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Treatment without consent – dialogue, or psychiatric language games?

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Summary

Aim. The main aim of presented paper is the discussion with the anti-psychiatry's and postpsychiatry's critique of psychiatric inpatient wards and their practices.

Method and subject. Basing on the story of one patient, the chance for dialogue with the inpatient even in the case of actual forced treatment is presented. Is a dialogue with a patient possible in spite of the fact that a "psychiatric language" takes place?

Discussion and conclusions. According to the authors the response to this question reveals the complexity of the reality hidden behind the locked door of a clinic. The reality of locked psychiatric wards is neither exclusively constructed by "psychiatric games" (as stated in the writings of anti-psychiatrists and the postmodern psychiatrists), nor it can be only the reality of running dialogue. The reality of psychiatric clinic is oscillating between the two different possibilities of contact with patients. Some ethical consequences of it will be considered in presented paper.

schizophrenia / locked psychiatric ward / forced treatment / discussion with anti- and postpsychiatry

INTRODUCTION

The anti-psychiatric movement and other schools of thinking about psychiatric treatment, derived from post-modern philosophy, have made locked psychiatric wards and their practice an object of their criticism. The anti-psychiatric movement defended "others", all those deprived of freedom and autonomy, supposedly on their behalf and in their best interest, but in fact it was to protect the social system endangered by "otherness". Each system, also the social system, aims at excluding whatever puts it in danger, in order to increase its efficiency. From the point of view of the system, the privileged are those who talk and act alike. Unity and acting in agreement as well as a kind of insensitivity to suffering are the key ingredients of the strength and durability of any system. Those "Others" – historically referred to as the "possessed", "insane" or "changelings", since the 18th century have been known as the "mentally ill" as they escape the system control and therefore become dangerous to it. According to anti-psychiatrists, since the moment it was born, a psychiatric clinic has stood to protect the system [1, 2].

The criticism of psychiatric clinic, undertaken by authors who admit that they sympathise with postmodernism, is above all concerned with the language used in clinics, the so called "psychiat-

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ric language games", and the reality constructed by it. Modernism of psychiatric and psychotherapeutic practice, as these are the terms used, is above all based on a clear division of authority: on the one hand, there is medical personnel with its specialist knowledge, expertise in health, illness and treatment process (expert at what is good for patients), and on the other hand a patient, seen as a laymen who is expected to simply become subordinate. The "psychiatric language games" not only "deprive of mind and speech" all those who are diagnosed as mentally ill but additionally, they stigmatise these people and exclude them from a healthy discourse [3].

The aim of this paper is to discuss this subject area from the point of view of a team working in a locked psychiatric ward. Based on a casuistic description, we will present the dilemmas facing a team treating a patient without his consent. Is a dialogue with a patient possible in spite of the fact that a "psychiatric game" takes place?

Casuistic description

Łukasz, a holder of a number of university degrees (including a degree in psychology) has lived in London for a few years. He was financially independent, having worked consecutively as a teacher, tutor, barman, and a waiter in high-end restaurants. He changed jobs frequently and found it easy to find work. His situation turned unexpectedly a few months before returning to Poland. He lost his job and his flat, fell into debt and spent most of his time trying to find work, without much luck. Finally, he ended up wondering the streets of London with a laptop under his arm. He stopped getting in touch with his family or his cousin, who also lived in London, because – as he explained later – he had no money for telephone calls. His parents, first anxious and then frightened by the news they had from London, and by the decreasing frequency of phone calls from their son; the news that he had no work, no place to live and his debt was growing, started an intensive campaign to make him return to Poland. Even back then, they were very concerned about his health, so they also consulted a psychiatrist in a psychiatric clinic. When, after many attempts, they managed to get in touch with Łukasz and persuade him to return to Poland, they were in no doubt that he was mentally ill. They thought he was unrecognisable: he lost a lot of weight, neglected his appearance, told them that he lived in a few parallel realities at the same time, that he was controlled from the "top", that he was burnt by electricity and had stones thrown at him. He tried to calm his parents down to say that his life was run by higher forces. He could not understand his family's fears and did not share their conviction that he should see a psychiatrist. Łukasz thought that he was entirely healthy and he explained his financial difficulties by the fact that he had no money to repair his glasses, and as he had worked in one of London's top restaurants, smart appearance was one of the main requirements for the job.

Because his parents could not make him undertake treatment and were becoming increasingly concerned for his life – one day for example he sat practically in the street – which made his parents think that in a physical sense he did not care whether he was alive or dead – and so the family began to try to get treatment for him in a psychiatric clinic, without his consent. They have tricked Łukasz, as his uncle promised to finance his return to London, in exchange for a consultation in a psychiatric clinic, and so this is how the family managed to bring him to the outpatients psychiatric clinic.

In the clinic, Łukasz refused to talk to a psychiatrist but he agreed to talk to a psychologist, and during the conversation he maintained that he was mentally healthy. The psychologist did not think that, under the circumstances, treatment without consent was justified and he shared his opinion with the psychiatrist.

A few days later, with the growing fear for their son's health and life, and facing increasing helplessness in their attempts to persuade him to seek help, the parents have again managed to bring Łukasz to the psychiatric out-patient clinic, with Łukasz's consent. Having examined him, the psychiatrist has made a decision to treat Łukasz without his consent in a locked psychiatric ward, based on the Mental Health Act of 19 August 1994.

As a patient, Łukasz accepted the doctor's decision full of ambivalent feelings and judgments. He interchangeably declared his consent to treatment and then withdrew it. Eventually,

he maintained that he was mentally healthy, and he does not consent to the rigour of treatment in a locked door ward. He also made it known that he would leave the ward should any opportunity present itself.

Finally, based on Article 23 of Mental Health Act, the decision was made to treat Łukasz without his consent. At a session attended by Łukasz, accompanied by a doctor and two psychologists, the judge ruled that the decision was justified and Łukasz was to be treated in a locked psychiatric ward.

Łukasz remained in a locked ward for the following ten days. He obeyed its rules and regulations passively and was discharged at his own request. Because the circumstances that committed Łukasz in the first place were no longer there, the psychiatrist discharged Łukasz from the ward, even though he did not share his view that the continuation of hospital treatment was unjustified. After the discharge from the hospital, Łukasz attended a few visits he previously agreed with his doctor. The latest information that the psychiatrist managed to obtain from Łukasz's family is that he went to England for a few months, in spite of the fact that he left for England ill; he did not follow any treatment and was recently brought to a hospital by the police because of his aggressive behaviour. He was admitted to a psychiatric ward but escaped from there. Finally, he has returned to Poland on his own accord and has been admitted to a psychiatric hospital.

Psychiatric language games, or dialogue with the patient?

The case described here will be now provided with a commentary in order to answer the question asked above. It must be emphasized that the patient's story has been told and commented on one-sidedly by the members of his therapeutic team, and it would probably be told differently if it were discussed by the patient.

Is the reality of a locked psychiatric ward a constructed space, as the anti-psychiatrists and postmodern psychiatrists have it, by "psychiatric language games"? If so, is a dialogue with patients possible at all in the space dominated by "psychiatric games"? The response to these questions is far from being unequivocal, as it reveals the complexity of the reality hidden behind the locked door of a clinic. What goes on behind this door is on the one hand, the "psychiatric game" and on the other, in spite of the game or against it, there are attempts in undertaking a dialogue. Some of the aspects of this complex reality and its consequences will be considered below.

Non-dialectic interchangeability or co-existence (?) of psychiatric games and dialogue

As soon as a person enters a locked psychiatric ward she or he becomes a patient rather than just a person of rather unidentified identity, as seen from the third person's perspective, that she or he was a few moments before. A person treated without consent becomes a patient against her or his will, subordinate to the will of the doctor who makes treatment decisions. Once the decision is made that this is the role that the person has to take, she or he is literally seen as a patient by others; the external identity takes over the internal feeling of who the treated person really is. The first manifestation of this "taking over" is the fact that once a person becomes a patient without consent, she or he has to face up to a number of expectations, most of which are about making the individual subordinate to the rules and regulations of the treatment system. In the case described here, Łukasz was immediately expected to follow the hierarchy of authority and operating rules of the system that he was now a part of, against his will; more specifically he had to follow the established schedule, meal times, medication times, conditions of accommodation which meant that he could not decide who he shared his bedroom with, orders to remain in the ward at all times, to inform the medical personnel of any intention of leaving the ward, the duty to participate in the community meetings and other forms of individual and group therapy and also to undergo tests recommended by his psychiatrist. The key to the ward is a symbol of hierarchy followed in the locked psychiatric ward, and of the related rights and duties: it is held by all members of the therapeutic team but by none of the patients. The symbolism of a key (according to W. Kopaliński's "Dic-

tionary of Symbols" a key is a symbol of authority, supervision, order, initiation, knowledge, deliberation and of phallus; the key to paradise, eternal life) emphasises even further the division of authority behind the locked door of psychiatric clinics [4].

On the other hand, from the very beginning of his hospitalisation, the psychiatric team undertook the dialogue attempts with the patient treated without consent. An important part of these attempts was inviting Łukasz and his family to participate in the so-called family consultation [5]. The invitation is not a euphemism here: both Łukasz and his family could either accept or reject the proposal. Also the way the consultation was held and the subject of conversation depended on the patient and his family: the therapist who began the meeting, previously uninvolved in Łukasz's treatment process (and in this sense in a way from "outside of the system") asked the persons participating in a meeting if they wanted to share their own understanding of this situation with the therapeutic team. The conversation was to be an opportunity to undertake dialogue for people who experience and understand the world differently and in this sense, everyone is an expert of their own perspective on the world. The conversation that took place during the consultation was a conversation between various experts, none of whom held the key to the reality as it really is or as it should be. The medical perspective, which dominates the psychiatric ward was suspended for the time of consultation, and replaced with other individual perspectives, such as this one expressed by Łukasz: "Even if health represents the highest value from the point of view of my family and doctors, and even if according to them my own health is in danger, and in order to protect it I must be deprived of the right to other values, something else is of the highest value to me. Just as it used to be for my father: he never underwent treatment for alcoholism, in spite of the fact that I begged him, asked him and tried to convince him to do so".

The ambiguity of realities behind the locked doors of clinics.

Another aspect of the reality described here is the difficulty (impossibility?) to decide whether what goes on is a "psychiatric game" or an attempt to run a dialogue with the person who is being treated. Both a dialogue and a game require an involvement of at least two parties. Each of them decides independently on a dilemma expressed in the question: do I participate in the game I am made to play, or am I holding a conversation; additionally the answer to the question is not given once and for all but it may be changing, sometimes from one moment to another. And the intentions of the people involved in the game or the dialogue, as the case may be, are often difficult to interpret explicitly. It may happen that what is experienced as an attempt at a dialogue from the perspective of a therapeutic team might be, on a part of a patient, understood as a game (strategy), which is to lead the system to an overall win. Often what is consciously intended by a therapeutic team as an attempt at a dialogue, in which a patient is to be treated as a partner, turns into an unconscious attempt at pressurising the patient to undertake treatment.

This ambiguity can be well illustrated by the following episode of Łukasz's stay in the ward. After a long hesitation, the therapeutic team agreed to Łukasz's presence in the court session taking place outside of the clinic. On the one hand, as the decision was risky, because Łukasz made his intensions to run away from the ward given the first opportunity absolutely clear, what one could see here is an approach leaning towards a dialogue with the patient, and the respect of the other person. On the other hand, however, as decided by the therapeutic team, Łukasz was escorted to the court building by three team members, just in case, as it was said at the time, he wanted to run away – and this is already a part of a "psychiatric game". Trusting a partner, and there is no point to even mention it, if you can anticipate his or her behaviour, which is a necessary condition for beginning a dialogue, has not emerged from the team's decision. It is the lack of trust which put the "psychiatric game" into motion, since as many as three team members accompanied Łukasz on the way to the court building (by the way, here is a missing piece of a puzzle that we are not even trying to solve: Łukasz did indeed try to run away on his way back from the court, he was stopped and escorted to the clinic. Would he run away

if not for the game with its underlying lack of trust and fear?).

One more episode illustrating the ambiguity of reality behind the locked door: when the justification for the forced treatment in a psychiatric ward was no longer there, Łukasz addressed his doctor with a request to be discharged. The psychiatrist agreed, although he did not think Łukasz's decision to be right. Was the doctor's consent to discharge the patient an expression of his dialogue approach, as we wish to think, or was it a part of a "psychiatric game" – after all the Mental Health Act clearly states when and in what circumstances the doctor can rightfully hold a patient in a psychiatric ward, without her or his consent (even the expression used in this context "the doctor's consent to discharge the patient" emphasize the ambiguity that is meant here).

DISCUSSION

The interchangeability of "psychiatric language games" and attempts at a dialogue with a patient reveals an overlap of two different realities and two ethics, understood as principles of actions, behind the locked doors of psychiatric clinics.

The reality of a dialogue is an unpredictable world, which cannot be pre-arranged; the world dominated by questions about how to establish a relationship with a patient; shall we try to do so at all, and if we do, then what is it in the name of? It is the world of not one answer but at least two. A one-sided approach is inevitably ambiguous in this world, also ethically ambiguous. In the reality constructed by dialogue, none of the parties that remain in relationship with each other can legitimately know anything better (especially what is good and what is not); both parties are in a similar situation: they are trying to enter into a relationship with another human being, although they do not know what will come out of it. None of the answers to "what for?" question explains these attempts. The interests external to the relationship contradict the idea of a dialogue. When one of the parties knows what they want to achieve, a dialogue can not happen. It is just the way to resist what the other person has to say. What is ethical is what serves the purpose of building a relationship. Good, as one hopes, simply happens as the relationship goes on [6, 7, 8, 9].

The reality of "psychiatric language games" is sanctioned by medical knowledge, treated as objective by the Western culture, which is still dominated by the Enlightenment mentality. The world of "psychiatric games" is the world "seen from the top" , based on "objective knowledge", established hierarchies and pre-arranged systems of hierarchically arranged rights and duties. It is the world of ready-made (but only seemingly so if one were to analyse them) answers, specified standards and procedures. It is the world of objective order of values, where life and health, understood merely as the lack of clinical symptoms, are the highest good. Whatever serves health is good, and for this value other values can be sacrificed, such as freedom for example.

These two overlapping realities of locked psychiatric wards have different corresponding possibilities and limitations. In the world constructed by dialogue a relationship is possible but so is the breaking of it. Each relationship is unavoidably ambiguous – on the one hand it is about getting close, on the other, about the distance which makes the relationship possible (without a distance it would be nonsensical to talk about relationships as they necessarily involve the presence of two distinct parties). By entering into a relationship with a patient one risks entering into the otherness: what can happen is not exactly what one wants to happen. Uncertainty and unpredictability are the price of a relationship.

In the world created by "psychiatric language games" one does not risk meeting the other but the same. The certainty inherent in the participation in a "language game" comes from the predictability of the world, which reveals in front of us what our game has already predicted. In the world of "psychiatric games" we see what we have anticipated to see. The game brings about the world which exists as long as the authority of those who have called it into being exists. A therapist, involved in a psychiatric game with a patient, can count on the fact that the patient will follow her or his recommendations, but she or he will have to consider, that the patient will be subordinate only as far as the therapist's au-

thority extends. What happens afterward is out of therapists' reach. Beyond the reality created by "psychiatric games" the other may happen, unaccounted for by the game.

CONCLUSIONS

The experience of working with patients treated without their consent in a psychiatric ward, which reveals the complexity of reality concealed behind the locked doors of psychiatric clinics, brings us to the following conclusions that challenge the views presented at the beginning of this paper.

The image of reality of locked psychiatric wards, as described in the writings of anti-psychiatrists, and their contemporary heirs – the postmodern psychiatrists – is simplified: the reality they describe is neither exclusively constructed by "psychiatric games", nor it can be only – as they propose – the reality of a running dialogue. In fact, various attempts are made to undertake dialogue with patients, in spite of the fact that a "psychiatric game" is indeed taking place. The reality of psychiatric clinic is oscillating between the two different possibilities of contact with patients.

This non-dialectic (not leading to Hegelian synthesis) interchangeability or co-existence of overlapping realities discloses an unsolvable conflict of values that therapeutic teams of locked wards are immersed in: on the one hand there is the order of values fixed in medical tradition, with human life and health leading the way (and it is worth emphasizing what is meant is the tradition of the Enlightenment), and on the other, the order of values commonly described as humanist, with freedom and right of independent decision making. The unsuitability of the conflict is consolidated by the question which always arises in this context: can one sacrifice the values of an individual to protect health defined from medical perspective? Who has the power to answer this question? Who holds the key?

The unavoidable ambiguity of reality behind the locked doors of psychiatric wards makes us think that the ethical dilemmas that psychiatric teams are facing today may never be resolved. To resolve something means that it is no longer bound together, also in a sense of being bound by duty. The dilemmas which are resolved no longer bind together, and no longer produce a sense of duty. The unavoidable ambiguity of locked wards can be and should be contrasted with the clarity of a requirement that has to be considered by therapeutic teams in a form of their duty to continually reflect on the rationale for their actions: why and in the name of what is an action taken? It is only by asking questions and by keeping the dilemmas alive that the professional ethics, though unresolved, keeps one committed.

Among other methods of coping with the ambiguity of realities of locked psychiatric wards, which were not only heard aloud but also endorsed, was, for example, the closing down and liquidation of these wards or treating patients without their consent only in the forensic wards, but these are merely the ways of liquidating dilemmas instead of facing up to them. Any attempt at facing up to these dilemmas means keeping them alive in spite of the related risks.

It is not clear whether any attempts made by therapeutic teams to help patients treated without consent are in any sense supporting them. Our experience teaches us that the old Hippocratic principle: "do no harm" implies "have doubt."

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