

Slaves Of The Little Something – Patient Symptoms In Mental Health Services

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Introduction

Mental health is a pressing and increasing health issue for society however approaches to mental health service reformation reinforce powerful unhelpful ways of working thus enslaving service occupants rather than bringing about desirable improvement. This paper, extracted from a larger study (Moore, 2012) of transference enactment in a mental health service, views accounts of a mental health service through “a lens informed by specific aspects of psychoanalysis” (Bicknell, 2005, p. 9) and demonstrates that the constituting nature of an institution influences the dynamic, the transference between individuals, suggesting that change is unlikely to occur without recognition of the impact of the unconscious (Fenichel, (1946) cited in Menzies Lyth, 1989, Menzies Lyth, 1988). The demise of physical institutions does not guarantee a demise of institutional practices based on control which are a reflection of group behaviour (Freud, 1921) supported by the institution of the law. The focus of this paper is the social bond between individuals which is a product of being inculcated into a pre-existing socially sanctioned group, the public mental health service. The service remains captivated by the jigs and reels of old despite visions for change, because it too is firmly rooted in the unconscious past.

The World Health Organisation ([WHO] 2001) estimates that

between one in four and one in five people will be affected by a mental health problem over the course of their life, equivalent to approximately 700,000 of the Irish population, (Keogh, 2002, p. 20). The Irish mental health system emerged as a system of confinement, over the past two centuries from developments in the conceptualisation and the management of madness common across the British Empire. Foucault pays particular attention to the birth of the asylum identifying that during this and the subsequent period of development “madness no longer exists except as that which is seen” (Foucault, 2006, p. 487), suggesting that;

The science of mental illness, such as was to develop in the asylums, was only ever in the order of observation and classification. It was never to be a dialogue. This could only begin once psychoanalysis has exorcised the phenomenon of the gaze, so essential to the nineteenth-century asylum, substituting its silent magic with the powers of language.

(Foucault, 2006, p. 488)

In Foucault’s analysis madness creates a double alienation in reference to the family, firstly an alienation that occurs through patriarchy and secondly by the reality of a mental health service which is closely modelled on the family unit.

Background

Public mental health services in Ireland are delivered by the Health Service Executive (HSE) under legislation provided in the Mental Health Act (Government of Ireland, 2001) which outlines a structure for the organisation, management and delivery of services by mental health teams led by consultant psychiatrists. Consequently people seeking mental health care are assessed, diagnosed and treated under a legitimised statutory patriarchal medical model.

The drive towards providing a service that respects the human rights (Salize, 2002) of the individual has led to the reformation of health policy. A process of change has been imposed with an overt

purpose of reformation and quality improvement. The Expert Group on Mental Health Policy developed a national policy framework for modernisation of services which promotes a community based “person-centred treatment approach” (Government of Ireland, 2006, p. 8), drawing from the humanistic tradition, the work of Carl Rogers (1902-1987). Rogers was extremely wary of any attempts to make sense of the unconscious, expounding a humanistic existential approach to life and therapy, where the concern is with living in the here and now and where memories and dreams are seen only as manifest content. Rogers disagrees with Freud and subsequent psychoanalytic theory arguing that Freud’s concept of the unconscious nature of the id and instincts is false and that “the inner core of man’s personality is the organism itself, which is essentially both self-preserving and social” (Rogers, 2004, p. 91). Adopting a person-centred policy disavows unconscious elements that impact on service occupants.

Fotaki (2010) argues that policy making, which contains objectives to improve services, also expresses societal fantasies that originate in the imaginary striving of the subject (Fotaki, 2010, p. 704). Service transformation is rarely concerned with intra and interpersonal encounters and when interpersonal encounters are considered the concentration, as demonstrated in the *Vision for Change* (2006) is on ego-to-ego relationships. This disavowal of the unconscious of service occupants enshrined in policy enables stagnation and the style of subject-Other relationships, ego-ego, enables regression. The outcome is a steady supply of people seeking mental healthcare and the generation of sufficient *jouissance* for service delivery personnel to flourish without questioning the regime. A paradox of intentionality exists between a conscious overt agenda of improvement and an unconscious covert agenda of stagnation and regression, maintained by a shared social fantasy and exhibited via transference in the social reality of service delivery.

The Pleasure Of Patients

Jouissance and discourse combine in a unique way in the mental health services through the actions and inactions of staff. This holds patients in a mental bondage promoting a master discourse and binds staff to unhelpful ways of working, patients and staff are enslaved in the system. Subject-Other relations use primitive styles of attachment as their template. Attachment to the (m)Other is marked by *jouissance*, a *jouissance* of the body of the Other as the infant initially is a primitive, fragmented being existing on a somatic level. There is a pleasure in the sense of completeness that is inclusive of potential annihilating anxiety. Once the developing infant enters the symbolic order, a shift from purely somatic to psychic existence occurs and through alienation by language the impossibility of completeness is established. The desire to feel complete and whole, to submit to being the desire of the (m)Other provokes anxiety. *Jouissance* refers to extreme threatening pleasure. "Sometimes it is translated as enjoyment, but enjoyment has a reference to pleasure, and *jouissance* is an enjoyment that always has a deadly reference, a paradoxical pleasure, reaching an almost intolerable level of excitation" (Levy-Stokes, 2001, p. 101). *Jouissance* is linked with excess, the excess of sexuality (libidinal drive) and death (death drive). The signifier both causes and limits *jouissance*. The lack of language to articulate everything indicates a beyond language experience, a real outside of the symbolic order.

This effects how we function, the sheer impossibility of an absolute articulation is an issue for everyone and an acute experience for the mentally ill subordinate to the phenomenon of the gaze, denied dialogue. *Jouissance* mandates repetition of something from the past and is always experienced as failure or loss. We constantly attempt to fill this gap. In contemporary services staff are encouraged to take a holistic approach to care planning (Health Services Executive, 2012, p. 93) in the naive belief that holistic solutions are possible and desirable indicating a disregard of the impossibility of completeness. Patient expectation and staff illusion of a holistic solution enslaves both groups.

Menzies Lyth (1988) found that the nurse is equated with the early imago of the mother, making the body of the nurse a potential source of *jouissance* for the patient. The nurse is subject to the patient's demand. Menzies Lyth (1988) recognised that individuals used identification with superiors (ego ideals) and peers (ideal egos) to protect themselves from the anxiety provoked by the patient's demand for satisfaction of *jouissance*. The identification with an-Other in a superior or powerful position offers protection from the patient's demand but can be polarised as an experience of love or hate for the other in the social world of staff. Staff are subject to the anxiety provoked by new and challenging situations consequently their unconscious concept of self is challenged by the work. They experience alienation and see something in others specular images, allowing them to develop a shared style of operating. Staff operate from a Master discourse and repress anxiety, regressing to primary defences to manage social bonds. Main's (1957) findings indicate that the regression in staff when they join a system with an established culture, results in established staff reverting to previous less helpful coping mechanisms to guard against anxiety. Anxiety is provoked by change; the change to a new system, community as opposed to hospital based care, and managed by reverting to primitive coping mechanism. Patient demands are experienced by staff as both challenging and overwhelming and in order to survive the overwhelming demand they curtail the desire to destroy the demanding patient by establishing an ego ideal/Big Other who can satisfy their desire. A template for this ego ideal/Big Other exists in the established legitimised statutory patriarchal medical model. This indicates that a particular style of managing social bonds, managing transference is visible in nurse-patient and nurse-doctor interactions.

Enslaving Social Bonds

Menzies Lyth (1988) holds that in addition to the patient regressing, the nurse overwhelmed by the patient's condition is subject to mas-

sive regression, the nurse cast in the role of (m)Other unconsciously participates by taking on the role of (m)Other; “They still warrant an admission because they are very unwell and their families are sick of them” (PN10)¹. This sets the scene that is repeatedly acted out in services, staff substitute for family when the family’s quota of libidinal energy is exceeded. Lacan concurs with the enactment of transference as an instinctual force stating that “the transference is usually represented as an affect” (Lacan, 1994, p. 123). The affect represented in the “sick of them” phrase is experienced by both the biological and the adopted service family. Positive transference is normally identified with love whereas negative transference is never identified with hate; instead we normally employ the term ambivalence which suggests that; “it would be truer to say that the positive transference is when you have a soft spot for the individual concerned,, and the negative transference is when you have to keep an eye on him” (Lacan, 1994, p. 124).

Participants repeatedly evidenced that they were “sick of” the patients alongside differentiating between good and bad patients and consultants that you might want to work with and that you have to keep an eye on, as they appear to make choices about working only with un-troublesome patients;

You see how busy we are and bed blockers, there does not seem to be anywhere for them to go – ahm – you talk to the consultants, their hands are tied as well. Yet some of them, in the community, they just seem to have the same patients, you know, good patients if you know what I mean, if there is such a thing as good patients, but they are the ones that they want and they don’t want the troublesome ones or ones that they have to work at. (PN10)

Even though a steady supply of patients is required for staff *jouissance* they are also required to be “good patients”. There

¹ From this point on direct quotes from participants from within an empirical and qualitative research study undertaken by the author are assigned codes e.g. Participant Number 1 = PN1 (Moore, 2012)

are other factors at play here as patients are subservient to a legitimised statutory patriarchal medical model in which the consultant plays the role of the father, a reality drama of a service modelled on the family unit.

“What is fundamental is that transference love – as Freud rightly pointed out – is true love, and love, in turn, is necessarily a deception” (Harari, 2001, p. 96). Desire is a deception because to desire is desiring to be desired. The libidinal drive is active but its aim is passive, its aim is not to love but be loved and to be loved by the leader would be more rewarding; “Someone up above just to think of the staff on the floor and try and ease, just a little, it sounds stupid, but just a little relaxation room or something to go to” (PN10). The lack of love in the system, the gesture requested as an escape from “the troublesome ones” is indicative of the desire to be loved by the Other and for a share of the *jouissance* generated by front line staff work of observation and categorisation. The lament is without acknowledgement that the relaxation room would only provide temporary respite from the excess of patient’s symptoms as the preferred option of dismissal of all patients is unachievable. The patient desiring to be desired is enslaved in their relationship with the nurse who is in turn enslaved by unconscious desire to be desired by the doctor, two steps in a process that ensures system stagnation.

Loving The Symptom

The non-recognition by staff of complicit participation in re-enacting early formative relationship leads to the creation and long-term maintenance of a social system inhibiting progress, binding all service occupants into a repetition. Staff acknowledged the parental role they take and the difficulties they experience in stepping away from this; “Patients are to be treated it’s not just give them tablets and things like that” (PN2). Within conscious acknowledgement of the difficulty in implementing change there is evidence of patients as object rather

than subject, "patients are to be treated" (PN2). They remain part-owned by staff, undifferentiated and disallowed from engaging in decision making processes. This ownership requires analysis, what is the value for staff in owning patients, what do they provide or produce that is so valuable - patients symptoms create a *jouissance* for staff - an incestuous pleasure enjoyed by both parties.

Transference emerges in every treatment and is a driving force, however recognising and working with transference is avoided in contemporary Irish mental health services. Staff fail to recognise their use of the same regressive coping mechanisms as patients when faced with the overwhelming suffering of the patient's condition. Staff, literally do not know what to do when they encounter the symptom of mental health services. What they are required to do, namely, being with patients is overwhelming therefore they constantly make themselves busy being with each other or attending to bureaucracy (PN1). Patients are an unhappy intrusion in services warranting admission "because they are very unwell and their families are sick of them" (PN10). The intensity of caring is a negative experience marked by suspicion and danger supporting Lacan's link between transference and hate expressed as ambivalence; the patient is a subject that you have to keep an eye on (Lacan, 1994), which supports the regime of observation and categorisation. The only un-troublesome patients are the institutionalised, encompassed in fantasy about the past and "real psychiatry" (PN10) predictable, unchallenging and more likely to support the passive aim of the libidinal drive, being loved as opposed to loving. The current dominant discourse needs to relinquish the *plus de jouir* to enable transference management. "'Plus de jouir' or surplus *jouissance* refers to the cause of human desire" (Skelton, 2006, p. 446). This is about the little something in the body of the loved one that makes them special and provides enjoyment. In the case of the mental health services the little something is the patient's symptom. Patients are loved for their symptoms not for themselves. Staff observe and catalogue the symptoms to justify and maintain a system organised around a patriarchy model.

Power In A Self-Propagating System

There is a shutting down of opportunities for patients to engage in therapeutic discourse. Participants spoke about the value of talking therapy and its relation to personal beliefs and the power of leaders this extended to anxiety relating to the power held by staff over patients;

I would not trust anyone at all to understand - to know me- I was afraid of myself and the power in my head – I was afraid of everything – I was afraid of people out there- people in the community – I was afraid of the doctors I felt I would be locked up if they only knew – in actual fact at one stage, to one of the doctors I said, if you only knew what was in my head in my thoughts you would lock the door and throw away the key. (PN1)

This expression of anxiety that the doctor could exert the power of detention and treatment if the patient was uncooperative was a common theme leading patients into accepting unsatisfactory treatments;

There are lots of physical symptoms from depression and from the medication and some of them are - ah – they are excruciating. Seriously ya, your vision gets blurred; your dry mouth and you might feel dizzy weak you know. Your muscles tense and all that like you know. Some of the side effects are desperate like you know. They can be very uncomfortable. I would seek medical advice and the Doctor would say ‘if its keeping you well just put up with the side effects and they will wear away,’ like you know sometimes they would and sometimes they wouldn't. (PN9)

The patient suffers the side effects as a cost of trusting the doctor's prescribing. The cure is unsatisfactory, yet investment in the ego ideal of the doctor enables acceptance the “put up with” discomfort. This is the price extracted from the subject for the attention of the Other.

Faith is retained by creating and maintaining distance between doctor and patient, by the creation of illusion about how the work of the institution is conducted;

They (Nurses) would assess you and they see how serious your condition is and they would take your clothes off you and you would be assessed by the nurses' on-going. They would assess you, write up notes and give it to the Doctor. The Doctor would go according to what the staff, the psychiatric nurses, would say in the notes and they would review you and would ask you how you were feeling and if they felt that you were a risk to yourself they would keep you in the hospital. (PN9)

The imaginary system described is staff cooperating in developing a treatment plan with the doctor's input mediated through nurses' symbolic inscriptions. This fiction is contradicted by observed evidence that nurses suggestions go unheeded and the observed lack of nursing language to contribute to the decision making process. The doctor is a leader at the mercy of a dependency group constantly failing as the ego ideal, his failure to listen leaves staff dissatisfied with the extent of his power and control over the clinical area. The unconsciously ascribed patriarchal position allows the doctor to demand satisfaction from his nurses;

We have no control at all. We are actually told by the consultant who is coming in or if we even know the patient we would know that when they come in here they cause trouble or they need to be discharged or whatever. Sometimes the doctors don't listen to us at all even though we would say; say Dr X said she is not to be admitted the next time she comes really.

(PN10)

Contrary positions exist, patients believe, nurses' speech influences doctor's decisions while nurses argue that they are unheeded and that doctors display a compulsion to repeat the symptom of multiple readmissions. The system facilitates the doctor as leader regardless of patient and staff needs leaving both groups feeling enslaved. For example weekly multi-disciplinary team meetings are scheduled but were occasionally cancelled or prematurely terminated due to absent consultants. "You have picked a very bad morning to come. I have a tribunal at 10.30" (FN10). This displays elements of a *plus de jouir*, a master discourse and the demands of the law. The doctor can afford

to cancel at short notice with no apparent regard for the effect this had on others contributing to their voiceless status as part owned objects. However the doctor is also enslaved, made subordinate to the demand of the law; required to attend tribunals.

In Lacan's formula for the master's discourse, the master must be obeyed, not because we would all be better off that way or for some other rationale, but because he or she says so (Fink, 1995). The requirement to obey the master extends beyond the clinical setting and is located in state bodies responsible for the quality and style of service delivery; "We can be positive or negative about the Mental Health Commission but it has defiantly got us on our toes and making sure we are getting our work done and improving the service provided" (PN2).

The master is in a position to address the slave who works for and produces something in terms of knowledge for the master; "Your heart would go out to people that need to talk to someone and they would absolutely know nothing and there is no one available for them to talk to – even just to talk to" (PN8). The master is disinterested in the subject's difficulties, his concern is continuance of the system. The subject's produce has a surplus quality for the master. There is a physical excess of patients and consequently a psychological excess of symptoms allowing staff to pick and choose patients for admission, however patients are also presented as coordinating their admission;

Some get very institutionalised it's like as if, we used to laugh about it, as if they are texting each other; 'I am after taking an overdose in hospital', because next thing they will all be in. The same little group and it's from the same area again. (PN10)

Patient's symptoms and numbers are considered excessive and negative transference is generated particularly in relation to patients with similar presenting features. The model of observation and categorisation has a rebound negative effect. With negative transference and excess patients, staff are enabled to maintain their position dismissing the level of distress experienced by individuals; "Sometimes people go to the hospital and they are not admitted, you know they are not

taken seriously by the doctors and I think this is absolutely disgraceful" (PN9).

An alternative interpretation favours the medical position; the doctor charged with diagnosis and treating has limited resources at his disposal and is compelled to make clinical judgements on resource allocation. However "not been taken seriously" reflects a power imbalance and failure to avail of alternative therapeutic approaches; "It is very rare that someone comes into the mental health service and would have a psychological or psychotherapeutic experience" (PN5). This suggests that the doctor like the father in Freud's primal horde (Freud, 1914) keeps it all for himself. Participant experience of talking therapy and a positive sense of the doctor is secondary to a new master discourse outlined in the *Mental Health Act* (Government of Ireland, 2001) and *Vision for Change* (Government of Ireland, 2006). The doctor as legislated leader retains receipt of patient pathology, the ownership of a surfeit of *jouissance* generated by symptoms on which to base service development enabling a disavowal of the unconscious and an analytic discourse.

Where an ego ideal is required and negative transference abounds, it becomes overwhelming to constantly attach excess negative transference to the doctor. In the excerpt below the doctor is not as clearly identifiable as the subject supposed to know, his power to prescribe is questioned and alternative interventions are considered;

In regards to medication you are tried on so many different medications. I understand with the doctors it's trial and error but there are so many chemicals going into your body you know and the side-effects, you know. So many chemicals, I think there should be more therapy used instead of medication. More talking and that you know one to one you know. Where medication can only do so much you have to do the rest but you need help, you need help so you need more medical help, more professional help, psychologists, counsellors, psychotherapists, you need more of that like more of an input of that instead of just being given medication, taking a load of chemicals and getting so many side effects whereas it affects you physically you know. (PN9)

The participant suggests alternatives to medical staff as ego ideal towards which a positive transference could be directed, an alternative object to contain and negate some negative unconscious beliefs. When this is required and no suitable ego ideal can be identified, a quantity of negative transference is split off and given to the institution;

I have seen great changes – a change from the interaction of the nurses with the patients. They are more on the computer now. They do marvelous work and I guess it is not up to the hospital to engage in conversation with the patients it's up to them when they are diagnosed or whatever.

(PN1)

This evidences conflict relating to the unconscious image of the nurse; unable to contain the quantity of negative transference it is split off and attached to the institution a place of potential indefinite detention. Criticism of the power of the leader appears as repetitions perpetuated by the system; “What we are working in is a self-propagating system that has no place in a modern world ... the consultant has all the power which means that there is a kind of a, at least a lot of power imbalance that shouldn't be there” (PN5). This form of criticism extends to other staff in positions of power and allows staff additional directions for the projection of negative transference;

I think there seems to be an awful lot in offices, whereas, if they ever heard me, if half of them came out of the office I don't think we would be as short staffed as we are you know. There seems to be an awful lot of managers around and there is a lack of communication in the office as well a lot of the time. Whereas you pass on a message ... When you come in the next day then you could be attacked on the phone.

(PN10)

Negative transference directed to managers results from regression to infantile responses to the Other. ‘You could be attacked on the phone’ is the projection of internal bad affects onto an external source alongside the introjection of good affects. Participants draw clear distinctions between ward based staff doing good work in difficult circumstances,

looking after the patients albeit as minors, while the Other with the power to reward or punish their endeavours remains closeted in an office. Some criticism of the patriarchy is tolerated, however there is an acknowledgment that he too is part of an enslaving system.

The hospital takes a big Other role and is the subject of powerful transferences; "If we could sort the outside out a lot of the hospital will look after itself" (PN2). The benefits of hospital care and patients' abuse of the system references it as "the hospital thing" (PN2). Crediting systems with unreasoned power of indefinite physical and psychological detention; "I felt I would be locked up if they only knew" (PN1), is followed by attempts to deny the attributed power; "I don't believe in it anyway" (PN1) and later attribution of significant power; "it's not up to the hospital to engage in conversation with the patients" (PN1), this positioning of the hospital not having responsibility to engage with patients is echoed by others; "When the medication kicks in we will refer them on" (PN7) placing the responsibility with community staff. Participants identified hospital with responsibilities and power and the negative attributes of a bad object, unresponsive to needs, silent to appeals for love, providing physical containment, a harsh inflictor of physical punishment and detention where all occupants are enslaved.

Recommendations To and For Psychoanalysis

Transference generates *jouissance* for staff consequently there is resistance to any interference with the current power balance which is sustained by the group's shared ego ideal. Staff fail to recognise their use of the same regressive coping mechanisms when faced with the overwhelming suffering of the patient's condition. Staff, literally do not know what to do when they encounter the symptom of mental health services. What they are required to do is overwhelming. Patients are an unhappy intrusion in services warranting admission. The intensity of caring was found to be a negative experience marked by suspicion

and danger supporting Lacan's (Lacan, 1994) link between transference and hate expressed as ambivalence towards a patient that you have to keep an eye on. These findings indicate the staff's position as reflected in an obsession with assessment, observation and categorisation and failure to have meaningful discussion or engagement around intervention treatment and recovery, patients identified this as staff spending more time engaging with information technology than patients with staff identifying their striving to increase opportunities for therapeutic encounters. This obsession with assessment, observation and system maintenance requires endless attention to paperwork which acts as a defence against encounters with patients. A total shift in approach to learning about and trying interventions with patients and engagement in supervision is required to unfreeze the current impasse. This would require giving up the current dominant discourse, relinquishing the surplus *jouissance* to enable transference management. In the case of the mental health services I argue that the little something, the patient's symptom is loved, not the patient, as a justification for concentrating on system preservation.

Where there is a deficit in symbolic interaction and an excess of anxiety the patient operates in imaginary relationships with the image of the nurse experiencing *jouissance* by basking in the love or punishment they receive. Excess *jouissance* is managed by diverting it through language. By limiting discourse with patients staff retain power to maintain the status quo of being the subject supposed to know; a mother knows best scenario, retaining the patient as a personal phallic object. The infant is a phallic object that fulfils desire for the mother; the patient serves this same function providing a satisfaction for staff's desire. If staff engaging in therapeutic work, used language to engage the patient, shifted from the imaginary to the symbolic order, they would risk losing the phallic patient and risk being exposed and castrated by language, instead they spent time creating basic assumption groups (Bion, 1990), which allow illusions of a therapeutic social bond to flourish.

In the traditional system the doctor takes the master role and

there is an obvious Oedipal triangular structure between doctor nurse and patient. Current service reform has strengthened this structure, however the introduction of additional professional groups and grades of staff has added complications to the equation as each have a competing master discourse. This has increased competition for retention of the patient as a phallic object or submission to being the object of desire for the master. The high value placed on doctors by society invariably casts them in the role of ego ideal, father and big Other making them the subject of powerful transference. This direct effect of being a subject supposed to know is welcomed by some and rejected by others as medical ascendancy. The literature indicates that the ego ideal can be based on, the father (Freud, 1905c), the mother (Klein, 1952) or the specular image (Lacan, 1993). This ideal ego based on the biological father is enacted in the role of a patriarchal figure, the head of the organisation, the one who must be obeyed. There is a constant deference to such a leader as ultimately he owns everything and everyone and can sanction actions. Menzies Lyth (1989) conceptualised the nurse patient relationship as a re-enactment of the mother infant bond placing an emphasis on the management of excess anxiety. The father is not excluded as he has a role in separating the mother/child dyad; he is the instigator of the law. Lacan shifts thinking about the development of the ideal ego demonstrating that we recognise the self through a specular image and emphasising language replaced the father with the name of the father, the law. The social bond is created via the symbolic order. There is a constant searching by the individual for sense making via language which reduces social engagement to internally and externally checking where we are positioned in relation to the Other. Interpersonal interaction is all about the self and where the self is implicated. If the social bond in a mental health service is structured on the conscious ego the transference is all about the position of the staff and the patient is reduced to the level of *jouissance* generating object, leading to a lack of love in the system.

“Things that have to do with love are incommensurable with everything else; they are, as if it were written on a special page on which

no other writing is tolerated” (Freud, 1912, p. 160). If any staff group articulated the desire in the relationship with patients they risk being incommensurable with everyone else; a significant risk. Mental health interventions concentrate on managing symptoms, the little something’s, tending to ignore or dismiss love as a troublesome complication in the manner of Breuer (Freud, 1901-1905). Being risk adverse not acknowledging and working with libido contributes to stagnation. Analytic treatment cannot ignore desire, it follows libido and makes it accessible to consciousness and serviceable to reality by commuting between the imaginary and the symbolic order. *Jouissance* and its subsequent (mis)management has come to the fore, mismanagement is a misleading term suggestive of conscious action. Staff do everything in their conscious power to disavow the unconscious creating an environment in which *jouissance* is unexplored and unmediated, unnamed it remains unaddressed.

Societal change, the decline of the traditional family or more precisely acknowledgement that the social fantasy that such a family really existed in a harmonious manner, demonstrates how groups operate. Groups are the fundamental building block of society through which language developed; they are bound together by love expressed through language and action. Service improvement will only be achieved if a working group (Bion, 1990) structure can be fostered. The shared ideal that binds the mental health services together requires re-evaluation, this has an implication for *The Vision for Change Policy* (Expert Group on Mental Health Policy, 2006). The ideal of the past, colleens dancing at the crossroads was supported by the banishment of Sean-nós dancers to the asylum and other institutions and replaced by the ideal of a River Dance where ever bigger groups dance to the same loud brash hypnotic and inevitably unsustainable beat. Study participants felt most sustained when their individuality, their Sean-nós quality was acknowledged and most alienated when it was dismissed, a postmodern style of group that can engage with a Sean-nós approach to mental health needs to be fostered. Psychoanalysis readily acknowledges not having all the answers to mental suffering. The evidence from

psychoanalysis demonstrates that as well as working with patients as subjects it is possible to work with those who work in the clinic of mental health transforming their ability to become part of a postmodern approach. Madness is alienating and enslaving; psychoanalysis could play a significant part in reducing alienation and slavery by supporting staff in transference management. An Irish psychoanalytic contribution to public debates on mental health is required to enable distinction between social fantasy and social reality.

Services are constructed on an illusion, a science of madness and normality; defended by recourse to the law and the Big Other. Previous studies have addressed the fallacy of the psychiatric assessment structure such as Rosenhan (1973) study *On Being Sane in Insane Places* in which participants feigned symptoms to gain access to hospital and reverted to normal behaviour following admission. The normal behaviour of the pseudo-patients was deemed as insanity by staff. A pseudo-patient study by Winkler (1974) yielded similar results and reported on negative transference between staff and the pseudo-patients; with the pseudo-patients reporting a sense of boredom and monotony which was "capable of producing behaviour normally labelled 'ill'". Similar to the Rosenhan study (1973), findings indicated that "normal" manners were suspended on wards indicative of a particular type of social bond. "Those who asked uncomplicated questions about their treatment were answered as though they were infants; if they became upset they were disregarded and disparaged by the inference that the complaint indicated irrationality. Patients were obliged to wear pyjamas following admission, or as punishment for various misdemeanours to make them realise they were sick" (Rosenhan, 1973). Almost four decades later this style of regime continues to flourish, patients in this study were required to wear pyjamas following admission and were disregarded, treated as minors and considered irrational; Oury's (Reggio, 2007) comment that the hospital is ill remains true. The social bond between staff and patients is characterised by unconscious preconceptions resulting in negative transference.

This analysis is not merely an anti-psychiatry argument as services

structures reflect society's belief that medicine embodies the subject supposed to know. Psychiatry's university discourse, that the truth of mental illness is biologically based, is challengeable by a postmodern approach where a single truth is unacceptable. Psychiatry dominates – anti-psychiatry has failed, however post-psychiatry and psychoanalysis can contribute to shifts in conceptualisation. Post-psychiatry and psychoanalysis need to make an intervention at the level of philosophy about the Other and ways of working with others. The asylum, as a social solution is a residue of a past founded on a conspiracy of silence and repression whose longevity is ensured by the unconscious transmission of its power to detain, repress and silence occupants within a narrow mental and moral framework for society. It operates as a big Other characterised by punishing sadistic methods that trap current occupants into an unconscious incarceration by a moralistic judgemental style of conceptualisation. Its punishing superego is cloaked in pseudo-scientific language by the subject supposed to know supported by the discourse of the Master and Law. Incarcerated staff attempt self-redemption by dismissing the patient as subject and by recourse to chemical solutions, physical restraint or unrealistic rehabilitation and recovery plans. The challenge for psychoanalysis is to address the structure and function of mental health services without being dismissed as unscientific.

This paper commenced with an acknowledgement of the reformation of the mental health services. Despite statutory revision (Government of Ireland, 2001) there is no evidence of a reformation of the management of the subject-Other relationship, instead the reformation of services has enhanced and entrenched the previous regime. Negative transference was as firmly established in the community, as in the inpatient setting, indicating that the shift to smaller inpatient populations and an extended community service has failed to address the critical subject-Other relationship. Freud (1912) noted the negative transference that exists in the institution, this negative transference still exists. Foucault (2006) identifies no possibility of a change in the foreseeable future due to the elevated status of the doctor, a shift in

the social order is required as noted in the findings that the position of the psychiatrist's is a dominant thing in society given status beyond its utility in mental health supported by the bizarre transposition of the value of other branches of medicine.

The patient investing in the ego ideal of the unconcerned leader suffers unsatisfactory treatment provided by the subject supposed to know. The fiction of staff cooperation contributes to retention of a dependant group and castrated leader in an anxiety provoking system structured to generate and facilitate staff *jouissance*. The physical excess of patients and psychical excess of symptoms managed by observation and categorisation enables staff to minimally engage; patients are seen and not heard. Excessive quantities of negative transference towards individuals are managed by projecting it onto service structures. This alleviates fear that the (m)Other will be destroyed with a consequential conceptualisation of a threatening social system with responsibilities, power and the negative attributes of a bad object. The hospital is named as not having responsibility to engage with patients and the responsibility for improvement handed to medication and external agencies. The hospital as bad object is oblivious to appeals for help, but provides physical containment and rejects the subject's appeals to be desired. Specialised working group exist to retain the status quo leaving the responsibility for change located in external agencies, protecting the group against the risk of action.

Tuke and Pinel (Foucault, 2006) recognised the family structure as a place where desire developed but when they replicated this in the institution were limited to a patriarchal structure. Nightingale's lamp (Flint, 2010) represents an authentic love, which has been dimmed by strict structure, replication and uniformity. The evidence of this study hinges on services dominated by a patriarchal model of institutional care, an un-illuminating conclusion unless there is consideration of something hidden. One of Lacan's final pronouncements on the Unconscious was that the Unconscious just is (Lacan, 2008) we all know what it is. Could there be anything less radical than saying that services are dominated by patriarchy, it's known, we cannot imagine

service without it therefore it's beyond question. It is an unconscious trap of such strength that we stop amalgamating in discussion the elements that keep it in place; the medical model (Foucault, 2006), the imaginary content of health policy (Fotaki, 2010) group psychology (Freud, 1921a), the impossibility of caring (Menzies Lyth, 1988), the operation of transference in the subject-Other relationship (Lacan, 1960-1961), and an on-going incestuous relationship between staff which excludes patients. Consistently high readmission rates (Daly, 2009) indicate both the failure and success of the patriarchal model. Staff unconsciously enslave patients, the only new treatment that should be considered is treatment for staff, as previously advocated by Main (1957). Irish consultation documents, commissioned research and government policy over the past ten years acknowledge deficiency and dissatisfaction with current regime's (Government of Ireland, 2001, Keogh, 2002, Crowe, 2004, Government of Ireland, 2005, Expert Group on Mental Health Policy, 2006), yet services persist in delivering the same unsatisfactory treatments. Ignoring the evidence of consultation and research evidences unconscious collusion with the retention of a system designed to pleasure those in charge paradoxically evidencing negative transference.

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