

ORIGINAL ARTICLE

Involuntary Care and Treatment in Psychiatric Settings – Manifestations of Power and Violence?

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In this article I am trying to disengage from the common forms of discussion about violence related to mental health service users/survivors, such as, for example, biomedical ideologies and statistical assertion that imply that service users/survivors are more likely to enact violence. I want to explore how service users/survivors experience involuntary 'care and treatment' in psychiatric facilities in Sweden today, and how their experiences can possibly be understood by taking into consideration the context, or more precisely the dominant ideologies/discourses surrounding mental and emotional distress/'madness' in Western countries, i. e. the biomedical model/bio medical models, and by drawing on alternative and counter discourses around 'madness'. Coming from a Mad Studies perspective, I argue, that the experiences the 'women' spoke about should be seen as manifestations of power and violence, and as breaches of Human Rights.

Keywords: violence; power; mental and emotional distress; Mad Studies; gender

Introduction

In this article I am trying to disengage from the common forms of discussion about violence related to mental health service users/survivors, such as biomedical ideologies and statistical assertions that imply that service users/survivors are more likely to enact violence (Daley, Costa & Beresford 2019). This focus on 'madness' and violence in Western societies can, among other things, be traced back to the 'enlightenment' and the rise of human services and interest in 'mad' peoples' behaviour. The 'issue' emerged again as a major public concern towards the end of the twentieth century following the running down and closure of psychiatric institutions and the shift to 'care' in the community in Western countries (Daley, Costa & Beresford 2019). I have an interest in the 'issue', but my purpose is, hopefully, to broaden the understanding of violence manifest in the lives of mental health service users/survivors and to explore the impact of institutions (psychiatric) that manage 'abnormality' in current Western societies and their practices. In this piece of qualitative research, I explore how service users/survivors experience involuntary 'care and treatment' in psychiatric facilities in Sweden today and how this 'care and treatment' affect their lives, and I explore how their experiences can possibly be understood by taking into consideration the context, or more precisely the dominant ideologies/discourses surrounding embodied mental and emotional distress/'madness' in Western countries (i.e., the biomedical model/bio medical models) and by drawing on alternative and counter discourses around 'madness'. Thus, this article draws on narratives told by 15 'female' service users/survivors in Sweden today.

Theory

The Individual Biomedical Model—'Mental Illness'

According to Beresford (2005a), there is a contradiction in mental health policy, practice and thinking. For example, on the one hand, there is an aim that all mental health services should develop a more holistic approach to 'mental health', and there is an interest in service user/consumer/survivor perspectives (Beresford 2005a). On the other hand

...and certainly, more visible in the public and political domain, are counter pressures to regulation, control and surveillance. The dominant approaches to "treatment" continue to be chemical. The trend has been towards an increase, not a reduction, in the number of compulsory hospital admissions. The emphasis has been on keeping "severe and enduring mental illness" in check, rather than on prevention and supporting people experiencing distress and stress-related problems. This approach has been framed in regulatory terms of "assertive outreach" and (drug) "compliance". There has been a renewal of interest in bio-chemical and genetic explanations of "mental illness" which emphasise the "otherness" of mental health service users/survivors... (Beresford 2005a: 33).

According to Beresford, there is an emphasis on regulation, control and surveillance in mental health policy, and an association between violence and 'madness'. This is a reflection of the medicalised and individualised nature of policy, practice and thinking in the field of 'mental health' and in contemporary Western society in general (Beresford 2005a). Individuals with experience of embodied mental and emotional distress are pathologized and abnormalized and viewed as a 'threat' (Beresford 2005b). Medicalising views of embodied mental and emotional distress are thus deeply entrenched in culture and socialisation on the broadest scale in the contemporary Western world, and it takes on a hegemonic status of common sense (Watermeyer 2013). Both practitioner and mental health professionals, scholars in the field of 'mental health', 'normal people' and service users/consumers/survivors may therefore accept medicalising assumptions without question when it comes to embodied mental and emotional distress (Timander 2015; Timander, Grinyer & Möller 2015; Timander & Möller 2016).

Mad Studies

Mad Studies is an emerging study/discipline and movement in, for example, Canada and the United Kingdom (Menzies et al. 2013). According to Menzies and his colleagues, the aim of Mad Studies is to explore the various ways of 'psychiatrization' in Western countries and to focus on the oppression and agency of 'Mad' subjects. In addition, it seeks to challenge the dominant psychiatric discourses/ideologies and highlight the battle against the psy-complex, also highlighting (and celebrating) manifestations of embodied 'mental and emotional difference' (Menzies et al. 2013). According to Menzies et al., activists, psychiatric survivors, academics, journalists and dissenting practitioners have been

...challenging the conventional biological paradigm of "mental illness"; exposing the systemic and symbolic violence that lie at the core of the psychiatric system; constructing radically creative ways of thinking about matters of the mind; linking the struggle against biopsychiatry with other movements organized around gender, race, disability, social class, culture, and generation; building a critical community that now spans all regions of the country; practising mental "difference" and recovery as liberating ways of expressing our humanity and engaging in political debate and practice' (Menzies et al. 2013: 3).

Thus, with this article I want to draw on the rich and innovative body of critical writing on 'madness', human rights and the 'psy-sciences' that has been flourishing in some countries worldwide over recent years. I am going to locate 'the psychiatry' and its human subjects within institutional and specifically cultural contexts, advancing the position that 'mental health' research, writing and advocacy are primarily about opposing oppression and promoting social and human justice (Menzies et al. 2013).

Power and Violence

Violence has been theorized and conceptualized in different ways (Daley, Costa & Beresford 2019). What is commonly held by scholars analyzing violence is that power is at the center. Power is a relation that structures interactions between people, and in analysis of structural formulations of violence, power needs to be taken into consideration. Thus, to study violence one needs to ground the study in a theory/theories around power. According to Lukes (2005), power is exercised in three ways: decision-making power, non-decision-making power and ideological power. Decision-making power is the most public of the three dimensions. Analysis of this 'face' focuses on policy preferences revealed through political action (Lukes 2005). Non-decision-making power is that which sets the agenda in debates and makes certain issues unacceptable for discussion in 'legitimate' public forums. Adding this 'face' gives a two-dimensional view of power allowing the analyst to examine both current and potential issues, expanding the focus on observable conflict to those types that might be observed overtly or covertly (Lukes 2005). Lastly, ideological power allows one to influence people's wishes and thoughts, even making them want things opposed to their own self-interest. Lukes offers this third dimension as a thoroughgoing critique of the behavioral focus of the first two dimensions supplementing and correcting the shortcomings of previous views, allowing the analyst to include both latent and observable conflicts (Lukes 2005). Thus, the third dimension refers to the social construction of practices, ideologies and institutions that secure people's consent to, or at least acceptance of, domination. Lukes' perspective on power (2005), the third 'face', is going to be used in this article to validate the narratives of those participating in this study and to identify who can be claimed to belong to a potential vulnerable group. Furthermore, Lukes' theorization of power provides a basis to challenge dominant discourses/ideologies and practices and institutions around 'madness'.

There are different types of violence, for example structural or systemic violence. Structural and systemic violence is violence that results from social arrangements and cannot be easily associated or attributed to a specific individual or social practice. Through structural/systemic violence, individuals and groups may experience harm, disadvantage or injury. This kind of violence is often subtle and sustains relations of domination and exploitation, including the threat of violence (Daley, Costa & Beresford 2019; Zizek 2008). In addition, an unjust social, political and economic system of inequality are understood as being sustained by symbolic violence. The mechanisms of power and domination are considered to work through bodies as they are embedded in the routines of everyday life (Daley, Costa & Beresford 2019; Zizek 2008). For example, complicity, consent and misrecognition are implicated in symbolic violence as '...the

dominated apply categories constructed from the point of view of the dominant' (Bourdieu 2004: 339). The perception of the dominant upon the dominated, and the internalization of these perceptions by the latter, normalizes and naturalizes unjust social orders as legitimately socially just. Lastly, subjective violence is the most visible form of violence, including physical violence, verbal violence and organized violence perpetrated by individuals, states and groups (Daley, Costa & Beresford 2019; Zizek 2008). These different types of violence mentioned above are of value to understand the experiences the participants in this study have encountered when being sectioned and being subjected to involuntary care and when experiencing embodied mental and emotional distress in a Western country of today. This article tries to encourage critical reflection on issues of power and violence with regards to 'madness' as they operate in and through ideologies, practices and policies that are too often assumed benevolent or neutral and legitimate.

Gender

According to New, sexual difference is real and salient; however, these differences are tendencies. Human beings are almost all sexually dimorphic, female and male. Sexual difference can be understood in many different ways, but bodies are only malleable up to a point (New 2005). According to New, there is thus a fundamental biological base to sexual difference (Gunnarsson 2011). Furthermore, New contends that the sex-gender distinction recognizes the stratification of reality. Sexual difference is a 'basic' lower level mechanism, which contributes to the development of gender orders at a higher level. However, gender orders cannot be read off from sexual difference. Sexual difference is a background mechanism among many other mechanisms, which are co-acting to produce the gender order. Thus, mechanisms at different levels exist simultaneously and they interact with one another in a non-additive way and affect each other (New 2005). Gender, according to New, refers thus:

...to the social representations of sexual difference: the beliefs, values and expectations attached to sex categories, and the social relations and ordered practices which they legitimate (New 2005: 64).

As New sums it up:

...sex is ontologically prior to gender, and is one of the many mechanisms the workings of which shape gender orders. Gender is necessarily linked to sex, but not in the sense that it expresses sex, or is reducible to sex, or is determined by sex. Gender is linked to sex because sex is its referent and its basis, the powers and properties which gender ideas and gender orders make meaningful (New 2005: 65).

I do not believe that it is essentialist or homogenizing to use categories like 'women' and 'men'. The category of 'women', for example, does not reflect the whole reality of concrete and particular women. However, it still refers to something real, for example, the structural position as woman, whether women wish it or not. However, women's actions and experiences are not determined or reducible to the tendencies that are inherent in their structural positions (Gunnarsson 2011). I draw on this perspective on gender to understand the experiences the women in this study have encountered when being sectioned. Thus, a gender perspective can broaden the understanding of power and violence the women have endured when being sectioned. I argue that inherent in the psychiatric practices and institutions, are patriarchal and sexist assumptions and ideologies.

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

In this article, I also draw on the UNCRPD because Sweden has ratified the Convention, and furthermore, the fundamental principle of the UNCRPD is that it prohibits any discrimination on the basis of disability (Webb 2008). The UNCRPD took effect as international law in 2008. Sweden ratified the Convention in 2009. As mentioned above, the entire UNCRPD is underpinned with a fundamental principle: it prohibits any discrimination on the basis of disability (Webb 2008). This is particularly spelled out in Article 12, which recognises that people with experience of disabilities have legal capacity on an equal basis with others in all aspects of life (Webb 2008). Furthermore, Article 15 is aimed at ensuring that people with experience of disabilities are not being subjected to torture or cruel, inhuman or degrading treatment or punishment (Daley, Costa & Beresford 2019). In addition, Article 25 prohibits medical treatment without consent (Webb 2008) Thus, there is a strong argument based on well-established human rights principles that involuntary psychiatric interventions meet all the internationally recognised definitions of torture (Webb 2008). However, the primary purpose of the Swedish Mental Health Act is to limit a person's human rights. The Act specifies the criteria for involuntarily treatment and care: if the person is suffering from a serious mental disorder, if the person has a need of psychiatric care and if the person refuses voluntary care, or if it is tenable to presume that the person due to their mental health status is not going to subject herself/himself voluntarily to care and treatment in a psychiatric facility (Lagen om psykiatrisk tvångsvård, LPT). These three criteria have to be met in order to, so called, legitimately section anyone in Sweden or give them involuntarily care and treatment. Thus, I would argue, the Swedish Mental Health Act (SMHA, LPT) from a human rights perspective clearly breaches the UNCRPD.

Methods

Recruitment Process

An important aspect of the research process is to formulate a distinct and well-defined research topic and to construct the sample in relation to the overall purpose of the study. Central to the selection process was to find women with the experience of embodied mental and emotional distress. Furthermore, they should have the experience of a recovery process and involuntary 'care and treatment' by the psychiatry. The participants were not defined through a medical diagnosis; rather, I wanted people to self-define having the experience of embodied mental and emotional distress and recovery.

The guiding principle when it comes to the inclusion and exclusion criteria has been purposive sampling, which means to 'identify groups, settings, or individuals that best exhibit the characteristics or phenomena of interest' (Maxwell 2012: 94). The participants were recruited through mental health service user/survivor organisations in Sweden. Thus, purposive sampling in locations and organisations of convenience influenced decisions about which participants to include (Maxwell 2012). The organisations were contacted by calling them and sending them information about the project, and some organisations were also visited by me to further inform about the study. Research participants contacted me after being given a brief handout material about the project.

Collecting Data and Ethics

The findings presented here are based on 15 qualitative in-depth interviews that I conducted during 2018–2019. Several follow-up interviews are also going to be conducted during the next following years. I transcribed the interview recordings verbatim and also carried out the translation of extract examples from Swedish to English. The interviews were recorded with the permission of the research participants, and both written and oral informed consent was obtained. Each research participant was given a cinema gift card with a value of £15 pounds for each interview. The name of the research participants in this article (and in the overall study) have been changed, and personal characteristics have been de-identified. Before the study began, ethical approval was obtained from a relevant authority in Sweden (2018, 2019).

Sample

The sample of 15 research participants cannot claim to be representative of women with experience of embodied mental and emotional distress and recovery in a statistical sense. However, it is important to note that the findings are based on women whose ages were fairly evenly distributed through the twenties, thirties, forties, fifties, sixties and seventies. Furthermore, they were from a variety of socio-economic, family and educational backgrounds. In addition, they all self-defined as having experience of 'mental health problems' and recovery, identified as a woman and had experience of involuntary 'care and treatment' by the psychiatry. However, none of those participating in this project openly identified as belonging to an ethnic minority. But some openly identified as lesbian. Above that, not many of the participants were in the forefront of the service user/consumer/survivor movements in Sweden and/or political activists in the movements. However, most of the participants were active and non-active members of the mental health service user/consumer/survivor organisations in Sweden. Furthermore, not many openly identified as belonging to a religious community. To conclude, this sample is quite varied, drawn from a cross-section of women in the wider Swedish population.

Thematic Analysis

In this study, thematic analysis has been used to analyse the collected data. This analysis method entails identifying, analysing and reporting patterns (themes) within data (Braun & Clarke 2006). Thematic analysis is not wedded to any pre-existing theoretical frameworks (Braun & Clarke 2006). Themes within data have been identified in an inductive, or bottom-up, way. That means that the process of coding the data have been conducted without trying to fit into a pre-existing coding frame (Braun & Clarke 2006). Thus, my use of thematic analysis has been data driven. Furthermore, the themes have been identified at a latent or interpretative level, and the analysis that was produced was not just description, but rather was theorized (Braun & Clarke 2006). First, I familiarized myself with the data and transcribed and read and re-read the data, noting initial ideas. After that, I generated initial codes and searched for themes. Thereafter, I reviewed the themes to check if the themes worked in relation to the coded extracts. Lastly, I defined and named the themes and selected vivid and compelling extract examples and in the end produced articles (Braun & Clarke 2006). However, even though the analysis was data driven, I am familiar with counter discourses, like Mad Studies, and also very familiar with the writing of Peter Beresford and British scholars coming from a Disability studies perspective. Thus, I have a pre-understanding, which entails a focus on social and human justice for so-called marginalized groups. But I have mustered my pre-understanding, and I am aware of it.

Results

Violence

Subjective violence

The women participating in this project told powerful narratives about, as I interpret it, experiences of subjective violence. Viktoria, for example, told the following about being mechanically restrained/'belted' and forced to electro convulsive therapy when sectioned:

Can you tell me about your involuntary psychiatric care? (Researcher)

I can tell you about one occasion. I had an urge to speak. There sat a guy. ... He was sitting and studying. And I approached him and talked about my experiences (Her spiritual interpretation of her so-called experiences of mental and emotional distress). But he felt disturbed. So, he pushed a button, and five mental health carers came running in a few seconds. He had pushed the alarm. And they are pushing me down on a bed, and gave me an injection. A so-called tranquilizer, which I did not need. Because I was calm. ... And the most frightening with that experience, was that they took me to a room, and restrained me, and there I was lying by myself, and could not move. In the beginning I was calm, but when I came to that room and was restrained, I started to feel tense and scared. So, I started to pick small tiny pieces from the madras. ... The whole floor was covered by small pieces from the madras. After one hour, or two hours, I do not know for sure, some mental health professionals came. They saw all the small pieces of madras on the floor, and one of the guys tells the other: "You see, she is totally crazy". But they did not understand that I was picking those pieces because I was afraid and tried to calm myself. (Viktoria)

Viktoria told also about her experience of involuntary electro convulsive therapy when sectioned:

I have been subjected to high dosages of medication, and I have undergone electro convulsive therapy. When I have been talking about God (Viktoria sees her experiences of mental and emotional distress as spiritual encounters with God.) I have been forced to undergo more powerful electro convulsive therapy so that I would stop thinking about spirituality and God. Then I have (inaudible) stopped talking about my spiritual encounters with God, so that I am not forced to undergo more sessions of powerful electro convulsive therapy. (Viktoria)

Viktoria's narrative about being mechanically restrained/'belted', forced to undergo electro convulsive therapy and injected with medications and sectioned can be interpreted as subjective violence, perpetrated by the state, through mental health professionals in the psychiatry. Her experiences, I would argue, are accounts of physical, subjective violence, and they are not examples of benevolent 'care and treatment' in solidarity by a neutral and caring psychiatry. Furthermore, making the case from a human rights perspective, according to Article 15 of the UNCRPD, people with experience of disabilities should not be subjected to torture or cruel, inhuman or degrading treatment or punishment. In addition, Article 25 of the UNCRPD prohibits medical treatment without consent. Both of these articles were breached in relation to Viktoria's narratives (and countless others who are experiencing involuntary psychiatric 'care') about her experience of psychiatric 'care and treatment' in a Swedish psychiatric unit. Thus, there is a strong argument based on well-established human rights principles that these experiences of involuntary psychiatric 'treatment and care' that Viktoria encountered meet all the internationally recognised definitions of torture. Furthermore, according to Viktoria, she had to undergo more powerful electro convulsive therapy, because she was expressing her belief that her embodied mental and emotional distress were spiritual encounters with God. Thus, she was expressing her religious beliefs and her interpretation of her experiences. But the professionals in the psychiatric unit understood her experiences from a biomedical perspective as signs of so-called mental illness. Her beliefs and interpretations were abnormalized and pathologized, and she was subjected to and forced to undergo powerful electro convulsive therapy. Again, this is a breach of human rights and the right to express one's religious beliefs and thoughts. Viktoria's account above is, I would argue, a powerful illustration of power. The mental health system in Western societies is a social construction of practices, ideologies and institutions. These practices, ideologies and institutions are created by human beings, and they have a history in a specific geographic and sociocultural context. Because they are created by human beings, they cannot be understood as neutral but rather as entrenched by interest and power. They are not examples of neutral and benevolent care and compassion; they are mediated by power and dominate those who are understood to be suffering from a 'mental disorder'. This domination of people who are deemed 'mentally ill' is not legitimate, coming from a Mad Studies perspective. According to a Mad Studies perspective, at the core of the psychiatric system there is systemic and symbolic violence, and one needs to challenge conventional biological paradigms of 'mental illness' and construct radically creative ways of thinking about matters of the embodied mind and emotions.

The theme of subjective violence was frequently addressed by the participants in this current study. Karolina also shared powerful accounts of restraints and being involuntarily injected with medication:

What kind of medication did you get? Was it high, what kind of medication did you get? (Researcher)

Everything. It was neuroleptics, which was the worst. It was lithium. Yes, different types of calming medication. Yes, benzodiazepines and lergigan. And also neuroleptics, as a calming medication. Yes, and sleeping pills. I do not know, during a period I could not talk, because I had been given. So it was. (Karolina)

Were you forced to take the medication or? (Researcher)

Either you take it, or you will be forced to take it. If I would, if I would disagree. I told them the whole time, that I did not want so many different medications, and lots of medication. But towards the end, I asked for medication, instead of. I was brainwashed, and thought that was the solution. (Karolina)

You must have been almost unconscious with that cocktail? (Researcher)

Yes (Karolina)

Was it also in high dosages? (Researcher)

Some of them were in high dosages. They doubled the dosage in relation to recommendation. It was one of them. Yes, that I even could stand up and walk! Would I have been given that today, I would be unconscious. But I have also been forced to medication by injection. (Karolina)

...

There were also times, when I did not really. I did not really know what happened. I had a black out in my head. I know that I panicked, and then I. Yes, I was pushed down on a bed, and mechanically restrained. ... Yes, that someone, a bunch of people are pulling and pushing me until I am lying on a bed as they want me to. They were hurting me a lot. (Karolina)

In what way was it hurting you? (Researcher)

It made me feel physically in pain. Yes, they were pulling and pushing me to harshly. And it was especially one incidence. I had a sweater. And they pulled so much that I could not breath, and they pulled out hair. And they restrained me so hard, that I started to bleed. (Karolina)

You started to bleed... (Researcher)

On my wrists and ankles. They were so rough that one nurse had to go outside of the room, because it was too violent. Her solution to the situation was to go outside of the room. (Karolina)

Again, Karolina's narrative could be interpreted as experiences of subjective violence by the mental health system—not benevolent and neutral 'care and treatment' in solidarity—and as breaches of human rights. What I want to underline with her account is not just the violent character of her experiences and her experience of trauma, but how the mental health system (and societies in general) responds to manifestations of embodied mental and emotional distress, how health care and its organizations breed violence in its practices. This is not caring and human treatment and care in solidarity, but rather it is breaches of human rights perpetrated by the state and the mental health system. This is, I would argue, oppression on the grounds of manifestations of embodied mental and emotional distress, and there is an urgent need for humane and caring responses to people in distress and crisis and for creative ways of relating and understanding distress experiences in current Western societies.

Symbolic violence

The women spoke also about other kinds of violence, for example, symbolic violence. In the following narrative, Karolina expressed accounts of, what could be interpreted as symbolic violence:

"There is no one that are going to believe the patient. So, I can say and tell exactly what I want". And what is worse, this is true. Because, even though you're telling someone about it, and the professional is believing what you are telling. It is still. The person is not taking responsibility and are doing something about the situation, or about one's colleague. There is some kind of loyalty that is not good at all. ... I have encountered people who have expressed that: "You are second-class citizen". In their body language, and their sighs. Everything to show how demanding I am, according to them. ... I was once called a hard-boiled egoist, because I had tried to take my life. In a very disrespectful way by professionals. ... You are made to feel as a second-class citizen. Ones opinions is of now worth at all. Ones experiences is of now worth either. (Karolina)

Karolina's narrative above is, I would argue, an example of misrecognition (i.e., symbolic violence perpetrated by mental health professionals in their routines of everyday work). By the mental health professionals' approach to Karolina, as a second-class citizen, Karolina is made to feel worthless. One could almost interpret her narrative as an experience of ontological insecurity. She is made to feel that she cannot make a claim of being an equal human being, of equal

footing as the mental health professionals. Her feeling of worthlessness and inferiority (i.e., ontological insecurity) is an expression of her internalisation of the oppression (sanism), misrecognition, perpetrated by the mental health professionals. Coming from a Mad Studies perspective, I believe that the psychiatric system is founded on a core of symbolic violence and the conventional biological interpretation of 'mental illness', which gives little room for radical and creative ways of relating to experiences of embodied mental and emotional distress and for working towards social justice. The unjust society towards people who experience mental and emotional distress are sustained by symbolic violence. Those who dominate apply categories constructed from the point of view of the dominant upon those who are dominated. The internalization of these perceptions by the latter normalizes and naturalizes unjust social orders as legitimately socially just. Karolina is made to believe she is a second-class citizen, and not of equal worth, and she internalized the ascribed identity of being second class and started to feel worthless. However, Karolina is also understanding her experiences as incidences of oppression and is aware that she is living in a society that is socially, politically and economically unjust. She has a 'double consciousness'; the 'dominated, the oppressed' will never fully internalize the devaluing assumptions about her/him (Du Bois 1969).

The gendered character of violence

The women also spoke about, as I understand it, violence in psychiatric institutions, which was gendered in character. For example, Rebecka told a lengthy narrative about structural violence, which could be characterized as gendered:

In psychiatric institutions, especially during the nights, most of the professionals are men. And you are supposed to sleep, and if you are not sleeping you are forced to take medication, at the same time you are aware that men might go in to your room (while one is unconscious/sleeping). ... And they have the key to your room. ... There was a man, a mental health professional, and he was nice, he was an older man, with a big belly. And we would talk about fun stuff, like for example books, when I could not sleep during the nights. But after a while I understood that he was like the rest. He could not see the issue of power in relation to a patient. He started to talk about his personal problems, and he would cry. And when he was leaving work in the morning, he said: "I rather would like to jump into the bed with you".

In this quotation above, I argue that Rebecka is talking about structural violence that is gendered in character. In psychiatric settings, there is an built-in power imbalance between mental health professionals and 'patients', which structure the relationship between them. As a 'mental health patient', one can be forced to different kinds of treatment against ones wishes, and these 'treatments and care' are not neutral and benevolent, but rather they could be seen as acts of violence and breaches of human rights. For example, as a 'patient', one is supposed to sleep during the night, and if one is not sleeping one is forced to take heavy medication so that one sleeps. Furthermore, problematizing this situation from a gender perspective, for Rebecka, it was very scary to take medication to become highly sedated during nights, because there were mostly men working during the nights on the wards. And her experiences of gendered violence made it even more traumatic to be forced to take sleeping tablets knowing that someone might enter her room whilst she was sleeping. In addition, according to Rebecka, several mental health professionals had made approaches towards her in relation to her 'being a woman' and not seeing her as a human being in need of care. Furthermore, according to Rebecka, some men (mental health professionals) had made comments about her experiences of rape and saw her as a 'fallen woman'. These experiences made Rebecka feel like she almost had a sign on her forehead that stated she was a 'fallen woman', a 'fallen woman' that any man could approach without repercussions and, in addition, ignore her cry for understanding, compassion and kindness.

Structural violence as a threat and a tool to comply with treatments

A recurring theme the women addressed was, as I interpret it, structural violence as a threat and a tool to force the women to comply with treatments so that the women behaved 'nicely'. The threat articulated by mental health professionals about being forced to undertake different treatments, or not being able to leave the ward for parole, or not being able to leave the ward until one had undergone treatment, could be seen as threats of structural violence towards the women and as breaches of human rights. The psychiatric clinic is a space structured around power, dominance and violence (geographies of violence) enacted by mental health professionals towards those who are deemed 'mentally ill' and 'mentally disordered'. Furthermore, the professionals are encouraged to get the 'patients' to behave 'nicely' so that the facility and its practices can be carried out 'efficiently'. Any disturbances to efficiency and order are interpreted as a threat and are treated and responded to by using threats about, for example, involuntary care and treatment. Arguably, this implicit structural violence made the women feel reality as highly insecure and conditioned and made them feel frightened and powerless, despite their need of relational care and compassion:

They say that if you do not stop (harming yourself) you will be restrained or forced to take medication, or you are not able to go outside or meet your mother. And you are not being able leave for parole. One should maybe not consider this as threats. But I interpret it as a kind of threat. (Astrid)

Or as Carolina stated in the following sentences:

Between the lines, the doctor wanted me to undergo electro convulsive therapy during 2015, if I wanted to leave the psychiatric clinic. So, I subjected myself to the treatment, so that I could leave the ward. ... Yes exactly, like: "If you do not comply to the treatments, we will still treat you, against your wishes". (Karolina)

Discussion

Coming from a Mad Studies perspective, I argue that the biomedical understanding of embodied mental and emotional distress is dominant in Western contemporary societies and that ordinary people and professionals are, to a greater or lesser extent, socialised to view experiences of embodied mental and emotional distress from a biomedical perspective (Timander 2015; Timander, Grinyer & Möller 2015). The issue here is the essentially medicalised nature of mental health policy and practice (Beresford 2005a). Thus, the biomedical model/models is a/are dominant conception/conceptions and materialised in institutions such as the mental health services (and the social services). I believe that at work here is the sedimented reality of a medicalized culture, in which repeated messaging often disqualifies those with embodied mental and emotional 'difference' from a legitimate claim to full citizenship. In contemporary Western societies, the hegemony of the 'rational and the sane' ideal commonly denigrates any and all variations (Watermeyer & Görgens 2014). Thus, the inherent problem with a medicalised perspective on experiences of embodied mental and emotional distress is that it is based on a pathologising construct; there is something 'wrong' with the person (Beresford 2005a). The trend in the twentieth century has been to interpret and reconstruct experiences of 'mental health' problems in predominantly medicalised individual terms (Beresford 2005a). In the age of modernity and late modernity, it is fair to say that the history of embodied mental and emotional distress was/is a story in general of segregation, isolation and violence from elaborate policies of powerful institutionalization to 'simple' cultural distancing by 'normal' people (Watermeyer & Görgens 2014). The biomedical interpretation of embodied mental and emotional distress from an abnormal and pathologizing perspective is materialised in psychiatric institutions and in their practices, for example in practices like 'patients' being sectioned, being forced to undergo electro convulsive therapy, being involuntarily injected with medication, being involuntarily isolated and/or restrained. These practices, ideologies and institutions are created by human beings, and they have a history in a specific geographic and sociocultural context. Because they are created by human beings, they cannot be understood as neutral, but rather as entrenched in interest and power. They are not examples of neutral and benevolent care and compassion, rather they are mediated by power and dominate those who are understood to be suffering by a 'mental disorder'. These practices are, I would also argue, acts of human rights breaches (Webb 2008). Thus, there is a strong argument based on well-established human rights principles that involuntary psychiatric interventions meet all the internationally recognised definitions of torture (Webb 2008). By interpreting the participants' stories from alternative and counter discourses, for example Mad Studies, one can more readily understand their experiences as manifestations of violence and power and breaches of human rights perpetrated by professionals working in the mental health system, the so-called caring professionals. This domination of people who are deemed mentally ill is not legitimate, coming from a Mad Studies perspective. According to a Mad Studies perspective, at the core of the psychiatric system there is systemic and symbolic violence, and one needs to challenge conventional biological paradigms of 'mental illness' and to construct radically creative ways of thinking about matters of the embodied mind and emotions. It is so important and urgent that we approach our day-to-day routines and conceptions about social reality with fresh eyes and develop new and creative ways of relating and understanding experiences of so-called embodied mental and emotional distress. What we need is a peaceful revolution where 'mental health problems' are seen as deep meaningful and human experiences and where we create alternatives beyond psychiatry and relate to people in crisis and distress with compassion. To conclude, this is about human rights and creating a socially just and humane world for everyone.

Conclusion

I would argue that the experiences the women in this present study spoke about, and some of which were presented above, are manifestations of power and violence and are not acts of benevolent and neutral and legitimate care in solidarity with people who experience manifestations of so-called embodied mental and emotional distress. Rather, these psychiatric practices (and institutions) dominate and violate people who experience 'mental health problems', and they are sustained through hegemonic bio medical discourses/ideologies.

Competing Interests

The author has no competing interests to declare.

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