observed." (9)

While modern chemical empires rely on the slavery of its patients and draw upon false narratives of healing to promote their mission and credibility, a major factor involved in aiding a disadvantaged patient lies in the hands of psychiatrists and other health practitioners. Within the context of a psych unit or clinic, those on staff have the responsibility to occasionally challenge norms and protocols even when pressures arise to take powers away from a patient entity through bureaucratic categorization and imposed chemical barriers. While rigid systems of treatment are already in place within such contexts, new avenues should be sought out which free deserving psychiatric vessels from total and partial institutions. In the words of D. L. Rosenthal:

“It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behaviors were controlled by the situation, rather than being motivated by a malicious disposition. In a more benign environment, one that was less attached to global

diagnosis, their behaviors and judgments might have been more benign and effective." (9)

Sources:

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(4) “Franz Josef Kallmann”, Wikipedia search

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