

**SENTOSA: A FEMINIST
ETHNOGRAPHY OF A PSYCHIATRIC
HOSPITAL IN SARAWAK, EAST
MALAYSIA**

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ABSTRACT

This doctoral thesis is a feminist ethnographic study of psychiatric patients in the State of Sarawak, East Malaysia. The study took place at a psychiatric hospital located in the capital city of Kuching, commencing in 1997. Although Hospital Sentosa is a small institution it is the only psychiatric institution in the State and therefore constitutes an important mental health resource in this region.

This ethnographic study primarily concentrates on the lives of women patients in keeping with my chosen methodological approach and seeks to explore the 'culture' of the hospital setting through facets such as daily interactions, activities and relationships. The feminist approach has not however precluded the accounts of male patients whose experiences are utilised in a comparative exercise with those of women counterparts. In addition the views of staff of both sexes and all ranks are considered in relation to their attitudes towards the care of psychiatric patients and the broader area of work-related concerns including collegial support and occupational hazards.

In keeping with an ethnographic approach themes developed in the thesis are drawn through an analysis of findings as noted by observation methods as well as through interviews with participants. Furthermore a self-reflexive approach has been an important aspect of analysis commensurate with feminist methodology, in which my role as a researcher is considered in relation to issues of culture, gender and class as well as some of the difficulties of research in a post-colonial and unfamiliar cultural context.

Although some avenues of inquiry in the study have not easily lent themselves to an analysis of gender, this thesis primarily argues that the hospital reproduces oppressive policies and practices that impact with greater severity on women patients. Oppressive practices in relation to gender and ethnicity at the hospital are viewed against a backdrop of contemporary psychiatric care as enacted on wards. It is argued that these practices can be viewed in turn as being, for the most part, historically premised upon imported British models of care replicated through colonialism in Malaya and by extension at a later period in the multicultural State of Sarawak.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

In 1996 I arrived in Sarawak, Malaysia, one of the two Malaysian states on the island of Borneo, to take up my first academic post in the capital city of Kuching. At some point during those first confusing and frenetic months of orientation I became aware of the existence of a local, discreetly located psychiatric hospital built some sixty or so years earlier. As I settled into my new life in Kuching it became apparent that the hospital had been virtually untouched by previous external research and yet appeared to offer an intriguing picture of post-colonial psychiatric care that demanded closer attention. Following an earlier study of mental health outreach services at the Hospital, I embarked on what eventually turned out to be a lengthy ethnographic study culminating in a doctoral thesis on Hospital Sentosa, a small psychiatric hospital situated in the township of Kota Sentosa on the outskirts of the city of Kuching (Ashencaen Crabtree, 1999a; Ashencaen Crabtree, 2000; Ashencaen Crabtree and Chong, 1999).

1.2 The aims and limitations of the study

Within the context of Malaysia, a developing country, where the academic elite almost exclusively adheres to a quantitative methodology, commitment to a qualitative approach such as ethnography, is still novel and somewhat lacking in credibility. Research into psychiatric care has largely been located within a medical discourse utilising quantitative methods reflecting the objectivisation of the psychiatric patient whose subjective

experiences have seldom been sought (Arif and Maniam, 1995; Lim *et al.*, 1994; Osman and Ainsah, 1994; Ramli, 1989; Varma and Sharma, 1995). Ethnography by contrast is committed to the study of people within the every-day environment of human interaction. Ethnography therefore seeks to embrace the complexities of the human situation and usually attempts to address the effects of the researcher on the study, tackling contradictions emerging from this endeavour. The ethnographic approach then eschews the artificial and prefigured conditions of the laboratory set-up with its drive to achieve a mechanistic, 'uncontaminated' process of producing replicable results (Hammersley, 1990: 1-2).

Ethnography has been subject to lengthy and meticulous descriptions, such as that of being 'open ended (Shipman, 1988: 40); 'rambling' but efficient (Bryman, 1992: 46-7) 'offering insights' on social, political and symbolic issues (Van Mannen, 1988: 127). Additionally, as an endeavour to understand the 'social meanings and activities of people' (Brewer, 2000: 11) as well as being the dynamic juxtaposition of 'authenticity *and* distance' on the part of the researcher (Pearson, 1993: xviii). Definitions however seem to vary widely, from the minutely detailed descriptions of cultural settings to seemingly any form of field research not using a positivist framework. As an introduction, however, and against a background of prolific descriptions and diverse terminology defining ethnography, Martyn Hammersley's description serves to summarise this form of social research as encompassing the following five features: that the study takes place in a normal environment; that data are drawn from a variety of sources; 'prestructured' models and strategies are not utilised; that ethnography can take place in single or group

settings; finally, that there is a commitment to understanding the meaning of the contextual situation (Hammersley, 1990a: 2; Robertson, 1996: 292).

In this study the aim of the ethnographic approach is an attempt, on my part, to engage with a complex social situation, that of a psychiatric hospital, and seeks an understanding of the 'culture' of the setting through an analysis of the condition of women in this setting, which is premised upon and grounded in their experiences and perspectives. Here then, I draw upon the words of hospital patients as well as those of staff, both female and male, in describing their experiences of hospital life albeit from very different perspectives. Daily routines are noted, while environment, behaviours and interactions are described supported by the comments and observations of informants. Consequently the study does not attempt to establish a substantive theory or test a conceptual model or hypothesis. The open-ended and flexible path that is taken where avenues of interest are explored and filtered through my personal perspective also forms the parameters of the project. This, being a study of a unique phenomenon in keeping with ethnographic principles, does not seek to lend itself to generalisation of psychiatric hospitals or psychiatric service users in general or even those specifically in the Malaysian context (Brewer, 2000: 105; Hammersley, 1990b: 50).

Furthermore, as will be discussed in more detail in subsequent chapters, the thesis does not attempt to obviate the mediating influences of my cultural background, but instead openly exploits this as a prism through which to interpret findings and my role as a researcher. My position as a British, white and female researcher therefore creates an

interesting resonance in research undertaken in a developing country with a British colonial heritage, which is explored in greater depth in the thesis. The study takes a feminist perspective and therefore issues of gender pertaining to my informants, as well as in relation to myself, are subject to analysis commensurate with this political and epistemological stance.

1.3 Personal, professional and political commitments

Whilst I have always regarded myself as a feminist in my private life, this has stood as a personal commitment that has rarely been allowed to emerge as a political statement in my professional life. In my former career as a social worker in so-called enlightened and aware environments such as UK social services departments I have only managed to achieve a very limited impact on direct institutional sexism as it affected myself, not to mention my clients. It would seem that whilst condemning discriminatory practices I have in fact too often been resigned to the 'realities' of the working world. Equally, as an academic I have frequently kept my feminist principles in the background and have publicly paid due to them in a circumspect fashion in the teaching environment. Whilst in the competitive, male-dominated worlds of research and publishing I have instinctively fought shy of using feminism as an overt means of analysis and interpretation. I have instead confined myself to appropriating the distanced and 'objective' voice of an authoritative, masculine, scientific discourse for fear that otherwise my work would be dismissed as subjective, inconsequential and invalid. From reading of the wider experiences of feminist academics it would seem that my inhibitions were well grounded

and that the marginalisation of such academics has too often been the rule rather than the exception (Stanley and Wise, 1993: 2).

This study therefore is an endeavour to demonstrate a feminist epistemology and represents a deliberate change in direction in terms of both my personal and academic positioning, and feels both risky and liberating in almost equal measures. Not least because it has been only in the recent past that I feel I have become more properly acquainted with the wide diversity of feminist methodology in all its plural and competing claims (Bhopal, 1997; Harding, 1986; Hartsock, 1990; Oakley, 1984; Ramazanoglu and Holland, 2002; Stanley and Wise, 1993). Valuable and fascinating though these arguments are, I have not found myself in absolute alliance with one specific position in the feminist debate and this at times has caused me to feel some epistemological anxiety. Upon further consideration however this ambivalent position has permitted me licence to consider these claims in terms of their validity and utility in relation to my study and accordingly, as discussed further in Chapter Three, I have found myself conforming quite closely with a feminist standpoint position. This feminist ethnography therefore is in itself a vehicle for the exploration of my own personal and political feminist development as well as attempting to directly offer a study of people living and working in an institutional psychiatric setting in Malaysia.

In reference to the topic of the study, I first became interested in mental health issues through my generic social work practice, in which I was at times allocated cases of individuals with mental health problems in addition to various life problems for which social services help was sought. This was an interesting time but one in which I learned little of mental health issues apart from some specific, practical social work intervention techniques. I did not study the subject in any depth until I returned to university to undertake postgraduate studies in the mid 1990s. My research-based Masters in social work explored the conceptualisation of citizenship in mental health issues and fuelled an increasing interest in mental health services and service user perspectives, providing me with a useful foundation for more ambitious future studies.

I have found the broad history of psychiatry in Malaysia to be an interesting one in which psychiatric hospitals were established early in the region's colonial past. Consequently much of psychiatry's later developments in this region can be traced back to parallel developments in Britain. Additionally Sarawak has a particularly rich tradition of ethnic diversity, which has kept alive cultural interpretations of illness and treatment of various forms. Conventional biomedical treatment in Malaysia appears to operate in, often unwilling, conjunction with these alternative forms of healing, this being as true of mental illness as of other maladies (Barrett, 1993; Razali, 1997; Wintersteen, *et al.*, 1997). Psychiatric biomedical care is, of course, widely practiced throughout the world, yet the colonial foundation of psychiatric care in Malaysia provides some interesting insights for an ethnographic study of a hospital, which until the end of the 1960s was superintended by foreign expertise.

Popularly psychiatric hospitals and asylums have frequently been regarded as deplorable institutions, redolent of abuse, neglect, abandonment and at best unmitigated tedium and rigid routine. In fiction Kesey's sensationalised novel *One Flew Over the Cuckoo's Nest* depicted medical treatment, specifically ECT (electro-convulsive therapy) as brutal, punitive and ultimately destructive of individual autonomy (Kesey, 1962). Medical procedures apart, asylum care has also been heavily critiqued within academic circles, where for example Erving Goffman's much cited work from the early 1960s subjected the American psychiatric hospital to sociological scrutiny in its formulation of the asylum as the 'total institution': a fundamentally dehumanising environment (Goffman, 1968; Goffman, 1991). In latter years British service users, for instance, have managed to speak out about the brutalities and repressions of institutional care (Laing, 1996; Rose *et al.*, 1998; Simpson, 1996).

In the West a feminist body of critique has built up to explore the particular significance of psychiatry in relation to women service users who, it is claimed, are exposed in great numbers world-wide to a male-dominated medical hierarchy that replicates the patriarchal oppression of society within the stigmatising and controlling confines of psychiatric services (Chesler, 1996; Russell, 1995; Showalter, 1985). Although the United Nations have acknowledged that women suffer massively from the trauma of violence and oppression, little has specifically been written concerning the position of women in psychiatric services beyond the ethnocentric focus of the West although certainly this is a subject that deserves greater academic focus (Wetzel, 2000). Consequently in considering

psychiatric care in developing regions, the condition of women is frequently subsumed by the generic plight of patients *per se* and in order to gain any insight the overall picture must be initially examined before identifying gender differences.

The 'chaotic and miserable' environment of Greece's psychiatric community on the island of Leros stands as a case in point (Strutti and Rauber, 1994: 309). This hit the headlines in Britain and elsewhere in the 1980s with photographs of naked, disorientated patients of indeterminate sex in many cases, being hosed down with cold water like so much cattle by indifferent and demoralised staff and seemed to typify the worst conditions of asylum care of an earlier age and maybe of developing countries in general.

Mental hospitals in the Third World are fairly dreadful places, and there are many in which custodial care is the only intention, ECT the usual treatment, staff brutality is commonplace, all patients compulsorily detained and few ever discharged. (Rack, 1982: 171)

Although psychiatry is a relatively new profession it has been besmirched by negative stereotypes, such as the examples cited above. The institutional environment in which psychiatry has traditionally practiced has traditionally been viewed with enormous social stigma accompanied by social anxieties. In the course of the thesis I argue that the exporting of the asylum model to the colonies, such as colonial Malaya, did not appear to evolve a new approach to care, but merely engaged in transferring not only contemporary skills and knowledge of the time, but social attitudes as well. This then is the background to the study of the hospital which, being built at the end of the colonial era, has seen many changes in the care of psychiatric patients. It continues to be an important example of

institutional responses to social and political developments towards mental illness and the welfare of those who use the services.

1.4 The social and historical background to the study

Kuching is a relatively small and prosperous city of a largely white-collar workforce, much of which is located in Government administration. It is a rapidly changing city in a region once wealthy in natural resources, but which have been regularly exploited, causing the dispossession of many indigenous groups. For the most part the region's resources are harvested by the less well-off and comparatively over-populated Peninsular. This is not to say that the new opportunities and prosperity have not succeeded in filtering down to many people. Nonetheless, for the social scientist it is not necessary to equip oneself for a lengthy expedition, to find many examples of hard-core, absolute poverty, literally on the ample, polished doorstep of the city, which is a main centre of commerce in Sarawak and boasts a multicultural population.

For the visitor and resident alike, Kuching appears to be fundamentally a Chinese city, however the city is itself now divided into two main areas segregated by the main river the *Sungai Sarawak* and more importantly by political and ethnic divisions. South of the river, the original and picturesque city was historically dominated by the city's role as a trading port, and many of the old shop-houses are converted dock-side wharves dating from the early to mid-nineteenth century. Historically the dock-side traders were largely Chinese immigrants encouraged to settle in Sarawak by generations of the Brooke family,

the so-called 'White Rajas'¹, and the new immigrants were valued for their skills as farmers, gold miners and merchants (Chew, 1990). From these beginnings and based on the rich natural resources of the region, Kuching prospered and laid the foundation of a large, urban Chinese population living in close proximity with a minority of Malay and Dayak dwellers, primarily Bidayuh². In 1957 Malaya gained its independence from Britain in 1957 and in 1963 Sarawak and Sabah joined Malaya, which then formed the Federation of Malaysia. Since then political lines have been drawn in the enshrinement of pro-discriminatory policies towards Malays and indigenous peoples in the country's constitution, whereby these groups are melded together under the title *bumiputera*, literally, 'sons of the soil'³. The effect of this in Sarawak has been that the *bumiputera* have been able to purchase land at a favourable price in all areas. The Chinese and other non-indigenous groups however have not been allowed this latitude and are concentrated in urban areas; this consequently has an influence on the demographic population of consumers of psychiatric services which are predominantly urban based.

¹ The Brooke dynasty started with James Brooke who was rewarded by the Sultan of Brunei in assisting to quell a state of rebellion in Sarawak, which was then under the sultanate of Brunei. As a reward he was made the Rajah of Sarawak in 1842. The reign of the last White Rajah, Charles Vyner Brooke, effectively ended with the Japanese occupation of Sarawak in World War II.

² The Bidayuh were historically and are still known as 'land Dayaks' as opposed to the term 'Sea Dayaks' which is applied to the Iban, the dominant Dayak ethnic group in Sarawak. Basically, these terms refer to the original demography of these two groups. The Bidayuhs have always been geographically closer to Kuching, and although these trends are changing due to social forces, the population of Bidayuhs still outnumber Iban city dwellers.

³ This political policy was at the basis of the conflict between the newly founded Malaysia and Singapore, which resulted in the latter's expulsion from the Federation in 1965.

1.5 Terms and semantics

The title of the thesis utilises the name of the hospital in a factual sense. In Malay it can however be translated in several similar ways and which the word 'tranquillity' corresponds with an acceptable and to some extent given the context, a playful allusion. The hospital was recently renamed in the spring of 1998 from the 'Sarawak Mental Hospital' to its current title following a municipal change in name of the small township it is located in, from '7 Mile' to 'Kota Sentosa'.

Although it was generally acknowledged that the former name of the hospital should be changed due to its offensive connotations, the new choice of name insisted upon by the Government was not welcome to the hospital staff in general. It was seen to merely reinforce the prejudice and stigma attached to the old lunatic asylums of former years and by association to all forms of mental illness. This was due to the unfortunate fact that the Government had named psychiatric hospitals on the Peninsula after similarly happy, cosy sounding moods e.g. 'peace'. By losing the prefix *Kota*⁴, it provided the psychiatric hospital with a new label in a notorious series and was seen as anything but a progressive step forward.

Furthermore, to continue with the deconstruction of chosen terminology, I regularly refer to people admitted to the hospital as 'patients' rather than the more progressive and popular term 'service user'. This term has become increasingly popular in the UK, for example, where it is strongly associated with consumer choice towards psychiatric

⁴ 'Kota' is simply translated as 'fort'.

services (including the issue of the right to refusal of services). It emphasises individual rights and empowerment and stands in contrast to the more passive term of 'patient'. Therefore my reasons for not using the term 'service user' are conscious and pointed and first of all relate to the fact that primarily the term is in rare currency in Malaysia. It is also one that is not used by informants at the study site and therefore I consider it more in keeping with an ethnographic approach not to impose titles relating specifically to the context but which are nonetheless unfamiliar to it. The term 'patient' by contrast is one generally utilised by parties employed, admitted or visiting the hospital and is therefore the one I have adopted throughout this thesis.

In the study the hospital is occasionally referred to as an 'asylum' by some interviewees. This term however carries very emotive connotations, as, for example, has been used to notable effect by Erving Goffman in describing the almost complete lack of autonomy characteristic of the 'total institution' (Goffman, 1991: 11). Some of the findings discussed in the thesis illustrate institutional practices at Hospital Sentosa, which are commensurate with Goffman's terminology and supporting examples. I have therefore appropriated the term 'asylum' on occasion and use it in describing certain aspects of hospital policy and episodes of patient care, which I feel comply more with a highly custodial and disempowering environment to patients and to staff, rather than with the practices compatible with contemporary consumer ideology.

Finally, in relation to the process of fieldwork, I refer to those interviewed as both ‘respondent’ and ‘participator’. I am conscious that I use these terms according to subtle nuances, in that ‘respondent’ tends to indicate to me a more formalised interview relationship than that implied by the latter term. Nonetheless for the reader’s benefit I would conclude by saying that in effect these terms are used more or less synonymously.

1.6 Organisation of the thesis

This thesis contains ten chapters, of which the first four discuss the background to the study, methodology and methods, whilst the remainder are devoted to findings. Chapter Two offers a critical review of relevant literature, which seeks to contextualise mental health services in Malaysia in relation to its colonial past as well as considering critiques of psychiatry in relation to gender and ethnicity. Chapter Three draws upon arguments in the debate on feminist methodology in relation to epistemological and ontological stances. These are considered in the light of how specific issues relate to this study and which have informed and challenged my role as a feminist researcher. Chapter Four covers a fairly broad area and discusses methods employed in gathering data and how these are analysed in relation to the methodology employed. This chapter includes a discussion of ethical dilemmas as well as issues relating to my role as the researcher in association with relationships developed in the field. Throughout the thesis I seek to bring my specific positioning in terms of a personal and political identity into the foreground. The self-referential is continually used to highlight my presence as the researcher and interpreter of the phenomena in a bid to create greater transparency in

relation to my assumptions and comprehension of phenomena with regard to gender and issues of power.

Subsequent chapters from Chapter Five onwards present the findings of the study based on themes identified through the process of analysis, as discussed in Chapter Four. Chapter Five therefore begins by placing Hospital Sentosa within a historical and geographical context before commencing an immersion into the routines, rituals and the socialisation process of life in the ward environment. Information on the legal framework surrounding admission and discharge procedures underpins data from patients and staff on the slowly revolving door to the psychiatric hospital. Chapter Six concentrates further on the hierarchical socialisation of individuals and relationships between patients. This concludes with an examination of the nature and utilisation of patient labour structured on stereotypical gender divisions. Chapter Seven reviews methods of patient control such as treatment programmes, including that of electro-convulsive therapy as well as considering the use of the 'open' ward system on male and female wards. This chapter concludes with patient and staff narratives on the issue of ethnicity and racism in the hospital setting. Chapters Eight and Nine are devoted to issues of staffing whereby the conditions of work at Hospital Sentosa, professional practice and career opportunities are drawn against a backdrop of national policy debate on service delivery.

Chapter Nine focuses on staff strategies of control and containment of patients as well as staff perceptions of risk and violence in working with psychiatric patients in terms of gender, collegial expectations and existing support systems. Finally, Chapter Ten draws the ethnographic findings together in conclusion to the study and offers a review of the limitations of the study and suggestions for further research.

CHAPTER TWO

PSYCHIATRY AND THE COLONIAL ENTERPRISE IN HISTORICAL MALAYA AND BORNEO

2.1 Introduction

The development of psychiatric services in the colonies provides a fertile ground for exploring the underlying values and practices in the care of the insane in the British context that would eventually be exported to the Crown territorial possessions. In this chapter therefore I seek to put forward the view that modern psychiatric services in Malaysia are best understood through a historical scrutiny of British attitudes and policies. The impact of the comprehensive transportation and imposition of a European philosophy of care on historical Malaya and Borneo through imperialism is a tantalising but enormously complex and contentious area. Consequently this chapter focuses on lines of inquiry regarding gender, ethnicity and the colonial enterprise in relation to modern critiques that are seen to offer useful insights into the findings of this study and serve to contextualise contemporary care at Hospital Sentosa. It is argued therefore that contemporary care at the hospital has deep roots leading back to historical developments in Western psychiatry and British colonial policy.

2.2 Psychiatry as an emerging profession

Specifically aimed psychiatric treatment of mentally ill patients in the West has only been in existence for approximately the last two hundred years and this type of care has in many ways changed almost out of recognition from early concepts of mental illness and appropriate methods of management. Prior to the era of the county asylum in the nineteenth century mental illness was primarily managed at home, the poorhouse, prison or the punitive atmosphere of the workhouse. Scull argues that in England by the mid-eighteenth century the status of madness was being altered from one of individual inadequacy, to that of being redefined as a condition subject to medicalised expertise (Scull, 1979: 14; Fraser, 1984: 33).

This period therefore saw the beginnings of a consciousness that the insane could be treated rather than merely contained. General institutional care in Europe prior to this was notorious for its brutality with the mad treated like wild animals that were moreover judged to be impervious to pain, cold, hunger and foul accommodation (Scull, 1979: 64; Foucault, 1965: 74; Jones, 1996: 126; Alexander and Selesnick, 1967: 114).

The whole system of treatment was also predicated on the assumption that mental patients are habitually disordered, malicious, base creatures. Every attempt was made to force them to renounce their foolishness and bring them to submission by abusing and punishing them. (Kraepelin, 1962: 24).

From the brutal incarceration of incorrigibles the concept of the asylum evolved to one in which the asylum in *itself* could be seen as therapeutic and as a means of achieving a cure. This revolutionary idea followed from the logic of the period itself, whereby

rationality was seen to sweep away the superstitions and rigid social structures of the Middle Ages, articulated, for example, through the measured reasoning of William Battie, a founding member of one of the new public sector asylums, St Luke's Hospital in London (Shorter, 1997).

Madness is ... as manageable as many other distempers, which are equally dreadful and obstinate, and yet are not looked upon as incurable; such unhappy objects ought by no means to be abandoned, much less shut up in loathsome prisons as criminals or nuisances to the society. (Shorter, 1997: 10).

The idea of the 'therapeutic benefits' of the asylum was one that was consequently transported to the American colonies and in due course to all other corners of the British Empire, including Malaya, over the following two centuries.

2.2.1 The historical development of the asylum in the eighteenth and nineteenth century

Foucault notably posits that historically the eighteenth century was the period that saw the establishment of the great and universal 'complicity between government and Church' in Europe, replacing earlier measures of support or oppression of the poor and infirm (Littlewood and Lipsedge, 1989: 32; Foucault, 1966; Foucault, 1976a). In evidence of this Foucault points to bureaucratically centralised France where by 1798 there were in existence 177 State sector custodial institutions, of which the most famous were Bicêtre, occupied by male patients, and Salpêtrière for females (Foucault, 1966: 40).

This argument however is contested by Peter Barham as being unrepresentative of the situation in England at that time where institutions were largely private, entrepreneurial ventures rather than State governed (Barham, 1992: 66). Whilst Shorter (1997) in accord states that there was slow development of the public sector traditional asylum in England, which numbered only a further seven charity run institutions apart from Bethlem and the numerous privately run institutions. These served to modestly supplement the numerous privately run institutions where the early version of the 'alienist' practiced or attended the afflicted but wealthy in their own home. Furthermore despite the rise of asylums in England at this time, admission numbers remained remarkably low:

By 1826, when national statistics became available in England, only minimal numbers of individuals found themselves in either private or public asylums. Not quite five thousand insane people confined in any form, 64 percent of them in the private sector, 36 percent in the public. Bethlem and St Luke's together numbered only 500 patients, and a further 53 insane individuals were in jails – this in a country of 10 million people. (Shorter, 1997: 5).

In accord with the new spirit of optimism towards the asylum as curative as opposed to segregatory and punitive, the view that insanity could be retrained into rationality manifested itself in a form of care known as 'moral treatment' as exemplified by William Tuke's institution for mentally ill Quakers, 'The Retreat' at York in 1729. Here the emphasis lay equally upon firmness but kindness in dealing with the antics of the insane, helping them to conform to the boundaries of rational behaviour and civil discourse, with work playing an important part in occupying hands and minds (Black, 1988: 2). Moral treatment was not applied to the mentally ill alone, for in the American colonies it was also considered appropriate care for physical illnesses in which there was displayed as

considerable a concern for moral and spiritual aspects as for physical rehabilitation (Luchins, 1989: 586). Due to admissions being based more on 'social and moral criteria than on the nature of the person's illness' hospitals in the late eighteenth and early nineteenth century were regarded as highly stigmatising charitable institutions (Luchins, 1989: 587). Moral treatment in hospitals, similar to asylum care under the same philosophy, emphasised the removal of the afflicted individual from the contaminating influences of their home and peer environment, thus rehabilitating them into 'humane, civil, productive and responsible citizens' able to withstand the 'temptations of their neighborhoods' (Luchins, 1989).

The concept of the *ideal* asylum evolved from the eighteenth up to the twentieth centuries and was seen to be one that was designated into functional areas. These provided, in literally concrete terms, a means for guiding the patient into the orderly rhythms of normality and the building in itself was seen 'to be a critical tool in rehabilitating the lunatic', architecture therefore being built on rational lines for the promotion of rational living (Saris, 1996: 543; Turner, 1992: 60). Lindsay Prior (1993: 26) notes that documentation from as late as the 1940s describes the ideal hospital environment as a completely segregated, self-contained community located in a large, secluded rural area where all categories of patients could be cared for, that included historically not only the mentally ill, but a miscellaneous population comprising of the mentally retarded, the sick, vagrants and criminals (Shorter, 1997:6). The concept of the self-enclosed community offers a chilling description that is immediately recognisable as conforming precisely to

Erving Goffman's definition of the 'total institution' (Goffman, 1968: 296; Goffman, 1991: 11).

The wish to implement humane and rational treatment of the insane could be delivered reasonably well in England and the Empire with only a limited number of individuals in asylum. Unfortunately the early nineteenth century saw a massive rise of admissions, a phenomenon that also occurred in Europe, the American colonies and, as will be seen, at a later date in colonial Malaya as well. The late nineteenth-century asylum would of necessity abandon much of the rehabilitative content of care and more importantly would become increasingly closed communities, heavily custodial and characterised by locked wards; and duly these responses to overcrowding would be re-enacted in asylums in the Malayan regions (Clark, 1966; Standing Nursing and Midwifery Advisory Committee (SNMAC), 1999)

Accordingly Shorter states that within the first decade of the nineteenth century there were sixteen new asylums built in the London area alone, including Colney Hatch which held 2,200 beds and the Hanwell Asylum, West London with 2,600 beds (Shorter, 1997: 34).

What were intended by early Victorian reformers as small country houses to provide refuge for not much more than one hundred inmates had been transformed by the end of the century into sprawling 'stately homes' that behind their elegant facades reproduced the worst conditions of urban overcrowding. (Barham, 1992: xi).

The reason for this enormous increase in the number of detainees in asylums is a highly contested area: for Sutton asylums in England became a 'dumping ground' for the physical and mental wrecks of industrial capitalism (Sutton, 1997: 52). Shorter responds by ascribing the increase to three main factors. Firstly, the enormous rise in neurosyphilis and secondly to a significant increase in alcohol abuse. Finally, Shorter, following Scull, points to a radical change in the structure of the family, which would no longer accommodate the disruptive presence of the insane in its midst (Shorter, 1997: 50; Scull, 1979: 26). While Catherine Lis and Hugo suggest that upper-class families initiated the search for custodial care for unruly, violent and immoral relatives, followed eventually by proletariat families and this largely on economic grounds that asylum admission would represent only a temporary suspension of labour particularly in the case of men (Lis and Soly, 1996: 200).

2.3 Psychiatry and colonialism

Sashidharan and Francis note that the eighteenth century saw not only the development of the new profession of psychiatry but also of theories about race and morbidity that informed early views of psychiatry and which continue to preoccupy the profession today (1993: 97). The authors assert that while theories of race were traditionally divided into hierarchical relationships, wherein European superiority was contrasted with the inferior, colonised races, these were now recast as theories of deviance revolving around the descendants of former colonised subjects (Sashidharan and Francis, 1993: 97). The colonial machinery therefore was run through the careful coalition of its essential parts, in

which psychiatry and medicine in general had a vital role to play in the consolidation of the Empire along with bureaucratic administration and the militia (Bhugra, 2001: 50-1).

Accordingly Roland Littlewood questions how colonial administrations were served by the rising profession of psychiatry developing in parallel in colonised regions.

We might note, for instance, some affinities between the scientific objectification of illness experienced as disease and the objectification of people as chattel slaves or a colonial manpower, or the topological parallels between the nervous system and imperial order. Both argued for an absence of higher 'function' or sense of personal responsibility among patients and non-Europeans. (Littlewood, 2001: 9).

In this analysis colonial authorities viewed subject people as being greatly in need of the new science of psychiatry due to their pathologically morbid tendencies and generally benighted and ignorant condition. These practices were therefore viewed as an essential part of the armoury that an imperial state could utilise as useful propaganda in aiding the ambitions of notably, although by no means solely, the British Empire.

Accordingly, Bhugra points out that the development of asylums in colonial India were predicated on European notions of medical hierarchy, management and care and governed over by enlightened, paternalistic and preferably Anglo-Saxon expertise (Bhugra, 2001: 59).

The ideal psychiatrist, like the ideal colonial officer or plantation owner, was a 'father to his children'. (Littlewood and Lipsedge, 1989: 10).

Furthermore however, in India the growth of asylums paralleled historical turmoil and was consequently built in areas of social unrest with a high colonial presence (Bhugra, 2001: 57). McCulloch in turn notes the increase in asylums in the European context and the corresponding growth of patient populations in relation to the analyses of the social control of the working classes. He argues however that this has little relevance to the development of the asylum system in the colonies where other issues tended to predominate (McCulloch, 2001: 87). Furthermore the author goes on to observe that in contrast, the building of asylums in the outback regions of colonial Africa symbolised a wish to emulate the 'civic virtues' of distant metropolises as well as expressing a need to control expatriate as well as indigenous deviancy (McCulloch, 2001: 79).

2.3.1 Colonial interest in anthropology and psychiatry; the arbitration of deviancy European observers have long entertained an anthropological interest in regional phenomena and their effects on local Third World populations. At the turn of twentieth century Emile Kraepelin, for example, carried out extensive travels in Java and Malaya noting regional manifestations of mental disorder (McCulloch, 2001: 78). Likewise throughout most of his career in Sarawak Dr. K.E. Schmidt the 'Government specialist alienist' and director of the former Sarawak Mental Hospital was busily engaged in the study of the ethnic and cultural peculiarities amongst patient populations (Chiu *et al.*, 1972; Nissom and Schmidt, 1961; Schmidt, 1964; Schmidt, 1967). While pathological conditions exerted a fascination for Europeans, the conditions of women in relation to mental disorders were subsumed under those of generic male conditions, with rare

exceptions such as that shown towards the phenomenon of *latah*¹ (Winzeler, 1995: 12). Accordingly Laura Stoler, in reference to Edward Said's analysis of *Orientalism*, indicates that Asian women preoccupied the fantasies of 'the imperial voyeur' in a different context from that which tended to animate the amateur anthropologist of this period (Stoler, 1991: 54).

Colonial enthusiasts, both contemporary and historical, have long expressed curiosity about such local phenomena as *koro*² and *amok*, in the nineteenth century, these were being increasingly viewed as simply bizarre local manifestations of known European disorders, albeit demonstrated at a more basic, primitive level (Littlewood, 2001: 2). Winzeler (1995) goes on to argue that this perceived tenuous commonality with Europeans and their mental disorders would not suspend European value judgements concerning Malayan people and their propensities towards mental illness.

In Malayanist versions of Orientalism, sensuality and femininity... were seldom raised, but instability was given great emphasis. It was axiomatic that Malays, Javanese and other Malayan peoples were by nature 'sensitive to the slightest insult,' 'volatile,' preoccupied with maintaining balance and composure and so forth. Such psychological tendencies were held to be in part a matter of inherent character and in part a consequence of despotic political rule and a rigidly hierarchical social order that was to be changed through the creation of a new way of life under European guidance. (Winzeler, 1995: 4).

¹ Defined as a nervous affliction characterised by involuntary verbal and bodily repetitions, frequently obscene in nature.

² Defined as an extreme state of anxiety, which can create an epidemic of hysteria in Chinese populations, concerning the conviction that the sufferer's genitals or nipples are fatally shrinking and receding into the body.

In this analysis therefore colonial rule could be seen as imposing a fundamentally civilising and benevolent force on territorial possessions that would sweep away regional and traditional tyranny and bring order and medical help to local populations. The issue of *amok* demonstrates this point in its description, as attributed to an English physician in 1891, as being a 'blind furious homicidal mania' that was 'peculiar to the Malay race' (Jin Inn Teoh, 1971: 20).

Amok was considered not only a disorder of the Malay (as well as the Javanese) individual but one that was peculiar to men and dishonoured men at that.

When the Malay feels that a slight of insult has been put upon him ...He broods over his trouble, till, in a fit of madness, he suddenly seizes a weapon and strikes out blindly at everyone he sees - man, woman or child, often beginning with his own family. (Swettenham, 1906: 143).

By contrast, *latah*, in its passive, imitative, non-voluntary and mechanical manifestations was seen as primarily a disorder of Malay and eventually Dayak women (Spores, 1988; Winzeler, 1995). Western responses to *amok* varied with divided opinions of whether this sort of indiscriminate slaughter could be classified as plain crime or insanity, medical opinion eventually veering towards the latter (Littlewood, 2001: 2; Hatta, 1996; Spores, 1988: 108). Commensurate with Winzeler's point, for Spores the gradual demise of *amok* was related to the enormous social changes taking place in feudal Malaya through the imposition of colonial law and order. Combining this with the medicalisation of *amok*, resulted in colonial authorities branding the *amok* runner a lunatic rather than notorious anti-hero, with all the associated stigma that this conjured up for Europeans and imparted to colonial subjects (McCulloch, 2001: 86).

The colonial psychiatrist therefore found himself in the powerful position of becoming the undisputed ‘arbiter of deviance’, redefining behaviours previously thought of as little more than local oddities towards classifications of mental disorders, from mild neuroses and hysterias, to the seriously deviant and criminally insane (Romanucci-Ross, 1997a: 18).

Psychiatry, with its function of defining, maintaining and ‘treating’ psychological disorder, often identified in the context of social disorder, provides the scientific basis and the legislative and therapeutic justification for a particular approach in dealing with madness. Furthermore, by asserting its expertise in dealing with madness, psychology provides the glue that binds the individually deviant behaviour in the socially sanctioned procedures for incarceration (Sashidharan and Francis, 1993: 98).

Psychiatric opinions could therefore be seen as a useful tool in aiding and empowering colonial authorities to apply methods of control towards labelled deviant individuals on the grounds of civil order.

2.3.2 Critiques of colonialism in modern psychiatry

The anthropological and medical curiosity towards regional behaviours reframed as ‘mental disorders’ continue to excite psychiatric interest for Western and Western-trained psychiatrists (Chiu *et al.*, 1972; Mo Gang-Ming *et al.*, 1995; Tsoi and Kok, 1995: 275-6).

In the mid to late twentieth century interest in the so-called ‘culture-bound disorders’ has generated large-scale research intent on establishing classifications that are strongly reminiscent of the endeavours of colonial psychiatry:

The extent to which such patterns could be fitted into a universal schema depended on how far the medical observer was prepared to stretch a known psychiatric category. (Littlewood, 2001: 4)

Consequently the interest in culture-bound syndromes can be read as providing continuing examples of perceived 'otherness' for Western observers, which become dislocated from the meaning associated with their manifestations (Cohen, 1999: 14-5; Warner, 1996). Culture-bound syndromes are viewed as strange exotica and reinterpreted within a framework of classification to make them more intelligible to unfamiliar audiences. According to Naomi Selig (1988: 96) the spate of cross-cultural psychiatric studies looking at the incidence of schizophrenia globally in the 1960s continued to exemplify the modern day 'colonial stance' (Jablensky, 1995; Leighton and Murphy 1966; Read, 1966; Savage *et al.*, 1966).

The attempt to identify universals in mental illness formed the basis of the World Health Organization (WHO) International Pilot Study of Schizophrenia in 1966. A significant finding to come out of this report was that, contrary to expectations, diagnosed schizophrenics in some developing countries had a better prognosis of recovery than those in the developed countries of the West. A follow-up study two years later supported this finding (Sartorius *et al.*, 1977). Other psychiatric studies in cross-cultural variables have specifically attempted to focus on the connection between psychiatric disorders and the 'sociocultural' environment using very large statistical samples of 'different groups of people' (Leighton and Murphy, 1966: 3). Both the WHO report of 1966 and cross-cultural psychiatry have been subjected to sharp criticisms, largely on methodological grounds. Arthur Kleinman (1988: 14-15) points out how disease has been

schematised into professional taxonomies, which when applied cross-culturally have fallen methodologically foul of what he describes as the 'category fallacy': that of applying cultural specific diagnostic nosologies onto culturally diverse samples (Bose, 1997: 2). This unwarranted application of nosologies persistently ignores the underlying point that *biomedicine* itself is merely another form of ethno-medicine but is nonetheless 'treated as a universal construct' (Nichler, 1992: xii) (Crandon Malamud, 1997; Fabrega, 1989; Loustau and Sobo, 1997). This underlying assumption is clearly conveyed by descriptions of cross-cultural psychiatry:

As an underlying principle (my italics) we take an attitude of inclusiveness in these regards just as we do in dealing with the range of psychiatric phenomena as defined by Western thought...it seems unnecessary to waver in the face of cultural relativism as though we completely lacked valid standards of functioning.' (Murphy and Leighton, 1966:12-13).

In consequence Dawn Terrell highlights the basic assumption of the study: that there is a universal identification of abnormality, which provided the baseline for the study, and effectively begs the question by so doing (Terrell, 1994: 135-6).

In connection with these points and in reference to contemporary black dissent regarding psychiatric practices and assumptions in the West, Chakraborty argues that for the most part modern psychiatry has failed to grasp the implications of ethnicity and continues to interpret cultures from a Western ethnocentric viewpoint only.

For most psychiatrists culture has meant odd happenings in distant places that did not apply to them. The difference that they found in other cultures was ascribed to childlike behaviour, magical thinking, or inferior social or psychological development. Old healing traditions were thought to be unscientific; healers were

judged to be abnormal or psychotic; and handbooks were written on how to study psychiatric symptoms among 'natives'. (Chakraborty, 1991: 12).

Fernando *et al.* (1998: 52) argue that contemporary as well as historical psychiatry continues to be a powerful instrument of social control of perceived and labelled deviants in society and go on to take issue with the racial bias that is built into psychiatric diagnosis. This, the authors contend, adopts stereotypic assumptions concerning the inherent alienness, inferiority and dangerousness of black people leading to custodial care (Fernando, 1995: 32-3; Fernando *et al.*, 1998; Nazroo, 1997: 3; Rack, 1982: 104). In this way racist assumptions from the past inform the present, and duly resonate with Littlewood and Lipsedge's point that the primitive being is already 'in a sense ill', or in other words, infantile and maladjusted and therefore less prone to mental illness (Littlewood and Lipsedge, 1989: 34). Accordingly Kleinman (1988: 37) recounts that depression has been seen by 'paternalistic and racialist' psychiatrists as uncommon in India and Africa due to, we are led to infer, assumptions concerning the primitive and non-introspective cast of mind of non-Westerners (Fernando, 1995: 31). Such views tally with the observation of Dr Schmidt in describing Land Dayaks as fundamentally superstitious, fearful and 'ignorant' (Schmidt, 64: 142; Schmidt, 1967: 357).

The racist overtones of such views are transparently obvious to modern-day scholars, but the cultural presumptions inherent in contemporary generic biomedicine, embodied in every-day medical practice and malpractice with minority groups, are being increasingly testified to in medical journals (Bhugra, 1997; Bose, 1997; Cohen, 1998; Cohen, 1999; Eskin, 1989; Fadiman, 1997; Hopa, 1998; Littlewood, 1991; McLaughlin and Braun,

1998; Murphy, 1978; Rodenhauser, 1994; Vanchieri, 1998). Furthermore, through historical associations and contemporary training, the racism of ethnocentricity is not confined to the West but is duly exported to other countries. Acharyya, for instance, identifies psychiatric care with modern-day colonialism: whereby 'Third-World psychiatrists' trained in Britain incorporate the dominant paradigm so completely that they find difficulties in evolving new methods of dealing with mental illness within their own culture (Acharyya, 1996: 339). Contemporary critiques of racist assumptions and values in psychiatry form a useful prism to view both modern-day practices in both the West and in former colonies such as Malaysia.

2.4 Benevolent medicine and colonial propaganda in Malaya and Borneo

The rise of the modern psychiatric movement in Malaysia derives its origins from its colonial heritage, whereby Britain as well as the Dutch in what is now Indonesian Borneo (Kalimantan) were busily exporting European concepts of illness and contemporary methods of care to their colonies. It should be noted from the outset that, as discussed in Chapter One, the developments in colonial Malaya were not greatly influential in Sarawak. The position of Sarawak under the Brooke rule can be seen to be an historical anomaly that was not specifically connected to British imperialism in Malaya, but that at the time the settlement of Singapore was counted as part of Crown territories in the Malayan region. The accession of Sarawak to the new Federation of Malaysia in 1963 tied its future firmly to that of the Peninsular, and eventually Singapore claimed independence from the Federation of Malaysia. All this lay in the future however and prior to this period Sarawak evolved at a quite different pace and under a very different

system; in which the development of psychiatry appears to have played a very minor role in comparison to that of colonial Malaya, as will be discussed later in this chapter.

2.4.1 Psychiatry in colonial Malaya

European health care in Malaya was first introduced into urban areas and only progressed to remote rural locations with the expansion of colonial authority (Manderson, 1996: 230). This stands in keeping with general colonial policy that health care should primarily serve the expatriate population, whether civilian or military and in this respect care of insanity was treated in the same spirit, with the siting of asylums in areas of British influence (Bhugra, 2001: 51; McCulloch, 2001: 81). Consequently the first recorded lunatic asylum in Malaya was built near the regimental hospital under the auspices of the colonial authorities in Penang, a Crown possession for some decades since 1786, to cater primarily for syphilitic European sailors (Baba, 1992; Deva, 1992). By 1829 however, there were a mere 25 inmates in the Penang asylum comprising of 23 men and two women, the vast majority being Chinese and Indian. (Eng-Seong Tan and Wagner, 1971: 5).

Commensurate with the rapid expansion of the asylum system earlier in nineteenth century England, the rapidly growing colonial settlement of Singapore saw the sequential building of several asylums (Eng-Seong Tan and Wagner, 1971: 6; Shorter, 1997: 34). Despite colonial concerns that asylums were required in Singapore, it does not imply that the perceived prevalence of insanity was comparable with that of England in 1900 where it was almost 30% higher than in the Singaporean community (Jin Inn Teoh, 1971: 22).

By 1887 however an English psychiatrist by the name of Gilmore Ellis³ was appointed to take charge of a newly built asylum in the recently established colonial settlement of Singapore. This building constructed in 1885 on the Sepoy Lines replaced the original asylum built in 1862 which apparently had been built to cater for a predominantly Asian migrant labour following a murder at the local gaol. A further institution was opened in Penang in 1860 but this did not remain for long, with the Sepoy Lines asylum at Singapore being subsequently obliged to absorb their internee population following closure (Murphy, 1971). The next institution on Peninsular Malaya was not established until 1909 when the Central Mental Hospital⁴ was built in Tanjong Rambutan, a few miles from the tin-mining town of Ipoh in Perak (Eng-Seong Tan and Wagner, 1971: 6). This name was later changed to Hospital Bahagia in 1971.

2.4.2 Migration, gender and asylum admissions

Admissions to Ellis' Singapore asylum in the late nineteenth century were noted to come from as far afield as Bangkok and Australia, where, in the latter case at least, psychiatric services were considered to be far more rudimentary (Jin Inn Teoh, 1971: 19). Apart from the Straits Settlements (Penang and Singapore) cases were referred from the States of Johore, Malacca and Selangor; the quality of early psychiatric services in Malaya at this time, therefore, was by no means deficient in comparison with other nations (Jin Inn Teoh, 1971). Even at the original Singapore asylum the number of psychiatric beds per

³ Ellis' name is under a certain amount of dispute; Robert Winzeler refers to him as Gilmore Ellis, whereas H.B.M. Murphy refers to him as Gilbert Ellis.

⁴ Additional confusion exists regarding when the Central Mental Hospital was established. Eon-Seong Tan and Wagner give the date of 1911, but Rostom and Lee state it to be 1909.

capita was roughly equivalent to that of Britain and ahead of America, with conditions for patients considerably preferable compared to the community and institutional abuses of the insane in North America (Murphy, 1971: 14). The types of admission to the new asylum were varied, with the first case of neurosyphilis in the Asian local population noted in 1906. By comparison in England, Shorter argues that neurosyphilis rose to epidemic proportions swelling the numbers of nineteenth-century asylums and resulting in mania, paralysis, dementia and death, with further cases of morbidity due to a rise in alcohol abuse (Shorter, 1997: 55). Accordingly from the beginnings of the twentieth century the socio-economics of the circumstances of the period dictated that 20% of all admissions to the Sepoy Lines asylum were suffering from signs of neurosyphilis. Whilst equally by 1906 in grim comparison it was noted that similarly alcoholic psychosis was beginning to replace illnesses caused by opium consumption (Jin Inn Teoh, 1971: 20).

Prior to Ellis' supervision of the new Singapore asylum the original hospital in Stamford Raffles' Singapore had an enviable discharge rate of 89% with most cases admitted suffering from acute psychotic attacks after the use of opium and other narcotics; this situation was not to last however (Murphy, 1971: 14-5). Madness and ethnicity were already viewed by medical authorities of the time as following certain racially determined lines and consequently Chinese migrant workers were perceived as suffering from their own distinct forms of insanity and increasingly so, as Victor Purcell states:

Insanity among the Chinese was attributed to drinking, opium-smoking and gambling, and in some measure to speculation ... Chinese lunatics suffered from dementia mostly, whereas the other races had mania, the former being due to gambling and opium-smoking. (Purcell, 1948: 65).

Gambling, use of opium and more notoriously venereal diseases were a feature of life for nineteenth-century colonial Malaya where migrant labour was overwhelmingly made up of male Asian workers from China and the Indian subcontinent. These men were largely brought to work in tin mines, on estates and railways, and in small private enterprises although in Sarawak Chinese farming skills were sought (Chew, 1990; Eng-Seong Tan and Wagner, 1971; Manderson, 1966). Whilst by contrast immigrant women were largely brought to work in brothels serving Asian migrant and white expatriate masculine needs (Manderson, 1996: 166). Prostitution however, carried its own penalties in the form of syphilis, which was initially a rare occurrence amongst non-Europeans.

General Paralysis of the Insane, a syphilitic infection of the brain which causes insanity, was never seen among Asiatics. Practically all cases were among those of European stock and it was then considered that the disease was peculiar to Europeans only and was a disease of civilised life running at high pressure, (Jin Inn Teoh: 20).

The inference here being that the *pressures* that the white expatriate community suffered from were similar to those of the Asian expatriate community whereby socially sanctioned conjugal relationships were unlikely in a social environment characterised by a lack of eligible females. British civil servants in Malaya, in common with other colonial regions, required permission to marry from their employers and this only after many years of service, which consequently gave rise to the institution of concubinage of local women (Stoler, 1991: 58). This, Stoler argues, was an expedient policy that preserved the health of expatriate males and helped to secure their continued employment and contentment in foreign regions (1991).

In relation to this point, Jin Inn Teoh notes that the majority of admissions to the Singapore asylum at this time were in an appalling state of health with women admissions, few though they may have been, in the worst physical condition of all (1971: 19). A plausible inference may be drawn under the circumstances that these were due to the ravages of a life of prostitution and its concomitant hazards, as much as from any other form of disease and hardship.

The low admission rates in Singapore at the turn of the nineteenth century have been in part attributed to the low percentage of women admissions, and this in turn due to very few numbers of women per capita in the community at this time (Jin Inn Teoh, 1971: 22). This has been estimated as standing in the region of three women to every 10 men, and as such represents a comparable situation to that of other conurbations of British influence in colonial Malaya during this general period (Eng-Seong Tan and Wagner, 1971: 5; Jin Inn Teoh, 1971: 16). This is a significantly interesting observation in its resonance with feminist studies of admission rates of women in England during the era, whereby according to Jane E. Kromm (1994), it denoted 'a clear shift in the understanding of madness as a gendered disorder'. She goes on to argue that theatrical and pictorial representations increasingly depicted woman as the embodiment of madness in various postures of *melancholia* as opposed to *mania* (Kromm, 1994: 507). Furthermore Showalter argues that the over-representation of madness amongst women was far from being merely a nineteenth-century and twentieth-century phenomenon, but existed from the seventeenth century onwards (Showalter, 1985: 3).

Denise Russell, in support of Kromm's assertion that there existed a preponderance of women in public mental hospitals in the nineteenth century, considers the late eighteenth-century interest in 'specifically female problems' as an origin of perceiving insanity as a gendered condition (Russell, 1995: 18, Showalter, 1981; 315). It is argued that these forms of feminine pathology were dominated by the medical preoccupation with female sexuality and moral purity; and which continues as a dominant discourse in relation to the labelling of women as suffering from mental illness (Barnes and Bowl, 2001: 72; Ussher, 1991: 71).

Joan Busfield (1994) however contests the assertion of overwhelming numbers of nineteenth-century women in asylum care and instead asserts that at least in relation to that century the empirical evidence pointing to proportional differences between male and female admission data is quite small. Statistical evidence notwithstanding, Jin Inn Teoh's comment is striking in conforming to some extent to the assumption that in the asylum system diagnosed insanity and high admission rates depended heavily on the institutionalised perception of woman as essentially associated with the likelihood of derangement.

Yet the Victorian era marked an important change in the discursive regimes that confined and controlled women, because it was in this period that the close association between femininity and pathology became firmly established with the scientific, literary and popular discourse: madness became synonymous with womanhood. (Ussher, 1991: 64).

While the debate concerning the precise numbers of women in asylum care in previous centuries will no doubt continue, there has been little dissent concerning the claim that there has been a predominance of women diagnosed with mental illness in the twentieth century (Miles, 1988: 2; Ramon, 1996: 85; Ussher, 1991: 163). Phyllis Chesler baldly states that more women are being hospitalised with a diagnosis of mental illness than 'at any other time in history' (1996: 46). These diagnoses are, she argues, predominantly affective depressive disorders in keeping with women's subdued and passive presence in society (Chesler, 1996) (Busfield, 1996: 100; Redfield Jamison, 1996: 122; Russell, 1995: 31). Chesler goes on to allude to the continuing dichotomised perceptions that have persisted, lying between the socially accepted, rewarded but inadequate role of the passive, melancholic female and her antithesis, that of the deplored voluble, 'aggressive', masculinised female counterpart.

When female depression swells to clinical proportions, it unfortunately doesn't function as a role-release or respite. For example ... 'depressed' women are even less verbally 'hostile' and 'aggressive' than non-depressed women; their 'depression' may serve as a way of keeping a deadly faith with their 'feminine' role. (Chesler, 1996: 51).

Wetzel (2000) in turn, in agreement with Jennie Williams (1999), argues that in both the developed and developing world, conditions of oppression affect women living in patriarchal societies, such as Malaysia. These forms of oppression towards women include low status, poverty and exploitation, sexual violence and other acts of human rights violation (Barnes and Bowl, 2001: 74, Wetzel, 2000). While other critiques have noted the relationship between mental distress and the oppressive features found in the institution of marriage as well as that of the role of motherhood as apparent risk factors

for women (Ramon, 1996: 86; Ussher, 1991: 166) and accordingly have resulted in a global bias towards a high risk of diagnosis of mental illness and admission to institutional care.

Long term psychiatric intervention (based upon psychosexual theories) has been inappropriately applied to women throughout the world, when their real problems were poverty, violence and economics. (Wetzel, 2000: 209).

The global bias towards the labelling of women as suffering from mental illness and consequently the high rates of admission of women into psychiatric care has a clear relevance in relation to this study (Gomm, 1996; Rosenham, 1993; Scheff, 1996: 65 Szasz, 1974). Admission rates based on gender variables as recorded in hospital records are therefore considered in the thesis as offering important supplementary data in addition to the ethnographic exploration of the perception of women patients towards their admission and internship at Hospital Sentosa and are duly discussed in Chapter Five.

2.4.3 Migration, ethnicity and mental illness

A further issue of interest lies in the ethnic breakdown of admission rates during this period and succeeding decades, whereby it has been noted that in 1900 in the Singapore community, asylums were composed of Chinese and Indian migrants who formed the vast majority of inmates (Jin Inn Teoh, 1971: 28). It is claimed that this situation continued over the next century and was comparable with other asylums in Malaya, such as, in Penang (Eng-Seong Tan and Wagner, 1971: 2). In view of this, indications of ethnic bias in terms of patient admission at Hospital Sentosa are reviewed in Chapter

Nine in relation to respondent accounts and where relevant are supported by contemporary hypotheses and critiques.

These critiques contend that migration, cultural dislocation and the consequential separation of individuals from their supportive networks play a significant role in the ethnic bias of psychiatry that in Britain witnesses a predominance of British-born men from African-Caribbean background diagnosed with schizophrenia (Acharyya, 1996: 341; Barnes and Bowl, 2001: 80; Nazroo, 1997: 3; Rack, 1982: 104). Furthermore an interesting aspect of the escalated ethnic presence in psychiatric services noted in Britain, and which appears to hold significant import for modern Malaysia, is that subsequent generations are also at greater risk of diagnosis and hospitalisation despite a level of familiarisation and acculturation in the adopted alien culture (Barnes and Bowl, 2001: 83-4). This said, Shulamit Ramon (1996) highlights the issue of class as being a further factor to consider along with ethnicity and migration. Whereby elements such as education and, presumably, upward social mobility can act as protective factors countering the effects of migration and cultural dislocation (Ramon, 1996: 77). Suman Fernando however draws a general conclusion of institutionalised racism encountering cultural difference; while others have considered the phenomenon in terms of actual illness and social stressors (Fernando, 1995; Fernando, 1999). In this vein Ajita Chakraborty condemns the 'value-based and often racist undercurrents in psychiatry' and goes on to note the fundamental tolerance of mental illness amongst families in India, with the inference that stigma is a persistent effect of Western colonial values (Chakraborty, 1991: 1208, McCulloch, 2001). This in turn tends to corroborate the

psychiatric assumption that most South-Asian psychiatric patients in Britain have a supportive family network and enjoy, what Nazroo describes as a 'protective culture', therefore having fewer mental-health needs than other immigrants (Nazroo, 1997: 7). Thus resonating with Jin Inn Teoh's assumption that separation from 'stable and emotional family support' represented a significant risk factor for Indian male migrants in colonial Malaya (Jin Inn Teoh, 1971: 28).

Finally, in contemporary Britain Chinese psychiatric service users are equally subject to stereotyping in terms of the assumption that they enjoy a supportive and insular family network, leading to the relative abandonment of carers by the support services (Yee and Shun Au, 1997: 41). In view of the Chinese diaspora and the issue of Chinese asylum admissions in colonial Malaya and Borneo, these latter day assumptions may contain useful references in understanding the position of Chinese patients in the modern Malaysian psychiatric institution, as is represented by Hospital Sentosa (Kleinman, 1998b: 38).

2.4.4 Care regimes in the therapeutic asylum in Malaya

Back in nineteenth-century Singapore, Ellis brought with him contemporary notions of therapeutic care, that involved rehabilitative exercises, such as occupational labour that in keeping with British values of the day, were in all likelihood gender normative, which for women revolved around the skills of the good housewife (Gittins, 1998: 107; Showalter, 1981: 321; Witz, 1992: 12-13). Ellis apparently diverted a considerable amount of

Victorian energy and new enthusiasm to improving conditions for the mentally ill commensurate with up-to-date British practices:

In the first year he abolished strait jackets, got 87% of the patients occupied in one way or another, usually at rope-making or weaving in the workshops, instituted a new and better system of record keeping, prosecuted an attendant for ill treating a patient, and arranged for a Chinese *Wayang* to come and give entertainment. (Murphy, 1971: 16.)

Nor was rudimentary after-care of discharged patients neglected; however despite all these therapeutic improvements, Ellis could not prevent a very high death rate from cholera and beri-beri amongst inmates. Acute cases with a rapid discharge rate were not typical admissions, as had been seen in the earlier Singapore institution, now psychiatric chronicity and physical morbidity were the main characteristics of patients at the new asylum, a situation that would be replicated in the later running of psychiatric hospitals of colonial Kenya in the 1920s (McCulloch, 2001: 82; Murphy, 1971: 19). The high mortality rate caused by cholera and beri-beri epidemics ravaged the internee population and were brought under control only to be subsequently replaced by syphilis and tuberculosis, so that the death rate was never below 20% and on occasions rose to 50% of admissions. Ellis's response was not complacent, where his own scientific investigations failed saltwater baths and the curative effects of visits to the seaside succeeded in reducing the mortality rates quite considerably (Murphy, 1971: 17-8).

In subsequent eras, these fairly benevolent regimes would be overtaken by new forms of treatment such as insulin coma therapy and lobotomy that as Tai-Kwang Woon dryly notes, 'did not bring any transient hope to the patients or stirred the enthusiasm of the staff' (1971: 31; Ramon, 1988: 8). The author (1971) goes on to note that medication was used to subdue and control patients, and where this failed, restraints in the form of strait jackets were applied. While in the case of Hospital Sentosa treatment included liberal uses of electro-convulsive therapy (ECT) supplemented by sessions of psychotherapy under the regime of Dr Schmidt, as will be discussed further in Chapter Seven in relation to patient narratives (de Jong, 2001: 139; Fennell, 1996: 140; Schmidt, 1961: 157-8).

Ellis's contribution to psychiatric care in Malaya can be seen to have been very much based in the tradition of moral treatment, whereby humane treatment and structured activities were seen to be a highly necessary component in achieving a 'cure'. Unfortunately these early improvements were not sustained and deterioration in care in association with larger admissions began to take place (Jin Inn Teoh, 1971: 15). In the West the loss of the earlier optimism towards affecting a cure for mental illness caused demoralisation amongst pioneering psychiatric professionals towards the end of the nineteenth century (Shorter, 1997: 191). This loss of vision could also be seen to be taking its toll on the standards of care even in the new Singapore asylum during this period. By 1909 Ellis had left to take up a new post as Chief Medical Officer in the settlement and a new chapter was opened in psychiatric care in colonial Malaya (Jin Inn Teoh, 1971).

2.5 Borneo: disease, disasters, colonial rule and colonial medicine

Our best accounts of the development of Western medicine *per se* can be found amongst accounts of Dutch imperialism in Borneo and these are very largely concerned with predominant diseases and their impact on local populations, rather than the more esoteric area of mental disorders, which are referred to in passing only. This is not to suggest that there existed a dearth of alternative treatment in this region during this period of Dutch imperial expansion. On the contrary, the literature indicates that there was already a wide variety of healing traditions in Borneo and likewise in Malaya (Gullick, 1987; Humholtz, 1991). The degree of competition between the diverse 'healing specialisms' remains unclear although Lenore Manderson in discussing the Malayan region generally asserts that colonial authorities were usually tolerant towards plural medicine, since this removed responsibility from the authorities, which could then continue to rest with the local communities (Manderson, 1996: 22). Writing in the mid-twentieth century Nissom and Schmidt (1967: 357) used local Bidayuh folklore to suggest that amongst this populous Dayak group mental illness has traditionally been regarded as rare, unavoidable and virtually predestined with few precautions available other than the observation of *patang* (taboo) rules. Schmidt (1964) further claims that the importance of traditional healers in dealing with mental illnesses should therefore not be underestimated and commensurate with Manderson's argument, should be viewed with tolerance.

As mental health workers in other parts of the world, it has become clear to us in Sarawak also, that native healers play an important part in the treatment especially of mental illness. They have done so successfully for centuries before modern scientific psychiatry ever came to the Sarawak scene. (Schmidt, 1964: 150).

As a point of interest, contemporary research continues to confirm that the use of traditional healers amongst the main ethnic groups of Malaysia (and the region in general) is far from being in danger of disappearance, (Barrett, 1993; Barrett, 1997; Bentelspacher *et al.*, 1994; Eskin, 1989; Fidler, 1993; Kleinman and Song, 1979; Laderman, 1992; Laderman, 1996; Laderman 1997; Lewis, 1995; Li, S. *et al.*, 1990; Pandian, 1991; Read, 1966; Silverman, 1967; Warner, 1996; Wintersteen *et al.*, 1997; Westermeyer and Kroll, 1978). Furthermore traditional healers, who are often greatly respected individuals, can be found practising across ethnic divides and often continue to be the first recourse for patients rather than conventional biomedicine, and this holds true for psychological concerns as much as purely physical complaints (Ashencaen Crabtree and Chong, 1999; Crandon Malamud, 1997; Razali, 1995; Razali *et al.*, 1996; Razali, 1997).

2.5.1 Imperialism and the propaganda of European medicine

To return to nineteenth century Borneo however, it would be untrue to assume that the colonial authorities were complacent about leaving health care to local practitioners and they appear at times to have made strenuous efforts at times to improve health. Dr. A.W. Nieuwenhuis, a Dutch physician in Western Borneo from 1891-1901 describes the scourge of malaria, smallpox, cholera and other virulent epidemics, which badly affected the local population in geographical pockets. Influenza, dysentery, skin diseases and notoriously syphilis, the unwelcome by-product of exposure to colonial trade, also took a heavy toll in terms of morbidity and mortality. Successful treatment, according to the author, assured good relationships towards the foreigners, facilitating compliance towards

Imperial rule, and to paraphrase Manderson, reinforcing the ‘moral authority’ and superiority of Western science over indigenous paradigms (Manderson, 1996: 231).

Treatment with antisyphilitica often gave striking results, pains which had been felt for years being relieved and finally cured. This undoubtedly contributed in just as great a degree as the distribution of quinine, towards winning the confidence of the Dayak tribes of Central Borneo in the Europeans, and towards making my scientific trips a success. (Nieuwenhuis, 1929: 16)

Whilst the benevolent ‘scientific European as representative of his civilisation’ was engaged in dispensing *free* and *modern* health care, Nieuwenhuis spares no pains in drawing a contrast between European science and local charlatans amongst the Malay and Chinese selling ‘quack medicines’ to the ingenuous Dayak to assure themselves ‘of an excellent source of income’⁵ (Nieuwenhuis, 1929: 33).

2.5.2 Anxiety and isolation: stress in local populations in Borneo

During the nineteenth century the low and even falling population density of Borneo was noted with concern by the colonial powers as an anomalous situation compared to the rest of the region that threatened to deplete the labour force available to them (Knapen, 1997).

Han Knapen records that consequently the authorities suggested with disapproval that this was probably due the assumed practice of infanticide or to Dayak women’s renowned expertise with birth control rather than through the series of natural and human-caused disasters that plagued the region (Knapen, 1997: 70; Knapen, 1998).

Floods and droughts caused widespread destruction as did epidemics while warfare and

⁵ Coastal Malay practitioners gained control over effective forms of treatment, such as variants of vaccination introduced by eighteenth century Chinese or possibly the later Dutch, which used exposure techniques to the pus or skin crusts of infected smallpox patients. Malay practitioners notoriously charged local Dayak people exorbitant amounts for this uncertain treatment (Knapen, 1998: 79).

headhunting combined with power play and struggles for dominance amongst local and colonial forces contributed to large-scale social upheaval (Knapen, 1997). While the death toll was very high amongst local populations, the colonial presence was also very badly affected by disease, as were indeed other migrants including the Chinese (Chew, 1990). Knapen (1997; 1998) goes on to say that trade and expansion of the region economically over the centuries was seen by local populations as the main culprit in the introduction and spread of epidemics from increased contact with Europeans, Javanese traders and other non-indigenous groups keen to exploit the wealth of the island⁶. So associated with disease were foreign traders that many Dayak villages took the precaution of extreme isolation to protect themselves from epidemics as well as involvement in local warfare and head trophy taking.

The only option which the Borneans had was to isolate themselves by declaring their villages forbidden territory, closing off rivers with rattan cords or tree trunks, excluding those infected from the village, fencing in their houses or, as a last resort, fleeing or migrating upriver. Nomadic groups like the Punan, of course, had much less trouble isolating themselves from the outside world. There are even indications of their practice of 'silent barter' (as being) a consequence of recurrent epidemics. (Knapen, 1997: 127).

⁶ Although trade expanded in the Borneo region considerably between the seventeenth and nineteenth centuries, the local population of Borneo has always relied on trade for essential and luxury items. Some of the most exciting artefacts traded vigorously between the twelfth and eighteenth centuries were ceramic ware from China, Vietnam and Thailand, these being highly coveted items for their practical and decorative possibilities (Harrison, B. (1991) *Pusaka, Heirloom Jars of Borneo*. Oxford University Press: Singapore.

Evidently the great uncertainties of life instilled locals with a deep fear of epidemics and understandably of foreigners as well. Expansion and advancing 'civilisation' brought in its wake the loss of traditional methods of controlling disease while increasing the number of epidemics and accelerating their growth to remote populations (Knapen, 1998: 88-9). Although acknowledging the psychological strains of these traumatic changes Nieuwenhuis, followed eventually by Schmidt (1964), ascribes anxieties amongst Dayak groups as a consequence of the benighted superstitions of individuals at the mercy of forces they could not control.

(Dayaks) Probably suffered more psychologically than physically and have therefore become extremely afraid of their natural surroundings ... Like many other tribes they ascribe this to an army of spirits which they imagine exist in all prominent places. Misfortunes, disease and adversity are regarded as punishments inflicted by these spirits at the command of the chief god, for offences committed on earth. Influenced by this conviction, they have developed their *pantang* system (taboo rules) and foretold belief until it dominates their lives. (Nieuwenhuis, 1929: 26)

Epidemics and natural disasters combined with the low population interfered with the expansion plans brought by the colonial powers. The background to the *enlightened* medical care which physicians like Nieuwenhuis brought to Borneo from Europe camouflages the economic interests that the Dutch had vested in exploration and colonisation. The imperialistic expansion of the Dutch found a counterpart in the equally determined expansion of the British Empire using similar tactics of paternalistic and benign medicine as envoys of peaceful intent and civilising rule. Manderson however identifies the liberal offering of European health care towards indigenous people as intimately connected with vested economic interests of Empire building.

Medicine is exposed as participating in the expansion and consolidation of political rule through its service to political, commercial and military arms of empire, leading to campaigns to conquer diseases that threatened the integrity and economic potentiality of the state, and to the systemic delivery of sanitary, health care and medical services. (Manderson, 1996: 5).

In Borneo Knapen, for instance, comments on the Dutch attempts to actively suppress headhunting out of humanitarian and economic concerns, a similar move to that carried out by James Brooke on the other side of the island (Knapen, 1997: 132). Similarly, epidemics caused not only death but also the full-scale evacuation of people from their homes, much to the despair of colonial plantation owners who were reliant on local labour (Knapen, 1979: 2).

It would seem therefore from these accounts that the main preoccupation, in the Borneo region at least, was the exposure of communities to virulent epidemics with further repercussions brought by political domination, debt slavery, localised warfare and trophy head-hunting taking a toll on the security of besieged communities. The prevalence of mental illness amongst individuals is therefore uncertain and little remarked upon in accounts but it is likely to have held a low priority as a health issue compared to the physical hazards that seem to have been a yearly event in which women and children were considered to be the most vulnerable to the psychological strains of uncertainty and fear (Nieuwenhuis, 1929: 26). The local population would however remain unacquainted with the trappings of civilised colonial rule in the shape of asylum care until the twentieth century. Kuching boasted of its first psychiatric institution in the 1920s under the latter

days of the Brooke dynasty, culminating in the Sarawak Mental Hospital, the site of the present study, which was built in 1957.

2.6 The demise of the ‘therapeutic’ asylum in pre and post-war Malaya

Prior to World War II three further psychiatric institutions were built following the example of the Central Mental Hospital in Perak. In 1933 the State of Johore, a sultanate under British suzerainty, established first of all a lunatic asylum and in 1935 a psychiatric hospital to absorb the overspill of admissions. In the Borneo States of Sarawak and Sabah, two further hospitals were built in the period leading up to the 1950s⁷, one of which is the site of this study (Eng-Seong Tan and Wagner, 1971: 6-7). By the Second World War the huge numbers of admissions had severely compromised the quality of care in asylums:

The concept that mental hospitals were asylums first and hospitals second probably led to the centralisation of facilities and huge catchment areas covering hundreds of miles. Thus patients with mental illnesses were transported by trains with escorts from all over the country ... The separation from families and its ill effects as well as that of long stay were not seen as problems. (Deva, 1992: 500).

Finally, Tai-Kwang Woon records a dark hour for Malaya’s psychiatric care following the invasion of the country by Japanese troops during World War II and the subsequent retreat of the British and Australian forces (1971). In the cities looting and anarchy

⁷ Unfortunately in the early decades following Independence large quantities of original documentation pertaining to psychiatric resources in the Kuching area prior to the building of The Sarawak Mental Hospital were irretrievably destroyed following the orders of the State Health Authorities.

reigned with a skeleton staff remaining to care for the patient population nonetheless. The death rate for patients caused by abandonment, starvation and gross neglect was enormous. The author estimates that 3,800 patients alone died at the asylum at Tanjong Rambutan, Ipoh under Japanese occupation and many female patients were kidnapped with, no doubt, grim results for there is no record of their safe return (Tai-Kwang Woon, 1971: 34).

2.6.1 Post-war modernation in the Federation of Malaysia

Following the war the asylums were once more inundated with patients overwhelming the disproportionately small staff numbers. In contrast with the dedicated improvement that had taken place in the past, the condition of, for instance, the Central Mental Hospital, Perak was rife with incompetence and malpractice, a situation by no means unusual in British asylums of this period either as has been attested to by former inmates (Bell, 1996; Eng-Seong Tan and Wagner, 1971: 6; Jane, 1996; Laing, 1996). These institutional abuses indirectly led to a Royal Commission of Inquiry in 1957 resulted in the discovery of various forms of malpractice taking place in the rigid hierarchy of asylum care. The culmination of these inquiries led to further investigations and recommendations for improvements by the World Health Organisation in 1960 (Deva, 1992; Deva, 1995).

By the time of Sarawak's accession to the Federation of Malaysia, apart from the four government-run hospitals, Hospital Bahagia (Perak), Hospital Permai Tampoi (Johore), Bukit Padang (Sabah) and Hospital Sentosa (Kuching) there began a move away from large, centralised asylum care towards community-based care reflecting a global trend and a new level of optimism (Busfield, 1996b; Campbell, 1996; Caplan and Caplan, 2000; Forrester-Jones, 1985; Ramon, 1988; Scheper-Hughes and Lovell, 1986). Decentralisation has to-date resulted in the development of several small psychiatric units in general hospitals now numbering nearly a score and growing. In addition there are now over 80 community-based psychiatric clinics spread unevenly over the country and in Sarawak, although generally regarded as less developed than Peninsular Malaysia, services do not compare unfavourably with those of the mainland. Yet despite the gradual growth of psychiatric resources in Malaysia the number of psychiatrists remains woefully low with a serious shortage of in relation to the recommendation by the World Health Organisation (WHO) which states that there should be a ratio of 1:100,000. The exact number of psychiatrists is in dispute, however it appears that the total number is under 105⁸ but it is known however that in Sarawak the ratio is closer to 1:270,000 with less than half of these psychiatrists in government-run practice (Ashencaen Crabtree and Chong, 2001: 25). Additionally the number of supporting health professionals is correspondingly low, with few trained psychiatric nursing staff and even fewer numbers of psychiatric social workers, evidently indicating that this is an area of care that does not attract skilled and qualified candidates in sufficient numbers (Ashencaen Crabtree and Chong, 2001: 25).

⁸ According to Rostom and Lee the number of psychiatrists is 43, yet the Malaysian Psychiatric Association puts the number as closer to 103.

Nursing and social work are professions stereotypically associated with women in industrialised societies like Britain and Malaysia, and consequently insights in relation to professional work and gender in this area hold a relevance for both countries through historical ties and economic similarities (Carter *et al.*, 1992; Day, 1992; Dominelli, 1992; Williams, 1999). Gittins, for example, notes that in the 1920s psychiatric nursing was seen as a considerably less attractive option for women than it was for male attendants, who found compensations in the 'perks' of the job, such as security, cheap lodging and free uniforms, in comparison with exposure to the exigencies of a depressed post-war economy (Gittins, 1998: 114). Many of these difficulties have not been resolved over time however and in contemporary Britain concerns are expressed that psychiatric nursing retains an unappealing profile and continues to be bedevilled by staffing problems that of necessity impact on patient care (Higgins *et al.*, 1999: 76-7). Noteworthy areas of concern lie in the 'burn-out' and demoralisation of staff working in a 'culture of blame' and managing with difficulty a heterogeneous and demanding patient population in an increasingly custodial and occasionally violent environment (Higgins *et al.*, 1999; Gostin, 1986; Standing Nursing and Midwifery Advisory Committee (SNMAC) 1999: 18). Once again, trends in Britain can be seen to be mirrored in the findings in the study, in which the views of staff at Hospital Sentosa towards such issues as personal risk and career opportunities are considered in juxtaposition with the perspectives of patients.

In conclusion the development of psychiatric services in Malaya, and to a lesser degree Borneo, can be viewed as not only running a parallel course to that taking place in Britain throughout most of its history but also as having been directly predicated upon its examples. The introduction, for instance, of the asylum as therapeutic and basically benevolent foreshadowed its deterioration as a vast and dehumanising warehouse of neglected inmates, while European attitudes towards ethnicity and gender informed psychiatric values and practices in colonised regions. Up to the present time the training of Malaysian-born psychiatrists has been undertaken in the West and philosophies of pathology, care and management frequently imported wholesale to the homeland to be applied to an ethnically diverse and culturally removed population from which psychiatry first emerged.

The fate of women in the psychiatric services in Malaysia however remains obscure and poorly researched, standing against a global picture indicating that women are highly vulnerable to material, sexist oppressions and to being categorised as suffering from mental disorders in significantly high numbers. Once diagnosed and placed in custodial care the experiences of female patients in Malaysia have evidently not been subjected to qualitative, independent investigation, although this may not be so surprising in view of the dearth of information on the experiences of 'service users' as a generic group.

CHAPTER THREE

A FEMINIST METHODOLOGY: PERSONAL DILEMMAS AND CHALLENGES

3.1 Introduction

Feminist methodologies have in general evolved dramatically over the past few decades and now espouse a highly complex and diverse theoretical basis. In view of the enormous scope of this debate, this doctoral thesis seeks to offer a condensed, critical discussion of critiques in relation to a feminist ethnographic approach that is seen to underpin salient issues in this study. The chapter commences therefore with a discussion of male dominated, androcentric perspectives in anthropology, moving towards postmodernist influences in the deconstruction of authority in classical ethnographic accounts. Epistemological concerns relating to validity in ethnography and the development of the self-reflexive approach contextualise the diversity of debate in relation to feminist methodologies. The final section is dedicated towards methodological considerations in this particular study. This utilises feminist critiques in relation to the representation of narratives, accountability and appropriation in reference to my chosen subject matter and methodological approach.

3.2 Anthropology, ethnography and feminism

The conviction of modernity as expounded by the rationalist eighteenth century movement 'The Enlightenment' has been that truth can be deduced through the application of reason and that this process is neutral and value-free, typified by a search for grand, universal theories underpinned by an undisputed science (Marchland and Parpart, 1995: 4).

Such a science has been exemplified by the hypothetico-deductive method and its characteristic of quantitative methodology has long been considered a 'hallmark' of good scientific practice in both the physical and the social sciences (Bryman, 1992: 14-5). In addition to the selection of certain types of data worthy of analysis, the positivist hypothetico-deductive method also asserts a standard of objectivity and clear criteria for the evaluation of these data through trial and error (Hughes, 1993: 73). Latterly such claims have been attacked from within the scientific community and by the postmodernist movement (Feyerabend, 1975: 295; Kuhn, 1964: 96).

Positivist-based standards have created considerable concerns for social scientists in the recent past engaged in, for instance, anthropological research, in their attempts to obtain scientific legitimacy and kudos through association with the dominant vehicle of rationalism. R.F. Ellen (1984) comments on the enormous attention given by social scientists to the discussion and analysis of ethnographic methodology in comparison with colleagues in the physical sciences.

The preoccupation with methodology in social science derives basically from the effort to deal - in one way or another - with the influence of the subject on the object and with the consequences of this influence for the process of knowing and the knowledge yielded. The main methodological problems of social science have thus typically been epistemological problems concerned with the nature of knowledge and understanding and their relationship. (Ellen, 1984: 14)

Prior to getting to grips with the whole question of objectivity and validity, a preoccupation of late twentieth-century ethnographers, anthropologists could by-pass the whole contentious issue by adopting the 'naturalistic' stance. Favoured in earlier forms of ethnography, this was perceived as a way of studying the phenomena without contamination by the researcher. Its covert aim being to emulate or at least counter critique by the positivists (Hammersley and Atkinson, 1983: 6).

'Naturalism' precludes the use of artificial conditions and requires an appreciation of the ecology of the phenomenon resulting in a 'thick' description of a 'culture'. The presence of the researcher is effectively written out from the account and an Olympian distancing of the researcher from the phenomenon is expected to provide the objectivity deemed necessary for validity (Hammersley, 1990a: 22-3). Indeed as Henswood and Pigeon appear to suggest, the absence of authorship appears to be a condition for legitimate ethnographic research.

Naturalistic research ... acknowledges the ways in which research activity *inevitably* shapes and constitutes the object of inquiry; the researcher and researched are characterized as interdependent in the social process of research. (Henswood and Pigeon, 1993: 24)

The relativistic perspective of ethnography enables social scientists to attempt to render an account that celebrates 'the richness of life', an account that is predominantly descriptive rather than being in addition explanatory (Hammersley, 1990b: 17; Hammersley, 1990a: 14). This optimistic endeavour to expose the exotic and bizarre within cultures as a scientific pursuit could, it is posited, create rationality from the most esoteric and opaque of phenomena. To clarify then, the plausibility of the account would lie in its ability to interpret meaning through objective scrutiny and complex and dense descriptions of the minutiae of human interactions.

Classic ethnographic accounts typified the naturalistic stance and attempted to offer a distanced and objective account based on an assumption that the representation of social reality, as van Maanen points out, is essentially unproblematic once a vein of rich data has been located and mined (van Maanen, 1988: 19). Anthropology, a male-dominated academic elite, tended to draw demarcations between the progressive West and the exotic, undeveloped world, in which ethnographic narratives, such as those of Malinowski as a classic example, carried 'the controlling motives and values of Western culture' (Mascia-Lees *et al.*, 1989: 9; Neumann, 1996: 176). It was additionally preoccupied with the social world of men and boys, with women and girls being placed in a generic position as largely incorporated into this world or occupying the footnotes of accounts where gendered differences were noted.

The fallacious distancing of the researcher from the object of research has called into question the inherent power differentials between researcher and the researched. Accordingly anthropology has been accused of privileging certain voices over others, notoriously, as Henrietta Moore (1992) points out, those of women, children, deviant and ethnic groups have been silenced.

They remain “muted” because their model of reality, their view of the world, cannot be realized or expressed using the terms of the dominant male model. (Moore, 1992: 3).

This dominant, masculine perspective has by its very nature excluded the accounts of women in socio-cultural studies (Abu-Lughod, 1990: 12). Such neglect has in turn generated interest in research from a feminist perspective. Traditionally however the female perspective in classic anthropology has often been the province of the ‘untrained’ wives of anthropologists, whose accounts therefore were relegated to the margins of the genre. (Abu Lughod, 1990: 19; Bell, 1993: 5; Visweswaran, 1988: 32).

3.2.1 Postmodernism and ethnographic authority

As Robert Aunger points out in his paper ‘On Ethnography: Storytelling or Science?’ the lack of an alternative ‘voice’ in classic ethnographic accounts has prevented its authority from being effectively challenged (Aunger, 1995: 97). Anthropology has since derived important lessons from the postmodernist influence, which has offered a compelling critique of modernity in its rejection of universal truths and those posited by the ethnographic narrative, which is relegated to the reduced status of ‘fiction’ (Clifford,

1986: 6). The Olympian 'god-trick' is abandoned in favour of heterogeneity and dissent, and in this fractured terrain feminism stakes a claim:

Postmodernist thinkers reject universal, simplified definitions of social phenomena, which, they argue, essentialize reality and fail to reveal the complexity of life as a lived experience. Drawing on this critique, postmodernists have rejected the search for broad generalizations... Above all, they call for the recognition and celebration of difference(s), the importance of encouraging the recovery of previously silenced voices and an acceptance of the partial nature of all knowledge claims and thus the limits of knowing. (Marchland and Parpart, 1995: 4).

Yet this is not to imply that postmodernism itself presents a homogeneous body of thought but rather a trend, which problematizes the concept of universalism and commensurability. Postmodernism and feminism call for an analysis of language as relations of power constructed within the text through, for example, binary oppositions identified in androcentric, sexist accounts, whereby the male and all that is embodied by that, is defined in strong and hierarchical opposition to the female (Beasley, 1999: 9).

By viewing ethnographic accounts as constructed 'fictions', this has enabled relations of power within the discourse of the text to be made explicit (Clifford, 1986: 6; Mascia-Lees *et al.*, 1989: 9). Acknowledging that the ethnographic account can only offer at best a partial and contested truth allows ethnography to be understood as an interpretative endeavour, in which the data are presented as a certain but far from exclusive account (van Maanen, 1988: 35). The bid towards greater transparency and critique of the hegemony of authorship in ethnographic narratives is in keeping with the inherent politics of 'critical ethnography', in which feminism along with Marxism forms a strand:

Critical ethnographers and conventional ethnographers differ fundamentally on the role of the empiricist project. The aim of the critical ethnographer is not to describe a vision of the world as carefully as possible to give outsiders an insider's view, but rather to subject the insider's view to critical analysis for an understanding of the manifestation of political, social and material disempowerment (as the ethnographer sees this). (DeLaine, 1997: 194).

Whilst by contrast with naturalistic accounts theory cannot be 'bifurcated' from method to avoid the charge of not merely sanitizing but of downright distortion (Quantz, 1992: 449). Thus Marxist and feminist perspectives have enabled researchers to take into account the subjective experience of oppression in the lives of respondents and link this to structural constraints and social policies without jeopardising the ethnographic enterprise (Everitt *et al.*, 1992: 20-1; Ramazanoglu and Holland, 2002: 49). Accordingly feminist methodologies utilise 'gender' as a primary category of analysis, this being a unique contribution of feminist scholarship (Harding, 1986: 29; Scott, 1986: 1054). Whilst 'problematics' are generated based on women's experiences of oppression which frame questions concerning the inevitability of women's position within patriarchal systems. Erica Burman posits that the nature of feminist research is centred on the question of what constitutes the criteria of knowledge and the 'gendered orientation' of epistemological undertakings (Burman, 1999: 124). The politics of feminist research are therefore fundamentally concerned with challenging sexist, hierarchical and oppressive practices, these being the conditions under which the feminist researcher herself struggles as well as for those whom she studies (Beasley, 1999: 36; Stanley and Wise, 1993: 59). Judith Stacey summarises the situation in the following way:

Discussions of feminist methodology generally assault the hierarchical, exploitative relations of conventional research, urging feminist researchers to seek instead an egalitarian research process, characterized by authenticity, reciprocity, and intersubjectivity between the researcher and her “subjects”. (Stacey, 1991: 22).

Consequently the struggle of the collectively oppressed complements the perceived need for the critical ethnographic approach to be a moral enterprise seeking to emancipate and in this regard must be seen as an ‘intellectual and moral positionality’ (Ortner, 1995: 173; Simon and Dippo, 1986: 196).

3.3 Feminist ethnography as situated objectivity

The postmodernism fracturing of epistemological certainty in ethnographic accounts has created what Norman K. Denzin refers to as a ‘triple crisis’ for ethnography. Here descriptions of cultures are questioned, as is the legitimacy of the methodology itself, the final problem being that of the dichotomy of text and social transformation (Denzin, 1997: 3-4). Berg posits that ethnography is an inexact science whereby hypotheses can be evaluated in terms of *plausibility* but not in terms of *validity* (Berg, 1989: 52-3). Hammersley responds to this point by asserting that plausibility however, does not in itself mean a valid link has been established between ethnographic theory and the data produced from it. As the reliability of the theory can be evaluated *prima facie* by the frequency of similar occurrences noted within categories inductively, it might not be unreasonable to posit *this* particular theory based on *these* particular observations (Hammersley, 1990b: 18). The argument continues that a critical scrutiny of a wider audience beyond the researcher is needed to evaluate how rigorously and scrupulously

research has been carried out and to this end we need to take into account that we are necessarily part of the social study and cannot be omitted from the account (Hammersley and Atkinson, 1983: 11).

This form of critique, indebted as it is to postmodernist influences, is shared by feminist methodologies, albeit with qualification in regard to the epistemological concerns Hammersley raises, as will be discussed later in the chapter. Here then the feminist researcher is obligated on both moral and epistemological grounds to ‘theorize ... on their own position as situated subjects of knowledge’. Ethnographic accounts do not stand on findings alone but are understood as constructed fictions, subject to the process of ‘textualisation’ of the data, in which, to utilise van Maanen’s (1988: 95) definition, data are subjected to the process of atomisation and classification through analysis (Aunger, 1995: 97). As Hammersley and Atkinson observe:

It is now widely recognised that ‘the ethnography’ is produced as much by how we write as by the processes of data collection and analysis. (Hammersley and Atkinson, 1993: 239).

Through these means, therefore, the attempt is made to address the critique of authorship, authority and cultural representation (Hirsch and Olson, 1995: 3). Yet as Burman points out, reflexivity for feminist research carries specific aims not necessarily shared by other qualitative research methods. Whereby for the latter (as typified by Hammersley’s stance) this may be seen as a means of achieving greater validity of research findings through making a public scrutiny of methods more transparent, for feminist ethnographers self-reflexivity pivots around the issue of accountability and emancipatory

goals as well as that of clarity (Burman, 1999: 124). For feminist ethnographers then the researcher/subject hierarchy is deconstructed through a self-reflexive approach that takes into account the specific properties of gender, class, ethnicity and other variables within the analysis thereby ensuring that:

Thus the researcher appears in these analyses not as an invisible, anonymous, disembodied voice of authority, but as a real, historical individual with concrete, specific desires and interests – and ones that are sometimes in tension with each other. (Harding, 1986: 32).

It can be understood that for feminist methodologies ‘gender’ as a deconstructed, debatable concept opposes the neglect of the oppressed in scholarly accounts and becomes part of a new analytical ‘triumvirate’, including class and race. Yet as Mary Maynard points out, it is unclear what kind of focus should be brought to bear upon the issue of gender, since feminist ethnographies have ranged from exclusively single-sex studies of women to ones with an equal focus on ‘men and masculinity’, the latter being particularly endorsed by Caroline Ramazanoglu and Janet Holland following the position held by Liz Stanley and Sue Wise (Maynard, 1994: 15; Ramazanoglu and Holland, 2002: 147, Stanley and Wise, 1993: 31).

3.3.1 The feminist consciousness and dissent

A further contention is raised once again by Martyn Hammersley who takes issue with what he comprehends as feminist strategies which exclude men from researching female subjects, whereby it is suggested that 'women have uniquely valid insights' into the condition of women as consciously identified members of the oppressed. Thus he sceptically comments that:

The experience of women is often treated as providing access to truths about the social world that are not available to men. (Hammersley, 1992: 188).

Hammersley proceeds by deploring previous academic neglect of the experiences of 'women and girls', but nonetheless somewhat peevishly questions the epistemological agenda of feminism, asking why gender in particular should be privileged. For Hammersley 'gender-blindness', to borrow Chris Weedon's term, refers to the exclusion of women in texts that focus on the experiences of men and boys (1995: 1). In response Lorraine Gelthorpe replies that 'gender' as used by Hammersley seemingly refers to women only and fails to acknowledge that gender relations entails the study of the interaction between women and men in society (Gelthorpe, 1992: 213). Stanley and Wise take an uncompromising position with regard to the proposition that male researchers can effectively offer a feminist position:

We reject the idea that men can be feminists because we argue that what is essential to 'being feminist' is the possession of 'feminist consciousness'. And we see feminist consciousness as rooted in the concrete, practical and every day experiences of being, and being treated as, *a woman*. Feminist consciousness ... is a particular kind of interpretation of the experience of being a woman as this is presently constructed in sexist society. (Stanley and Wise, 1993: 31-2).

The term a 'feminist consciousness' suggests a subjective but shared understanding of the collective oppression of women, enabling the individual experiences of the oppressed to be appreciated and comprehended as contributing to an overarching perspective of the female condition and as such points towards a variation of standpoint feminism (Ramazanoglu and Holland, 2002: 66; Webb, 2000: 42). This subjectivity therefore is the foundation for a feminist epistemology that subverts, to paraphrase Caroline Ramazanoglu, the rationalist, masculinist dogma, such as is espoused by Hammersely's position and which feminists take issue with in the first place, thereby drawing attention to the cleavage between, 'the goals of science and rationality, and the goals of politics and personal commitment' (Ramazanoglu, 1992: 207). The common ground of shared oppression by women has legitimised feminists' subjective experiences as containing kernels of truths about their own condition, which to quote Maynard and Purvis, has been 'one of the hallmarks of feminism' (1994: 23). Thus Hammersley's challenge of standpoint positions, as exemplified by feminism, under a camouflage of 'methodological purism' is taken up by feminism (Hammersley, 2000: 125). Ramazanoglu and Holland point out that a partisan commitment towards research for women does preclude claims to detachment but not that of producing 'valid knowledge' (2002: 49-50).

We are reminded however that the postmodernist legacy offers a challenge to the notion of a 'feminist consciousness' in that premised as it is upon dissent and difference, this position encourages engagement with *heteroglossia*. Multiple perspectives offer the postmodernist challenge to a unified and subjective conception of the world, whereby even the individual subjective is fragmented. Commensurate therefore with a

commitment to plural discourse and dissent an adherence to the concept of an individual and single subjective is called into question:

“Subjectivity” is used to refer to the conscious and unconscious thoughts and emotions of the individual, her sense of herself and her ways of understanding her relation to the world. Humanist discourses presuppose an essence at the heart of the individual which is unique, fixed and coherent and which makes her what she is....poststructuralism proposes a subjectivity which is precarious, contradictory and in process, constantly being reconstituted in discourse each time we think or speak (Weedon, 1995: 32-3).

Accordingly gender is, as Harding reminds us, merely another artificial construction and open to deconstruction, which reflexivity of the gendered self attempts to make transparent (Hirsch and Olson, 1995: 17). To sum up, the paradoxical dilemma emerges more clearly in that on the one hand postmodernist influences have permitted feminists to consider how the position of women has been subject to cultural and historical constructions and relegated to the *inferior* through patriarchal oppression. On the other hand, however, the inherent danger for feminism lies in the postmodernist deconstruction of categories, such as ‘patriarchy’, ‘women’ and ‘oppression’, which collapses the very bases of such analysis (Mascia-Lees *et al.*, 1989: 27).

Following Nancy Hartsock, Mascia-Lee *et al.* (1989: 15) make the wry observation that it has only been since women and minority groups have found a voice to articulate their dissent and to reclaim validity of their subjective experiences that postmodernists have riposted that these statements have no direct correspondence with reality. Consequently the decentring of the dominant Western and masculine voice of authority has been in response to the challenges offered by women and minorities who until recently have not

been allowed to speak for themselves (Bell, 1993: 7). Whilst Hartsock makes the point that the experience of marginalisation and subordination has created a number of ways of developing knowledge through, for example, collective subjectivities that owe little to the postmodernism of Western philosophy and that these alternative means of knowing must be acknowledged in order to effect changes in the dominant power relationships in the empirical world (Hartsock, 1990: 29-30).

Marginalisation of perspectives however makes a powerful contribution to the debate on dissent and difference from within the ranks of feminism. Ann Oakley in defining the relationship she enjoyed with the women she studied as being one of 'sisterhood', in which hierarchical considerations of researcher and subject were overturned in the light of shared oppression, yields before vociferous protest of spurious identification (Oakley, 1984: 48). The comforting position of empathy and engagement of the 'insider's view' as defined by the stance of 'sisterhood' is routed by Daphne Patai who draws attention to the fault lines of assumed commonality, dismissing this position as fraudulent where women are evidently 'divided by race, ethnicity, and class' (1991: 142). Thus the postmodernist encouragement of engagement with *plurivocality*¹ enables women from minority groups to critique their positions of marginality within the dominant discourses of feminism (Marchland and Parpart, 1995: 7). This critique however demands more than that minority experiences are merely absorbed into existing definitions of feminism, rather that these dominant accounts are subject to an in-depth analysis that satisfactorily addresses what Jan Pettman describes as

¹ 'Plurivocality' is a term borrowed from Diane Bell (1993) in D. Bell, P. Caplan and W. J. Karim (Eds) *Gendered Fields: Women, Men and Ethnography*. London/NY: Routledge.

The vast and traumatic historical experiences of colonisation and slavery, which still determine global national power and the very different experiences of people who are socially defined as black. (Pettman, 1992: 153).

The message therefore is clearly conveyed, an over-reliance on the 'insider's view' threatens to essentialise women as sharing similar properties and experiences. The notion of 'sisterhood' is seen to be at best conceptually flawed and politically naïve.

On this view, gender is implicated in a disastrous and oppressive fiction, the fiction of "woman" runs roughshod over multiple differences among and within women who are ill-served by a conception of gender as basic. (Di Stefano, 1990: 65);

Pettman suggests that in relation to ethnocentricity, ethnographic accounts have yet to adequately address racism and ethnocentrism, in terms of how far, for instance, colonialism has constructed gender in terms of subject people (1992: 150). Whilst acknowledging the vociferous dissent from 'black-and-Third-World-women-of-color', Abu-Lughod considers what Pettman refers to as 'feminism's crisis of representation'. While Pettman simply acknowledges the problems of welding a feminist coalition and thereby resigns herself to a plurality of 'feminisms', Abu Lughod ruefully desires commonalities between the experiences of women regardless of cultural background (Pettman, 1992: 150). Abu Lughod comments that once the single voice of authority articulating the political parameters of feminism has been deconstructed, feminism itself 'dissolves' into a plurality of identities many of which are eager to entirely disassociate themselves from a perceived ethnocentric, heterocentric discourse. The danger for

feminism, to paraphrase, lies in the problem of satisfactorily embracing difference *within* a political 'coalition' (Abu-Lughod, 1990: 23).

3.4 The researcher in the field: methodological and ethical considerations

In the following section I reflect upon methodological considerations that inform and challenge this study with regard to the critiques reviewed. The following discussion explores three broad but interwoven areas underpinning the project, namely that of relevant epistemological issues, representational concerns and finally the politics of feminist research in relation to issues of accountability.

3.4.1 Epistemological considerations

First of all, to reiterate that although this study is partisan towards the perspectives of women, I take into account Stanley and Wise's prescription in favour of including the perspectives of men for comparative purposes, as well as the need for contextualisation of phenomena (1993: 31). In accord with this position I note that Pettman endorses the need to explore alliances between women and those between women and men for a more complete picture without abandoning the search for solidarity (Pettman, 1992: 158). Consequently this study does not seek to privilege women's experiences by excluding those of male counterparts, but attempts to seek an understanding of the lives of 'patients' as they are informed by gender and this acts as an important but not exclusive category of analysis and forms the *problematics* of the study (Harding, 1986: 30).

Ethnicity and class, as well as material and intangible hierarchical considerations, are also subjected to analysis within a medical institutional setting, where medicine is premised upon dominant spheres of power and strata of influence 'that endorses the *status quo*, and therefore acts as an agency of social control' (Roberts, 1981: 14). In reference to power issues, Rita Felski warns against feminist hypotheses that are 'unable to account for the heterogeneous positioning of female subjects' (1989: 227). In this vein Sherry Ortner warns of the dangers of sanitising 'gender politics' where the internal difficulties and hierarchies of power amongst women are not sufficiently addressed for fear of undermining their own position and those of their cohorts or alternatively through the romantic fiction of *sisterhood* (Ortner, 1995, 179).

With these caveats in mind I do not assume equal positions of power even within classified categories of respondents. Instead I attempt to offer an account that addresses relationships of power and dominance, avoiding the assumption of an equal oppression amongst those who appear to share surface similarities (Felski, 1989: 227; Hale, 1991). Although clearly medical care normally depends upon a veritable army of women staff, classed according to rank, typically overseen by higher-ranking males, this study also seeks to note any examples of dominance and subordination amongst female patients with a view to incorporating this into a wider analysis of power. Finally, it should be noted that I have chosen to include the perspectives of staff both female and male, as I believe that these will provide essential insights into the gendered terrain of the hospital setting and in doing influences the lives of those who work there as well as those who are interned as patients.

Epistemological considerations therefore are dependent on an ethnographic method in which data are predominantly, although by no means exclusively, derived from the narratives of respondents. In terms of this study and the concrete specificities of location, where women patients and staff interact within a male-dominated medical setting, I believe that being a woman researcher in such an environment is likely to provide important insights not necessarily available to male colleagues, through such considerations as physical access, as well as intangible aspects such as rapport and mutual interest. Here then I consciously place myself in a somewhat controversial position by asserting that I accept the point that the agenda of white, middle class feminists, to make a gross and almost parodied generalisation, are not those shared by all women and particularly maybe, those of colour. Nonetheless I maintain a belief that there are points of mutual interest that the majority of women share, tenuous though these may be. In utilising Di Stefano's critique, I reject the move towards *essentialising* the women I study, in that I do not make any claims to universal qualities that may be found in any collectivity of women in terms of characteristics, behaviours or virtues, in which of course I must include myself (Di Stefano, 1990: 73). Following Abu Lughod (1990) therefore my stance in this study is that a mutual resonance of common ground may well emerge at times between myself and the women I study, albeit under circumstances subject to qualification, reservation and distinction.

The ontological question of whether this study can offer a truthful account of lives gives way to the postmodernist critique of demoting the authority of the ethnography to a 'constructed fiction'. Yet paradoxically while accepting this to be the case I seek to maintain that the epistemological perspective chosen does contribute valid knowledge of the lives of women at Hospital Sentosa to a wider audience. In accord with the position taken by, for example, Ramazanoglu and Holland I reject therefore the need to sever the commitment to a feminist perspective in order to achieve a detached objectivity (2002). To this end then, I do not claim a totally committed partisan stand on any particular epistemological stance within the feminist debate although feel that my approach is resonant with that of a standpoint position. Additionally, the political positioning of my methodological approach conforms in basic essentials to the three conditions for standpoint feminism as outlined by Sue Webb (2000). Accordingly it attempts to overturn hierarchies of power between the researcher and those researched, and secondly, clearly endeavours to be a study for the benefit of women by a woman, and finally, commensurately attempts to embrace the 'merging of the public and the private' through self-reflexivity (Webb, 2000: 42). Consequently I do not accept the need to address issues of an epistemological tension between that of establishing an absolute claim to truth in my account against that of relinquishing all validity to an absolute relativity (Ramazanoglu and Holland, 2002: 63). As Hammersley points out the epistemological dilemma of how experience relates to knowledge production remains however (Hammersley, 2000: 158). Therefore while I fully accept that my account does not offer a claim to objective validity, as naturalistic ethnographies have done, I also claim that the narratives that were heard and are re-presented in this study, do offer the

reader *truths*, albeit not *facts*, regarding the lives of the women studied. These narratives then are open to, but not invalidated by deconstructive stratagems borrowed from a poststructuralist tradition and utilised in a feminist analysis. In this way a semantic analysis of binary oppositions and the sexuality of women patients, for example, are deconstructed in relation to the context in which they operate for deeper insight into the way language constructs meaning and how this relates to oppressive, sexist practices (Scott, 1986: 1065-6; Weedon, 1995: 107).

3.4.2 Representation and appropriation

Linda Alcott raises the problem of representation in ethnographic studies. She initially points out that the social location of the speaker affects the ‘meaning and truth’ of what is said, in addition to the concealed dangers inherent in speaking on behalf of less privileged groups. The discursive problematics of speaking *for* and speaking *about* are brought to the foreground, whereby the latter is in danger of being conflated with the former, in an exercise which is perceived as being an act of unwarranted appropriation and ethically unsound. The crisis of representation is only partially resolved by a refusal to represent the position of others and to speak only for ‘oneself’. Or alternatively by employing the following strategy of emphasising the commitment to speak solely ‘about’ but never ‘for’, along the lines of ‘this is *my* story of *their* story’. This being an act of interpretation unconditionally ‘owned’ by the author and not presuming to be an exclusive or uncontested voice of authority on the subject matter (Alcott, 1991: 6-7; Hew, 1999: 15). All however, is not lost, a way forward is proposed:

It *is* possible (and indeed desirable) to speak of ‘others’ but only when the reader can clearly see where the speaker is ‘coming from’. Autobiography (read as self-identification) becomes the basis upon which white feminists authenticate speech, such that *failure* to identify speaker location is potentially racist and classist and sexist. While the act of ‘identification’ may precede equally oppressive practices, it nonetheless signals a more ‘honest’ beginning. (Lyons, 1999: 6).

What Lyons is proposing is a methodological stance grounded in self-reflexivity, whereby the focus revolves around the location of the speaker in the interpretative process of ‘textualisation’ or construction of data. This effectively responds to a question posed by Pettman of how ‘dominant group women address their whiteness’ in relation to cultural difference, a question of significant import in view of this study (Pettman, 1992: 155). Self-reflexivity is seen by feminist anthropologists therefore as a way of addressing how post-colonialism in cultures has impacted on their position as researchers.

Insisting on the opposition between a unified female self and a male other removes the power categories that exist between all anthropologists and their subjects: the ways in which women anthropologists may pass as honorary males in some societies, or as persons of higher status by virtue of their membership in Western culture². (Visweswaran, 1988: 30).

Self-reflexivity is regarded as providing the necessary conditions whereby researchers can both identify their background to an unseen audience whilst attempting to explore the meanings attached to the contingency of ‘location’. Patai however remains unconvinced that the spadework of self-analysis is little more than ‘rhetorical manoeuvres’ using facile announcements listing personal properties of colour, gender, sexual orientation and the

² A typical example of being promoted to the status of an ‘honorary man/woman’ can be found in Otome K. Hustheesing’s account of fieldwork in a Lisu village in Thailand. Hustheesing, O.K. (1993) ‘Facework of a female elder in a Lisu field, Thailand’ in D. Bell, P. Caplan and W. J.Karim (Eds) *Gendered Fields: Women, Men and Ethnography*. London/NY: Routledge.

like, worn as trophies or displayed as apology (Patai, 1991: 149). In interview with Hirsch and Olson, Sandra Harding concurs that these strategies imply a dishonest evasion where the link between the properties and location of a researcher and her analysis is not sufficiently explained. Harding makes clear that the apologetic stance of the white researcher in such scenarios militates against the tension created being used as research strength.

There's been a tendency to think that only the dominated, only the marginalized can use their social location as an instrument of the production of knowledge. They certainly *can* use it and *do* use it, but it's also the case that the people in the dominant groups can learn how to use their position ... to ask the kinds of questions and think the kinds of thoughts that would make use of the resources of that particular position. (Hirsch and Olson, 1995: 19).

In the meantime Kirin Narayan exhorts us to 'feed' our specific locations into the text regardless of whether we feel empowered or disempowered in society, yet reminds us that we personally hold 'multiplex subjectivities' rather than single ones, allowing one or another to emerge depending on who we are with and the prevailing 'vectors of power' (Narayan, 1997: 31). The self-reflexive exercise is not merely a question of honesty or of stronger objectivity, Narayan argues, but one that invites the dissolving of divides, through the exploration and self-acknowledgement of identities which are 'hybrid', partial and positioned (Narayan, 1997: 28-9).

Throughout this study therefore I attempt to utilise a self-reflexive approach, locating myself in terms of gender, age, culture and class in relation to a developing country still trying to shrug off the influences of its colonial past, of which I am also a product. In

keeping with Erica Burman's summing up, this serves a dual purposes commensurate with feminist ethnographic methods (1999). First of all I hope to clarify the means by which analysis is reached. Of equal concern however is my endeavour to explore assumptions, stereotypes, contradictions and paradoxes inherent in the relationship between the participants I study and myself. This strategy is not viewed as the gambit of an apologist nor is it seen as a superficial bid for credibility but as a legitimate means of achieving greater rigour.

Narayan's reference to the 'vectors of power' directly impact on my specific position as a researcher. As an academic employed at a local university in Kuching, Sarawak I have relied on professional factors to assist me in terms of access to resources that perhaps would have been unavailable without this legitimacy, despite a general xenophobia towards foreign researchers dabbling in sensitive issues. That said, being a female researcher undertaking a qualitative study that concentrates largely on women psychiatric patients in a male-dominated, patriarchal medical setting is not, I would argue, a highly credible pursuit. My research experiences confirmed that little kudos could be attached to a commitment to a marginalised methodology as used in the study of a highly marginalised group, whose subjective experiences were invalidated through the multiple oppression of the stigma of mental health in combination with the subordinate positions of gender and class (Ashencaen Crabtree, 1999a) Whilst cultural and ethnic issues in a post-colonial setting create as many obstacles and barriers as they may at times open doors.

The issue of a 'First World' woman carrying out research amongst 'Third World' women is fraught with contention in relation to stereotypic and culturally hegemonic bias. The social significance of research on the lives of the researched is now more than ever being scrutinised and the ethics and application of such research hold questions of fundamental importance in seeking legitimatisation of research activities.

We do not own the field notes we make about those we study. We do not have an undisputed warrant to study anyone or anything ...The writer can no longer presume to be able to present an objective, noncontested account of the other's experiences. Those we study have their own understanding of how they want to be represented. (Denzin and Lincoln, 1995: 351).

Chandra Talpade Mohanty suggests that the dearth of literature on feminism in the context of the Third World has been obscured by the abundance of material on development issues, which as is not the same thing at all (Mohanty, 1991: 4). The discourse of development and gender carries with it inherent assumptions about the role of women in 'Third World' countries wherein they are portrayed in familiar stereotypic roles, such as the 'cloistered' wife and mother under strict patriarchal control. In relation to this point, Chowdhry adds that the oppression of 'Third World' women leading passive and limited lives, 'circumscribed by male-dominated and unquestioningly accepting of their confinement', stands in sharp contrast to the liberated woman of the West, this being a polarity which is steeped in hierarchial power (Chowdhry, 1995: 27; Mascia-Lees *et al.*, 1989).

Clearly such concerns impact heavily on this study, where an easy assumption can be made that women patients *are* indeed confined under a patriarchal regime and evidently demands critical deconstruction to avoid essentialist notions. In reference to critiques of representation, I draw on Lyon's point and do not seek to appropriate the narratives of respondents but seek rather to offer a constructed account that could be contested. This study therefore is seen to be both partial and mediated by culture and context, in which, to reiterate, I use myself as the self-reflexive instrument of research, subjectively located, contextually and historically situated.

3.4.3 Feminist politics and accountability

Whilst it is understood that the feminist researcher is inherently engaged with issues of emancipation and transformation, how these are to be achieved through empirical research is far from clear. Such is seen to be the mission however and one particularly suited to female researchers as suggested by Diane Bell who comments that taken from the standpoint of the distinctive social position of women, this enables them to be particularly sensitive to the domination of others (Bell, 1993: 6.). Here I would state that with specific reference to this study, I do not assume that there exist relations of especial sensitivity between women living under patriarchal conditions, such as a psychiatric institution. Additionally Henrietta Moore offers the warning that being a woman researcher in the field does not of course erase issues of power, and which, as I would argue, in consequence needs to be addressed in the account (Moore, 1992: 10).

As seen, postmodernism in its rejection of generalisations and the politics of collectivity sets an effective challenge to the emancipatory goals of feminist research in its quest to challenge patriarchal structural oppression (Maynard and Purvis, 1994: 22). In reference to Foucault however, Nancy Hartsock (1990) takes issue with the postmodernist analysis of political power as a dispersed system in which even as we unmask it we are all implicated. To briefly summarise this position then, attempts to transform political agendas merely enmesh us in further collusions of power play and they become therefore a fundamentally futile enterprise (Hartsock, 1990, 23). For feminists the identification and struggle against patriarchy as an oppressive structure in their material lives becomes disintegrated into merely another competing construction in the discourse of power in which all are oppressed and oppressors simultaneously. This position Hartsock scathingly regards as in leading to passivity and (specifically in reference to Richard Rorty) degenerating into ‘edifying conversation’. Feminist research however is characterised by its commitment to a political agenda wherein:

The moment that feminist scholars begin to address themselves to women’s experiences, their inquiry necessarily becomes concerned with questions of power and political struggle and their research goals become defined by that struggle. (Mascia-Lees *et al.*, 1989: 23).

A more devastating challenge to feminist politics is made by Judith Stacey who asks whether it is ethically possible to carry out ethnographic research as a feminist despite the perception that this approach is apparently particularly appropriate to the skills and politics of female researchers.

I find myself wondering whether the appearance of greater respect for and equality with research subjects in the ethnographic approach masks a deeper and more dangerous form of exploitation. (Judith Stacey, 1991: 113).

Stacey's point is that although research may be seen to be an agreeable exercise in solidarity, it is nonetheless intrusive and essentially exploitative and manipulative through the necessary business of having to root out informants' experiences for aims that are likely to be solely to the advantage of the researcher. Strategies for reducing exploitation may range from a postmodernist exercising of self-reflexive critique to methods of attempting to return the fruit of research to the community of informants. Nonetheless Stacey articulates a fundamental concern regarding unequal relationships of power, which reverberates sharply in relation to the issues of difference. Furthermore, even in the attempt to make due allowance for difference amongst informants, the desire to create solidarity with informants as part of the political enterprise of feminism presents shifting and difficult terrain to negotiate.

Daphne Patai compounds the challenge by questioning whether ethical research of Third World women is possible when carried out by First World academics, framing a contentious question in the following way:

Is it possible - not in theory, but in the actual conditions of the real world today - to write about the oppressed without becoming one of the oppressors?
(Patai, 1991: 139).

For Patai the answer appears to be ‘no’, in that in line with Stacey’s concerns, utilising the lived experiences of informants is necessarily exploitative. Furthermore, exploitation is more likely to be present given wide material inequalities between researchers and their respondents. Maria Mies adds the comment that relations of domination influenced by a history of colonialism may lead to distortion of data (Mies, 1994: 65). Patai concludes with the following caution:

Facile assumptions about our commonality as women, and celebrations of the intimacy generated by ‘feminist’ research methods, are inadequate responses. Instead, I believe we must question the entire system that seems to allow for no other approach than manipulative distance, on the one hand, and spurious identification, on the other. At the very least, this will keep us from mistakenly assuming that the discourse of feminism itself constitutes a solution to the fact of women’s oppression. (Patai, 1991: 145).

From Patai’s perspective it is therefore extremely difficult for me, evidently an educated, privileged woman of the West, to carry out ethical research amongst underprivileged women from a developing country. Stacey in turn appears to pull the ground out from under the feet of feminists by suggesting that the very means of rectifying imbalances of power between the researcher and her respondent is fundamentally exploitative and unethical. In response to these challenges it has to be admitted that certainly I owe an enormous debt of gratitude to participants for their trust and their time, for which they were not rewarded in any material way. I do not accept however that this trust has been abused for gain and claim that the research encounter can represent a genuine reciprocation provided that confidences gleaned were obtained in accord with standard ethical practices and are used to further the emancipatory aims of feminist research.

Based on her experiences Janet Finch sums up this view in the following way:

Almost all the women in my two studies seemed to lack opportunities to engage collectively with other women in ways which they would find supportive, and therefore they welcomed the opportunity to try and make sense of some of the contradictions in their lives in the presence of a sympathetic listener. There seems no reason to doubt that most women who similarly lack such opportunities will find such an interview a welcome experience'. (Finch, 1993: 169).

In specific reference to this study I would also add that my research encounters with participants were imbued with attention and respect on my part and that there was genuine reciprocation. The study provided a validation of patient concerns that few participants would normally experience in the hospital setting, where medical staff routinely dismissed patient exchanges as nonsensical ejaculations on the grounds of their diagnosis. Finally, I would argue that to abjure entirely on what I would regard as overly generalised and alarmist grounds, seems unnecessarily defeatist and in its own way unethical and indeed racist. To avoid the contentious area of Third World women in a psychiatric setting, who are already a deeply marginalised and conspicuously voiceless minority, and have few opportunities for dialogue with society at large, strikes me as tacit collusion in their oppressed status as well as expedient evasion. If the politics of feminist research are to be realised at all then engagement with the research encounter, fraught as it is with implication and problems, must be undertaken. I would argue that to take any other courses is to lapse into the very helplessness that feminists grapple with in relation to the postmodernist position where any attempt to achieve a feminist, transformational politics is conceived of as basically futile (Hartsock, 1990).

In my opinion a more vexatious question for feminist researchers is how to alter power relations between researchers and informants commensurate with our political commitments; and in addition, how to convey the nuances of our situated selves in our accounts. Inherent in this is the critical need to interpret these accounts in ways that reflect the complexity of experiences with honesty and ethical integrity, as well as combining this with the need to provide an account of academic merit. Kelly *et al.* (1998) point out some of the difficulties translating the politics of feminist research into practical research objectives and state that in terms of achieving emancipatory goals it is quite likely that participating women may not hold the same values as the researcher herself, thereby making an emancipatory quest very difficult to achieve. They point out that unfortunately the majority of women will not experience transformation in their lives through participation and that perhaps such a goal is unrealistic:

In this context the 'empowerment' of research participants is not and indeed should not be our goal. If that concept has any meaning it must relate to the groups over which these individuals and institutions exercise power. One, position, taken by many radical researchers is that the end results of a project will be a contribution to challenging the power relationships exposed by the study. (Kelly *et al.*, 1998: 38).

For Kelly *et al.* (1998) in line with Neil Thompson's view (1997: 57) the achievement of 'empowerment' by respondents in feminism appears to be precisely the dynamic act of transformation of hierarchies, in which the researcher is fundamentally implicated. In this vein therefore I am aware that it is very unlikely that my respondents will be in a position to benefit directly from the fruits of my research. The politics of transformation are

unlikely to be achieved in any concrete or revolutionary fashion through, for instance, a closure of Hospital Sentosa (assuming that to be a good thing) or a rapid democratisation of the Malaysian psychiatric system. Furthermore actions such as those of offering participants publications of the study appear laudable but are in fact disingenuous and even false as those who participated are most unlikely to have equal access to the material in order to read it or be able to comment on it in order to adequately contest my account³. This problem is not based on practicalities alone but more importantly refers to the way that the voices of psychiatric service users in Malaysia are muted to the point of silence⁴. My account therefore is more likely to be read and commented on by another audience altogether and which one would hope might involve professional psychiatric staff. This should be viewed as by no means a bad thing and is seen to be a means of achieving feminist emancipatory goals. In conclusion therefore I hope that through the process of research, dissemination and debate a transformatory contribution in the lives of the women I have been privileged to study may occur even at a modest level, in keeping with the aims of a feminist methodology.

³ The practical difficulties relate largely to language and literacy, whereby few patients (or staff for that matter) are fluent in English or particularly used to digesting texts written in dense academic language. A further difficulty revolves around cognitive problems for many psychiatric patients whose concentration levels are highly dependent on their current state of mind and the levels of tranquillisers or other treatment they are undergoing at the time. This of course relates only to patients currently admitted and therefore it is to be hoped that views may be obtained from discharged or ex-patients, although the means of dissemination remain unclear.

⁴ Psychiatric service users are notoriously underrepresented in mental health movements nationally. In all the years I have served on the committee of one large mental health NGO in Sarawak not once has there been any concession to the complete exclusion of service users from serving as committee members.

CHAPTER FOUR

COMMENCING FIELDWORK

4.1 Introduction

Locating and accessing the site of the field study effectively form the start of fieldwork and are a complex exercise, which navigates precariously between the formulation of the research design and the logistical parameters within which the study can be carried out. Once *in situ*, which is by no means a straightforward affair, the limitations of study begin to become more apparent as practical considerations and ethical concerns are revealed. This chapter therefore covers a broad area relating to commencing fieldwork and how it was carried out, including problems and dilemmas encountered in the process.

The following sections are divided into four main parts: the first discusses how the site was chosen and accessed. A subsequent section discuss methods used in collecting data and data analysis commensurate with a feminist ethnographic study. Whilst the final sections consider language difficulties encountered in this study and some of the ethical issues encountered during fieldwork that affected my perception of my role as a researcher.

4.2 Accessing the site

4.2.1 Choosing the location

Classic anthropological ethnographies have almost invariably taken place in locations far removed from the home environment of the researcher, such as those of Malinowski in New Guinea (1922) or Mead in Samoa (1943). These locations have often been perceived as exotic or in some other sense removed from the familiar. Nancy Scheper-Hughes, for instance, leaves the United States of America and chooses rural Ireland which appears to represent a sharp contrast to her own cultural background and subsequently writes an account of anomie, social and arguably cultural stagnation and mental illness (Scheper-Hughes, 1982). Sue Estroff, by contrast, emphasises that her ethnographic study of mental illness in Wisconsin takes place in her own hometown. Although this was a study from home, she manages to powerfully convey the polarisation between the underground existence of a deeply marginalised group of people and the privileges of the comfortable and conventional living standards that she is familiar with (Estroff, 1985). In further reference to Scheper-Hughes, an account is offered of neonatal mortality in impoverished communities in Brazil. This locates the mature author as a foreigner from the First World, but whose association with the country and rationale for research has been formed through the influences of a period of residence there as a young voluntary worker (Scheper-Hughes, 1992).

My own particular situation approximates in some ways to that of Scheper-Hughes in the latter example, in that Kuching has been my home and place of employment for some years, and as such represents one of the longest periods of time ever spent in a single place. I therefore occupied the ambivalent position of being both familiar with as well as being a stranger to the region. My status however was that being that of a non-permanent resident with no citizen rights and subject to the terms of temporary employment. I was therefore only partially assimilated with tenuous ties and commitments, which I was aware, would atrophy with my departure. Any identification I felt was filtered through the conditions of being a foreign alien and therefore, as John Clammer points out, my fieldwork experiences were mediated through layers of belonging, with all the associate problems of immersion in an unknown cultural context (Clammer 1998: 77-8).

The choice of study site was dictated in part by practical considerations: Hospital Sentosa was situated close to where I lived and therefore did not require extended periods of fieldwork away from Kuching which I could ill afford due to employment commitments. I had also carried out a previous study there on outreach services and had been struck by fragmented but vivid impressions of life on the wards (Ashencaen Crabtree and Chong, 1999b). Additionally, I was aware that while Hospital Sentosa represents an important resource in Sarawak as a centre of service delivery, it also stands in a certain amount of isolation compared to developments, funding and political focus which are concentrated in Peninsular Malaysia. Finally, the study took place during an interesting period of change in terms of mental health service delivery at a national level. The hospital is currently facing the dilemma of how to address the practicalities of ideological

developments in health care within the context of contemporary political debate in Malaysia and which represent significant challenges for the future direction of the hospital and its community services.

4.2.2 Gatekeepers and participants

Although permission had been granted for my studies from *the Jabatan Kesihatan Negeri Sarawak* (the Sarawak Department of Health), the director's consent as the main gatekeeper was crucial for work to proceed. I am doubtful whether my position as a foreigner actually assisted in the facilitation of this process of consent, as Punch discovered in his study of an Amsterdam police force, although it is clear that my status as a local lecturer was quite definitely helpful (Punch, 1993: 178). Fortunately the director of the hospital Dr Tiong Mee Siew was already known to me from my previous study and furthermore we both served on the committee of a local mental health NGO (non-government organisation). Burgess describes how an attempt to return to a previous field site for further studies was not welcomed by the principal gatekeeper (Burgess, 1991: 47). By contrast in my own case I found that the director was amenable to further work at the hospital since familiarity with my prior studies worked in my favour and proved to be very valuable in allaying concerns about my integrity and ability as a researcher. Furthermore the inclusion of the director's participation in the role of an external supervisor in my doctoral studies ensured further cooperation and continued interest in my work.

This alliance proved to be extremely helpful on numerous occasions in smoothing the path of obstacles in relation to access to wards and interviews. In his role as the main gatekeeper of the site, Dr Tiong was in a position to grant a general consent on behalf of his staff and to a large extent in practical terms those of his patients as well. In relation to this practice Roger Homan raises issue with the ethics of such generalised consent, whereby the right of consent by, for instance, individual staff members is effectively withheld (Homan, 1991: 83). Additionally Burgess points out that even where the consent of main gatekeepers is obtained this does not remove the need to negotiate terms with individual staff informants as informal gatekeepers who may otherwise provide blocks to adequate research (Burgess, 1995: 49). With regard to informed consent from individual patients, I followed ethical guidelines for research as laid down by the University of Hertfordshire in relation to doctoral studies. Thus I verbally explained the outline of the study to potential interviewees, following this up with an explanatory letter and obtained signed consent forms, with copies for both parties (Appendix I). Although the ethics behind such a procedure is apparent, in practical terms the rather cumbersome procedure could not ensure the formal consent of all respondents in the study. As I began to sink deeper into the 'subjective soaking' provided by immersion into ward life, I found that attempts to remain strictly in control of participation were eroded and almost relinquished entirely to circumstances (Clammer, 1998: 77). Controlling involvement by respondents gave way therefore to the opportunities for encounters that arose once the decision to participate was shared more completely with respondents, as is discussed in more detail later in the chapter.

Naturally responses to participation varied, many patients expressed positive opinions, although others were clearly quite indifferent to my reasons but just welcomed the chance for a chat with an outsider. A small minority rejected my advances outright and in keeping with the experiences of other ethnographers, some participants became close allies and main contributors of insider knowledge (Glick, 1998: 242; Punch, 1993: 190). After all my precautions regarding confidentiality and consent I was fairly surprised at first that few patients seemed particularly bothered by this issue in terms of broader dissemination. More important to most patients on the ward was my ability to keep a secret when it came to whispered confidences about a particular 'scam' or an incident of abusive behaviour from a certain member of staff.

Gaining consent for interviews with individual patients, in addition to Dr Tiong's expansive gesture in handing me the keys to the hospital, as it were, did not completely ensure a smooth passage to fieldwork and here problems were threefold. First of all the director's consent was generally broadcast via a memorandum which apparently was not circulated to all members of staff and therefore my presence needed to be explained, clarified and re-checked on numerous occasions throughout the field study period. It was therefore quite common for my credentials to be inquired into time and again, and occasionally pointed inquiries were made about whether the Dr Tiong's permission had *really* been granted.

Secondly, this form of generalised consent from a superior did not necessarily guarantee willing participation from respondents, exemplifying the simple observation by Miles and Huberman, that 'weak consent leads to poorer data' (1994: 291). This could additionally be seen when initially, in a bid to be helpful, some members of staff tried to coerce patients into cooperating with me. Mindful of the ethical constraints of the study this practice was quickly discouraged although at the time I was also aware that this kind of unwelcome cooperation by staff could also act as an effective strategy of diversion away from individual members of staff.

Finally, and connected to the point of weak consent, despite the director's consent it was nonetheless quite difficult to engage in a further process of negotiation with staff members acting as 'gate keepers' to their wards. I found that staff were often reluctant to discuss terms with me and seemed to prefer this to be confined to my discussions with the director and then mandated by him. This seemed to be particularly true of female nursing members of staff and junior male counterparts, whereby both groups often appeared to share a common and lowly status in the medical hierarchy. Yet, by not being able to negotiate openly with members of staff, I felt that their concerns were not specifically addressed and frequently I perceived their unspoken or indirectly conveyed resentment and anxiety about my research role. I was regularly directed to talk to a more senior member of staff in corresponding male or female wards, under the pretext that this person was a more knowledgeable and experienced individual. In reality a formal repository of professional knowledge was usually not the best informant as in this role such individuals tended to deliver set pieces of information concerning policies governing the

management of the hospital that rarely provided useful insights into the lived experience. Instead it seemed to be that this role was largely a symbolic one designed to keep parties from the outside at bay as well as providing the authority to speak, so clearly lacking among many women workers and inexperienced younger men.

Unfortunately I found that discomfort and hostility towards my presence on the ward were not uncommon features of fieldwork. Like Van Maanen I did on occasions experience something approaching 'unambiguous rejection', although not as bluntly expressed as his examples quoted from hard-bitten New York cops (Van Maanen, 1991: 36-7). On one occasion Sister Magdalene, a senior member of staff, audibly instructed a subordinate to inform me that she was far too busy to talk to me when so far as I could see the ward was very quiet and she did not seem to be specifically engaged in work. It should be noted that this conversation took place within a few feet of where I was standing and delivered in a tone of annoyed dismissal to be subsequently delivered in evident embarrassment by the auxiliary nurse. Two further examples taken from my field notes illustrate this rejection; the first takes place in an episode on Male Ward where as usual a patient is helping two medical assistants with medication to be dispensed to patients on the locked section.

Field notes. Male Ward 1:

Ahi, a Malay MA (medical assistant) turned up (he's not too friendly towards me most of the time) just as I was writing down the patient audit from the nursing chart. He starts helping Bong to hand out medication to the locked section with Hui Ling helping. As usual I am surprised by how compliant and passive people are when they take their meds. One poor man in the open section keeps asking to go back home in Malay '*balik kampung, bila?*' (When do I go home to my

village?). The MAs ignore him. He then appeals to me, maybe because I am white and possibly influential, to take him back to his remote Iban kampung in Serian. Bong helps with translation.

Bong: He says that he has had ECT so now wants to go back home.
Researcher: Has it helped him?
Bong: Yes, he is much more stable now. [To Ahi] How many more?
Ahi: 3 more, course of 6.

While I am talking to Bong a patient in the locked section is hanging around the grill and talking incessantly, non-stop and apparently unintelligibly. After some time of this I comment on it to Bong.

Researcher: This must be hard for people to cope with.
Ahi: [overhearing] That's why he is here. He talks all through the night, the brother says it drives them up the wall. Non-stop talking, the words don't hang together though. [Pause] He talks so much he should get a job as a lecturer.
Researcher: Yes, he'd be perfect ... all he'd have to do is make sense.

[Ahi gives me a sly, side-look and laughs. Later as I am leaving]

Researcher: Well, I must go now.
Ahi: I hope this is worth your time.
Researcher: I know it seems strange.
Ahi: Yes.
Researcher: But it is very interesting ... you learn a lot by observing.

This interaction with Ahi is a typical encounter representative of our relationship, in which in the space of a couple of hours he manages to get in two digs, the first conveying that I talk so much rubbish that I am no different from a particularly incoherent psychiatric patient. The second that I am wasting my time just hanging around watching the staff and no doubt, the message is also that I am wasting their time as well. Not surprisingly I never enjoyed spending time on the ward when Ahi was present as I usually found myself in the position of trying to observe the ward while wincing somewhat at the pinpricks he delivered, when he was willing to acknowledge my

presence at all. The second extract from my field notes highlights the difficulties of gathering data while in a state of awkward discomfort at being pointedly ignored by members of staff.

Field notes. Female Ward 2:

I wanted to follow up with the nurses on incidents of violence but was unable to get far. The staff sister, a handsome Iban woman didn't seem at all pleased to see me despite a polite but frozen half-smile and made no attempt to talk to me or make me feel welcome. She sat with her back to me the whole time and ignored me throughout. After a while of this I went out onto the veranda to strike up conversation but the other two nurses seemed unwilling or unable to talk to me (perhaps they felt the bad vibes from the sister in charge or maybe their English wasn't up to it). These incidents made to feel about as welcome as – (proverbial expression).

I see this as all part and parcel of the research process and in fact research does act as both a wonderfully protective umbrella when it comes to all this negative grist to the mill. Yet there is a human dimension to all this which I feel and is not easily shrugged off - it is this aspect in part which makes going into the field, an uncomfortable, anxiety-making business where you feel vulnerable, inquisitive - rarely wise and often foolish. An ambivalent position of unwelcome visitor and anticipated guest. As usual I often feel far more accepted by the patients than by the staff, today some seemed mildly interested and even pleased to see me.

Despite the general consent by the director to fieldwork, these examples clearly show the power held by informal gatekeepers to enable or block research activities through fairly simple but highly effective human strategies. Whilst of course knowing that this provides useful and additional insights for research, the discomfort generated by being made to feel something approaching a pariah acts as a significant handicap that needs to be constantly addressed and overcome (Shaffir, 1991: 74). Through these episodes I became deeply familiar with the almost ever present and heart-sinking sensations Van Maanen aptly refers to as caused by the 'stigma of the research role' (Van Maanen, 1991: 32).

4.2.3 The selection of wards

Once access to the hospital had been established it was necessary to consider which parts of the institution to study. After due consideration I decided to concentrate on four wards, two of which were acute wards and two were long-stay wards. Of these four wards, two each were allocated to female and male patients respectively, the latter being used as a means of comparison for the purposes of my study. In addition I visited other wards, such as the forensic ward, which was exclusively male, and the sick ward. Finally, I spent some time on the private wards and long-stay wards periodically for orientation and comparative purposes. The occupational therapy department provided some extremely useful insights into gender stereotyping and patient labour.

The acute wards, Female Ward 1 and Male Ward 1 and the long-stay wards Female Ward 2 and Male Ward 2 were chosen on the basis of a combination of factors. First of all the acute wards provide an interesting basis for comparison with the long-stay wards in view of the fact that the selected long-stay wards are not exclusively but generally more likely to be the eventual destination of acute patients later perceived to be chronically afflicted. The daily routines, recreation and patient and staff interactions are livelier on the acute wards with the exception of the forensic ward. On the selected wards most of the patients enjoyed comparative youth compared with the remainder of the long-stay wards and therefore, to generalise, were more likely to be able to communicate with me as opposed to wards where there were a greater number of elderly and mentally infirm patients.

4.3 Data collection and the ethnographic process

The ethnographic goal is defined by Beverley Skeggs as a critical endeavour, an investigation of how societal structures are reproduced, engaged with and resisted, not so much a 'method' but 'rather ... a theory of the research process' (1994 : 76). While J.D. Brewer states that ethnography represents both a 'method and a methodology' (1994: 232). One in which, with some exceptions, data collection and data analysis are not contained in sterile seclusion with each other as in the positivist, scientific framework but, as Brewer points out in a subsequent publication, interact in a continuous process of analysis (2000: 107). With this in mind therefore, the following section is divided into subsections covering the broad area of how data were collected in this study, in discussion with associated problems and subsequently moves on to discuss analysis of the data.

4.3.1 The research design

In common with Janet Parr, I found that formulating the original design for research was a formidable experience in combination with the heavy baggage of positivist authority I carried with me from my days as an undergraduate in the philosophy of sciences (Parr, 1998: 89). After a considerable amount of time addressing these conflicts, bids towards quantitative legitimacy through graphs and tables were wholly abandoned and a research design evolved that was compatible with my chosen methodology and topic revolving around typical ethnographic methods of interviews, observations and extensive recording of data. Initially the design incorporated the use of an interview schedule (see Appendix II) but, as will be discussed later in the chapter, eventually the selection of respondents

gave way to a more participatory approach in which sample size was finally estimate rather than strictly defined and adhered to from the outset (Appendix III).

Over time and in the face of a number of epistemological contradictions this study has changed considerably from my initial formulations. My original preoccupation was to explore service user perceptions of the psychiatric hospital using an ethnographic approach that would consider both in-patient and outpatient experiences. Later this was refined to a feminist study of gendered experiences of psychiatric care of interned women patients and later still, included the perspectives of members of staff in order to add deeper insights from formal caregivers. The resulting design therefore encompasses privileging the experiences of women patients, informed by the comparative study of male counterparts, as well as the perceptions of staff, male and female, who contribute their voices on topics such as care, working conditions and collegial expectations. Finally, it should be noted that pseudonyms are used throughout the thesis to protect the confidentiality of participants.

Although I had many preconceptions regarding the conditions of women patients at the hospital and the attitudes of staff, I expected to have some of these assumptions confounded and disputed. Additionally, while I did have several topics I wished to explore in relation to my respondent categories, the main focus of the study was to permit issues that were relevant to my participating respondents to emerge, rather than those issues that I regarded as significant (Hammersley, 2000: 19). Whilst I believe that this attitude represents a valid investigation, I am aware that some issues that I would have

expected to be uppermost in the minds of my respondents have apparently not been those which were in fact raised as important and occasionally this has flown in the face of a body of literature I have relied on. In practice then this has proved to be very challenging to my assumptions at times: in relation to Stanley and Wise's comments on the realities of achieving 'hygienic' (i.e. unproblematic) research, I found that negative examples of hypotheses formed in the ethnographic process have made me feel on occasion that I inhabit uncertain and questionable terrain as a researcher (Stanley and Wise, 1993: 153).

The study therefore has developed into an open-ended account, in which the parameters of the study are held together by the aims of a feminist epistemology in that the study focuses on an attempt to locate the voices of the muted, those of women patients, in a wider scrutiny of sexist oppression in the hospital system. Following on from Goodall's point in reference to data gathering and recording that 'fieldnotes, once written, *mediate* between lived experience and ethnography' (Goodall, 2000: 87), I fully accept that the account is not only an artificial and partisan construct, but so are the very data that was collected and analysed.

Altogether a period of sixteen months was devoted to fieldwork from the middle of June 1999 until October 2000. This time was divided into two blocks with a main break of approximately 6 weeks spent on study leave in addition to a couple of short recuperative spells. The study leave, as suggested by Steven J. Taylor, proved to be an extremely useful time which allowed work to be reflected on, data integrated and new avenues considered, which were then explored upon my return to the field (Taylor, 1991: 242). In general my routine was composed of a couple of days spent on site weekly, with the

times of my visits being varied in order to gain an overall impression of day-to-day routines and the associated behaviour of patients and staff. Interviews with respondents varied from an occasional one-off encounter to several encounters on a one-to-one basis or in a group. The study therefore developed some aspects of a longitudinal study, which proved to be extremely useful in relation to the transition I was undergoing of deeper immersion in the culture of the hospital and my relationships with participants.

4.3.2. The use of critical observation

Overt observation techniques provided the major part of the data I gathered and were used consistently throughout fieldwork and even prior to fieldwork, when I spent approximately two months at the hospital simply observing and familiarising myself with life on the wards. This information provided sufficient information to obtain some insights into particularly interesting phenomena, such as, methods of control or the use of patient labour on the wards. This period of initial observation enabled me to make an informed decision on which wards should eventually be selected for closer scrutiny, as well as drawing my attention to those individuals whom I felt I could approach and those who might represent a threat.

Whilst Hammersley points out that all ethnography necessarily involves observation, in my own case at least this did not conform to the kinds of strictly demarcated roles that are often defined in ethnographic literature (Hammersley, 1990a: 30). Instead I initially adopted a more 'holistic' approach to use Marshall and Rossman's term (1995: 79) in which, to utilise Bannister's phrase, 'diffused' observation was employed in taking in a

panoramic view of what was taking place (Bannister, 1999: 22). My own description would be that my observation technique in these early days was closer to that of a 'shotgun' approach in which interesting people, events and activities were noted down with little discrimination and less understanding, in a small, handy notebook on site. As the study progressed my comprehension of events taking place around me increased and allowed me to target certain phenomena on the ward. Patient mealtimes, medication routines, bedtimes and awakenings were just some of the events I sought to observe at certain times of the day and night. I therefore made myself present for early morning breakfast rounds on the wards, and mid-morning snacks; present for soporific afternoons and patient siesta time, and occasionally kept a night-time vigil with the staff night shifts. These latter shifts proved to be the most sociable and companionable, with staff most amused by my persistence and supportive of my endurance. On these occasions I could rely on coffee and *mee goreng* (fried noodles) to be liberally supplied to keep tired eyes open, including mine.

At first I had felt grotesquely conspicuous and felt that staff in varying degrees were self-conscious when going about their 'normal' business under these artificial circumstances. I did however eventually manage to achieve a certain invisibility where everyone, staff and patients alike apparently ignored my presence on brief occasions. These however were punctuated by my participatory activities, in which individuals would engage me in conversations for instance. With regular appearances on the wards I felt that people, including myself, felt more at ease with my role and that observation appeared more natural and less intrusive on the whole. I believe that in time my explanations regarding

observation techniques began to be accepted by participants: namely, that I wanted to see what it was like on the wards and the kinds of things that could happen on a typical day.

Here then the method used to collect data in this study relied heavily on observation strategies, which appeared to straddle at times Burgess' definition of 'participant-as-observer' and 'observer-as-participant' (Burgess, 1995: 80-2). In retrospect however I regard my observation strategies as conforming closely with the definition of the 'participant as observer', as defined by Tim May (1999). In which observation is an 'overt' and public role, where an attempt is made to develop working relationships with participants as informants for the study (May, 1999: 140). The former is seen as offering 'great potential' to the researcher in its scope to participate actively as well as to observe, and in its flexibility to pursue interesting opportunities for research activity as arise, whereas the latter are seen as formalised, brief and non-participatory. Ladislav Holy by contrast describes the 'participant observer' role as involving observation as the primary tool for data collection complemented by other techniques. In contrast to my observation strategies, Holy prescribes that the 'observing participant' role is one of prolonged immersion in the daily social activities of the subjects of research whereby

The researcher should refrain from asking even simple questions if they are ones which a subject would not ordinarily ask. Asking questions prompted by the researcher's current theories means forcing the subjects to adopt an attitude which is not ordinarily part of their praxis. (Holy, 1995: 29).

Clifford and Auger however warn the reader of the problems associated with ascribing legitimacy to ethnographic representations drawn from observation where research bias is not subjected to scrutiny in relation to the study of cultural forms (Clifford, 1986: 14; Auger, 1995: 100).

With regard to assumptions drawn from poorly comprehended phenomena, I would state that my own methods of observation were heavily dependent on the context of the situation where I found myself. I am aware that there was much seen where the relevance escaped me at the time, and much recorded that later events and ensuing reflection revealed to be representative of my assumptions alone. Based on the number of observations I recorded, I can only vaguely extrapolate on how much I must have been oblivious to although it was literally taking place before my eyes. Opportunities for observation however usually pivoted on my judgement of what would be appropriate and ethical behaviour at the time, such as opportunities to observe patients bathing or alternatively being medically examined in the public arena of the open ward. I was not in a position to actively participate in ward activities therefore my involvement was largely already defined by the hospital based on the restrictions of a unique role of being neither a member of staff, a patient nor an ordinary visitor.

In this way therefore my observations narrowed down over time from a broad sweep of noting everything and anything that caught my attention to a narrow, and hopefully, more acute focus (Bannister, 1999: 22). Critical observation was a very useful method for the exploration of issues that I regarded as particularly interesting and relevant to the study,

such as the confined conditions that existed on the female wards, as discussed in Chapter Seven; these being accepted as a norm and consequently little commented on in respondent accounts. Through the use of observation techniques employed in a comparative exercise, I found that data from observations both informed and synthesised my developing hypotheses in a rigorous and synergistic relationship (Burgess, 1995: 79). Once however that I felt that I was beginning to see many repetitions of recorded phenomena, I began to have some indication that my data were achieving some level of saturation and that my fieldwork was reaching completion.

4.3.3 Interviewing participants

My observation strategies on the wards allowed me freedom to adjust to situations taking place and consequently I would often engage or be engaged by patient and staff informants. Most of these were informal conversations on a particular topic that I wanted to explore further (Shaffir, 1991: 79). These being unstructured and flexible, informants participated in guiding the conversation along areas they had chosen and on many occasions initiated the conversation from the outset (Lee, 1993: 110). Here my interviewing strategy tended towards a deconstructive manoeuvre of attempting to overturn hierarchal distinctions through an appearance that was casual, informal language and mannerisms, and generally trying to avoid with varying degrees of success the attitude and appearance of an *orang puteh* (white) lady visitor. Conversations with patients were fluid and spontaneous with participants joining in and departing from the discussion at hand as they pleased. This less formalised approach meant that patients chose the location to discuss matters and involved various settings. Occasionally we sat

on stools under trees, or on the open veranda that most wards had, sometimes in the canteen or otherwise just sitting on beds inside the ward or in the rather bare recreation room. Some conversations took place in the occupational therapy department with patients chatting to me while they worked. Sometimes patients, usually men, would approach me ask for a cigarette, which I did not have, or money, which I concealed, and then following this overture a discussion might be struck up. Similarly casual conversations with staff took place at the nursing station on wards, in private offices during tea breaks or while carrying out duties.

At other times interviews were more formal where I wanted to discuss a range of issues based on a semi-structured interview guide that I had prepared earlier. The only criteria used for these interviews with patients were that they were willing to talk to me and fit enough to be interviewed and here I relied on advice from the ward staff on the patient's state of health and lucidity. Semi-structured interviews with patients, as opposed to informal discussions, took place in the treatment room at the end of the wards. This room separated from the main ward by a grill gate and was about the only private place that could be allocated to me. Nonetheless interviews were often inadvertently interrupted by the nursing staff, cleaners or other patients who wandered in. Interviews would then be momentarily suspended if possible, before continuing. Semi-structured interviews with selected members of staff were conducted at various intervals with medical officers, nursing staff and allied personnel, such as occupational therapists and the two social workers, as well as former members of staff. Normally these interviews required careful planning due to medical schedules and out-patient appointments and therefore they were

usually tape-recorded supplemented by extensive note taking during the interview process itself.

Semi-structured interviews with patients were usually taped with their consent. The open use of a tape recorder in informal situations was eventually seen to be too intrusive for general conversations after I detected that, in particular, members of staff felt uncomfortable and inhibited by the idea. Furthermore I had the impression that the tape recorder was distracting for patients as well as intrusive and tended to curtail spontaneous disclosures. Occasionally, with many misgivings about the ethics of such a procedure, tape recordings were made covertly by using a tape recorder concealed inside a bag but this was abandoned as the quality of sound was so poor and my discomfort too great to merit such intrusive strategies (Mitchell and Charmas, 1996). In general however I found that by not using a tape recorder, although something of a strain on my memory, the flow of conversation was not interrupted and a more relaxed and confiding atmosphere could be created. At such times I would attempt to exit the ward in order to write up my notes in secluded corners before returning, this however was a device which more often could not be employed due to the fact that I was not able to freely move in and out of certain wards due to 'lock-up' procedures, as is discussed in more detail in Chapter Seven. Consequently my only recourse was to memorise as much as possible or occasionally whip out a very small notebook from my pocket and record as I went along if I felt that my informants would not be disturbed by it (Emerson *et al.*, 1995: 23). On one memorable occasion I had borrowed a medical textbook from the hospital library and on the pretext of making notes from it was able to sit on the ward and record my

observations at leisure. No doubt the sight of a foreign, female academic choosing a noisy and overcrowded male psychiatric ward to study in must have seemed deeply incongruous.

In order to maximise the choice of methods available to an ethnographic enterprise and in the hope that groups of single-sex cohorts would stimulate further discussion, I attempted to hold focus group discussions to supplement interviews and conversations. These were held with several different groups of psychiatric service users, from those attending local community services to in-patients at the hospital. The first set of focus group discussions were carried out with the residents of the 'halfway homes'. This was an NGO-run supported housing scheme, whose residents had all originally been referrals from the hospital and were obliged to return to it periodically due to relapses in their mental health. For the second set of discussions participants were invited from the psychiatric day centre located in the grounds of the Sarawak General Hospital. These participants came from a variety of backgrounds, some were now discharged and living at home once more, whilst others were in-patients at Hospital Sentosa or residents at the group homes. Finally, two group discussions took place separately with male and female patients from Male Ward 1 and Female Ward 1.

Focus group discussions are meant to engage participants in a 'permissive environment' that seeks to capture a variety of opinions on specific topics and therefore seemed in theory a useful method in my ethnographic toolbox (Marshall and Rossman, 1995: 84). Unfortunately this did not prove to be a particularly fruitful method and few of the data

gathered was used. The groups were chosen according to consenting cohort selections based on single sex groupings of similar ability in terms of cognition and verbal skills, familiarity and orientation with hospital practices and procedures. The topic of conversation was designed to elicit responses to these aspects of hospital life, as well as opinions on community values in relation to mental health issues and work-related topics.

Upon reflection I suggest that there were a variety of reasons why this method proved unsuccessful. In part this was due to the artificial nature of the cohort selections, as opposed to the natural groupings of chosen companions in informal discussions, in which I did not intervene with a selection process. Conversations in natural groupings generated a confident companionship that participants shared with each other and to which I was invited. Topics discussed were those that my participants thought were interesting and relevant to their lives and not just those that I thought worth pursuing. The focus group discussions overturned these more equitable arrangements and here it was I alone that chose topics that I considered useful to myself and apt for my participants. It is therefore quite likely that the topics were therefore not the ones participants might have wished for, given the choice. I can speculate that maybe there was too broad a focus for the groups or that probably the topics seemed abstract or irrelevant, but this would distract from the main point that it was I who had the power to force the agenda in these discussions rather than sharing this with my participants.

A further and more prosaic consideration is that the day centre tended to care for individuals who had suffered from a long period of psychiatric history and who in consequence may not have been sufficiently well enough to respond with many insightful comments. An additional point in relation to the day centre and half-way homes is that as I had invested most of my time and energy on the selected hospital wards I had not managed to develop sufficient rapport with respondents. Therefore individuals at these two resources may well have been cautious about discussing in-depth issues with me, particularly as they were reliant on the support of affiliated if not directly connected service-providers.

4.3.4 Rapport, reciprocation and power in the interview situation

Although I had initially hoped to engage a wide range of respondents, in reality some were considerably more responsive than others and opportunities to talk to both patients and staff were seized more on the basis of luck than design. In this way the selection of informants usually from those who were simply present at the right time and place is commensurate with Burgess's definition of 'opportunistic sampling' (Burgess, 1995: 55). To reiterate, in common with some research accounts I managed to develop a small network of primary informants amongst patients and staff who, generally speaking, could be relied on for a friendly and informative reception (Shaffir, 1991: 76; Gearing, 1995: 199).

Amongst the patient population my key informants were nearly all women; male patients tended to shy away from contact or at any rate often seemed less likely to respond to my questions with relevant information. On the face of it this is in keeping with the rapport Ann Oakley discovers in her research activities through the democratisation of the interviewing process, premised on the notion of shared commonalities, of which she writes:

The women were reacting to my own evident wish for a relatively intimate and non-hierarchical relationship. (Oakley, 1984: 47).

However I lacked the basic common grounds that Oakley held; she was a British mother, interviewing British mothers. Whereas I was a foreign woman who had never been admitted to a psychiatric hospital and was attempting to develop a rapport with women, many of whom had spent years of their lives being processed by the Malaysian psychiatric services. Yet, despite Daphne Patai's critique of pseudo-identification on my part, I remain convinced that empathy of sorts was created during these times, albeit fractured with misunderstandings, cultural and social and sexual dissonances (Patai, 1991). Women patients were often very friendly and even affectionate to varying degrees. I was subjected to a lot of gentle physical contact, and complimented, while at least one woman attempted to develop greater intimacy with me through sexual overtures.

The enveloping, cordial, affectionate and sometimes cloying atmosphere on the female wards was not replicated on the male wards. Rachel Forrester-Jones (1995: 116), in reference to Ann Oakley, discusses the problem of creating reciprocal relationships with informants of the opposite sex to the researcher, where heterosexual and gender issues permeate the platonic boundaries of the relationship (Bailey, 1996: 60-1). She concludes that reciprocity is jeopardised by unshared gender expectations and politics, where women researchers may receive or be threatened by the possibility of unwanted sexual advances from male informants. In accordance with this view Sue Estroff discusses the difficulties of negotiating relationships with male psychiatric informants whose social unfamiliarity with women creates a potential for painful misunderstandings.

Being female helped and hurt. Over half of the subjects were men. My gender served as an entrée to contacting them and eliciting some interest, but it created tensions as well. Many had never had a female friend, that is, a symmetrical, platonic, heterosexual relationship. This led to some confusion of their part when their sexual advances offended me, and to reluctance on my part in entertaining situations with them that might be misconstrued. It was often inappropriate to participate with the group as the only female, and as a sexually inaccessible one, at that. (Estroff, 1985: xvii).

Unlike Estroff's case, my contact with male patients did not take place in the social context of the community, but with only one exception, took place on the ward and for the most part in full sight of other patients and staff. Nevertheless it was awkward and embarrassing to be the regularly subjected to so much inquisitive, blatant or forlorn attention from male patients. Perhaps most painful to my sensibilities was how to deal with patients who persisted in calling, flirting and chatting to me through the bars of the locked section. I was of course very aware that I was free to stay or go and they were

confined, bored and excited by any break in the tedium, which no doubt I represented. By persisting in staying on the ward, as fieldwork demanded, I was aware that I was also guilty of encouraging and exacerbating this mortifying sexual attention in an atmosphere of palpable, claustrophobic voyeurism which verged on sexual harassment (Gearing, 1995:192). Furthermore, evasive strategies could not be properly mobilised, such as the feigned dignified, and casual indifference of a woman passing a building site, as this directly conflicted with the research guise of keen-eyed vigilance to detail. For the most part therefore, I tried to encourage relationships with male patients that were polite, friendly and neutral, in an atmosphere where physical contact and verbal, personal intimacy was subtly discouraged. Obviously there were exceptions to the rule, whereby some of my relationships with male patients were mutually respectful with no hint of a sexual overture on any occasion.

Contact with staff provided a fascinating contrast, in that, as stated, while female nursing staff were often reticent, their male counterparts the 'medical assistants' on the male wards were much more willing to disclose information to me than the female nursing staff and could be, when they chose to be, cheerful, amusing and friendly in their interactions with me. Such was the peculiar and intriguing balance, in that in general women patients and male nursing staff were by far the most helpful and friendly towards me, whilst male patients and female nursing staff, were often distant, close-lipped and occasionally overtly suspicious of me. One suggestion that would explain my cordial reception with male staff is that women researchers may be seen as more harmless (and usually less socially important) than male researchers by male informants and therefore

as less likely to use information in a damaging way (Bailey, 1996: 62; Gurney, 1991: 60; Warren, 1988: 18).

Any perceived lack of status on the grounds of gender may therefore have worked against forming a good rapport with female staff, in which there were few incentives for them to overcome the insider/outsider power dichotomy in an environment of closed ranks. Furthermore, Taylor (1991) points out that in his own research in a male dominated setting rapport with informants was built upon a foundation of male solidarity, socialising activities and initiation ceremonies, something I was culturally barred from in my own research with men and one which did not materialise with women members of staff. Yet a few friendships were developed between myself and female members of staff, one nurse occasionally pressed on me bottles of homemade *tuak* (rice wine), which at first I thought I was expected to pay for and only later realised were spontaneous gifts. In accordance with feminist epistemology I did not feel that these friendly, even intimate, relationships jeopardised some idealised objective stance but felt that these enabled me to develop deeper and more meaningful understanding of life on the wards. Although inevitably these too provided further arenas for moral considerations to be resurrected.

In conclusion therefore, the conditioning of women to conscientiously observe the boundaries between the sexes will continue to mediate relations in a research encounter. These will qualify the nature and depth of disclosures by informants as well as altering the agenda of what can be discussed in comparative safety for informants and researchers alike. I was, for example, very interested in learning more about the sexuality of male

patients but this proved to be a problematic area for inquiry, and one where responses from male staff and patients were unsatisfactory, superficial and laden with implications. Lesbianism however was a subject that could be discussed with women, once relationships of comparative trust had been satisfactorily built. Reciprocity therefore is heavily dependent on gender relations in the field and consequently influences the quality of disclosures from informants. Like Forrester-Jones (1995: 117), I feel that a male co-worker would have been able to elicit information from male informants that was to some degree inaccessible to me as a woman researcher in the field.

4.3.5 Documentation and statistical information

In his ethnographic account of psychiatric patients in Australia Barrett makes full use of medical records and attends team meetings to augment information on informants (Barrett, 1996: 6). However at an early stage of research I decided that I would not request access to patients' medical records although did note verbal information on patients from staff¹. My reasons were partially practical and partially ideological. Current medical notes were kept on the ward and staff consultations of them took place in plain sight of patients so that it was not possible to avoid being seen reading them. Any such activity by myself would have been conspicuous and instantly noted by patients and I feared that this therefore might interfere in forming relationships of trust with patients. Furthermore I felt that these could probably contribute little in the way of understanding interactions in the hospital: my interest was located in everyday events and the perceptions of informants rather than in turgid medical information which could largely provide me only with details of admissions, discharges and medication. I also felt

¹ I did not need to consider whether to attend case study meetings as these did not occur at the hospital.

strongly that this was a transgression of privacy, which my status as researcher could not entitle me to with any real justification, particularly when patients prefaced their interviews by asking me if I had read their medical notes. I felt that my reassurance that I had not read them created a more confiding environment in which to seek personal disclosures from patients who might otherwise see me as a sort of member of staff or some such similar type of authority, although this of course did happen.

Despite my good intentions however, I had not bargained for the frequent invitations by staff to read the notes. The nurses and medical assistants often seemed to feel the need to fit me into some type of legitimate medical role and offered me the records on numerous occasions, sometimes opening them at certain pages and putting them in front of me, which made it difficult to refuse a quick perusal. This bears comparison with Burgess's research experiences in a school setting, where he describes a similar need by staff to try and neutralise him through assimilation into the professional corps he was in part studying (Burgess, 1995: 85-6). Similarly therefore the invitation of medical notes not only legitimised my presence but also my research, which otherwise probably seemed a nebulous and unscientific way of going about things. The notes offered concrete and valid information in the eyes of staff, as opposed to the naïve and no doubt foolish questions I asked. My insistence on sitting with and talking to patients was commented on, to reiterate, with levity, incomprehension or thinly veiled hostility (Lee, 1993: 121).

In addition to my other privileges I was given licence to access the hospital's statistical records, which covered most aspects of admittance and discharge based on demographic features going back over several years. These data enabled me to explore in-patient populations based on gender and ethnicity that proved to be very illuminating and is consequently referred to in the study. Statistical information therefore served to orientate me in relation to this specific study, while providing insights into the general state of affairs in some of the larger institutions in Peninsular Malaysia.

4.3.6 The process of analysis

To return to my introductory point, data analysis in ethnographic methodology does not occupy the discrete, hygienic position of analytic processes in the hard sciences. In some qualitative texts however, such as that by Huberman and Miles (1994) ethnographic analytic codes are illustrated in a quantitative manner that appears to emulate a positivistic framework (Brewer, 2000: 107). In ethnographic 'grounded research' analytic methods seek an inductive position where hypotheses are developed from analytic categories, grounded in the data (Glaser and Strauss, 1967; Rennie, *et al.*, 1988). Reflection is not permitted to inform the research process prior to the latter stages of analysis. The researcher is therefore not expected to contaminate the data *a priori* by a theoretical positioning (Henwood and Pigeon; 1993: 22). Although Janet Parr asserts that 'grounded theory' in this formulation is compatible with a feminist methodology, Stanley and Wise (1994) point out that for feminist research the borders between data collection and data analysis in the research process are blurred as one informs the other (Parr, 1998:

90). Inductive reasoning is supported by a subjective consciousness influenced by a political positioning.

It isn't possible for feminists to do research on sexism in such a way as to leave 'us' untouched by this. But the kind of experiences we had, which we suggest are inevitable wherever feminism encounters sexism, are something which researchers are generally counselled to prevent. Often, indeed, it is suggested that the point at which such involvements begin is the point at which research should be terminated. (Stanley and Wise, 1993: 160).

Consequently this study presupposes from the outset a theoretical, political hypothesis that sexist oppression exists towards women patients in the study, although the way in which this is manifested was as yet unknown. Self-reflexivity was used as a means of developing a reflective stance in analysis as well as comprising data in itself as defined and elucidated by Brewer,

Data are seen as created in and through the interactions that occur between the researcher and the people in the field, and that analyses must therefore illustrate the situated or context-bound nature of the multivocal meanings disclosed in the research. Reflexivity is thus a critical part of the analyses in these types of ethnography, in which the ethnographer constructs the sense-assembly procedures through which the data were created, locating them, and therefore the analysis is the processes that brought them about. (Brewer, 2000: 108).

To provide greater rigour in terms of validity, a triangulation method was used to compare the different accounts given by participants towards specific issues that had been raised (Roseneil, 1993: 201). This rarely resulted in a corroboration of 'facts' but provided ample opportunity to explore the perspectives of respondents to issues, such as the rationale behind sexual segregation of patients in the hospital, which proved to be very illuminating, as Carol Tindall points out:

Accounts from people differently positioned within the context are unlikely to fit neatly together. They do, however, highlight how experiencing and thus understanding are context bound. (Tindall, 1999: 146).

Data therefore were collected in the main through extensive note taking and here two different types of recordings were made with textual subdivisions that I refer to as memoranda and acted in effect as a computerised 'research diary'. One type of recording was used to note down activities, events, narratives and descriptions of people and locations. The second ran a parallel course and was used to record my responses, attitudes, emotions and thoughts to the same phenomena in a self-reflexive exercise. The data, quickly imparted to notebooks, would then be formally written-up into my memoranda at the end of each working day in the field.

Although traditionally ethnographers have analysed data by hand I decided to assist the analytic process by using software dedicated to qualitative research as the bulk of the data being accumulated threatened to be overwhelming in terms of efficient management. Software programmes have been subjected to criticism as not facilitating sufficient in-depth analysis of data due to the limitations of programmed classification types in which it is suggested that a cut-and-dried procedural model can encapsulate the ethnographic endeavour (Brewer, 2000: 18). Given these caveats, the software Ethnograph v5.0 was chosen and used throughout data collection and analysis on the grounds that this did indeed represent a means of not only managing the data, both 'raw' and reflexive, but was sufficiently flexible to be a useful analytical tool. The features of this piece of software are that first of all, it is dedicated to the ethnographic task and was developed

within qualitative academic circles and was not adapted from general commercial software (Lee and Fielding, 1991: 9). As an introduction to a description of the software therefore it enables the researcher to write expanded research notes in its word processing facilities, which are then available for coding at increasing depth in the analytic process. In this way it replicates the ways that ethnographers have conventionally recorded material manually for the generation of hypotheses, which could then be checked during the process of data collection and analysis (Silverman, 1993: 21; Spradley, 1980: 69).

In this way therefore, using different but connected types of documentation programmes in the word processing facility, the descriptive 'raw data' and the self-reflexive data could be recorded in a simultaneous, mutually referential process. Document formats in the software supported the development of a variety of 'memo' notes, which could be inserted at given lines of text in a coding format, enabling me to record comments and observations in a spontaneous, specific but easily retrievable form. Personalised memoranda of a self-reflexive nature stood independently of the primary 'raw data', and conformed in some ways to what Brewer, following Stanley, refers to as 'descriptive and analytic' reflexive recordings. Insights based on descriptions as well as those containing reminders and checking procedures were consistent with a descriptive self-reflexivity, whilst my concerns about what I was seeing in relation to what I understood by it, conformed in some senses to an analytic self-reflexivity (Brewer, 2000: 130). Through these means the design of the chosen software was found to be a means of facilitating the conventional ethnographic process of data recording and analysis that was found to be easier to comprehend and manipulate than, for example, the more unwieldy NUDIST

software programme with its complicated 'tree structures' of hierarchical relationships (Brewer, 2000: 119).

The coding exercise is therefore a highly personalised form of analysis in which the significance of the data resonates with the preoccupations and partisan positioning of the researcher (Hammersley, 2000). Whilst feminist researchers go further and suggest that being so, this is in fact an oppressive exercise albeit one that offers no particular solution to my situation.

The data analysis stage can be viewed as a deeply disempowering one in which our respondents have little or no control ...We dissect, cut up, distil and reduce their accounts, thereby losing much of the complexities, subtleties and depth of their narratives. (Mauthner and Doucet, 1998: 138).

In writing up the data, therefore, initial codes relating to emerging themes and patterns could then be developed as appropriate, there being effectively no limit to the numbers of indexing codes permitted in the software. Categories of phenomena, classified into indexing codes, could then be checked to see if they acted as single instances or formed recurring patterns that could then developed into themes. These themes form the findings of the study and are the basis for Chapters Five to Nine in this thesis.

As for obvious reasons a proliferation of codes is unwieldy the software permitted codes to be combined and collapsed according to the analytic process, whereby a number of themes could be identified as identical phenomena as opposed to, for example, branching from a common coded factor. The software codes were displayed in two different ways,

firstly through an expanded 'family tree' and secondly through a list that records sequential 'parent' and 'child' codes. Both types of display revealed the connections in the 'branching' process of developing analysis.

Through these means primary indexing codes could be developed in the initial stages, allowing a further process of coding at an in-depth level, which was dependent at each stage on cross-referencing techniques. In this way, data could be analysed in a linear, horizontal fashion, in which a chronological order of events and thought processes could be scrutinised. In addition a vertical analysis was brought to bear, whereby data were subjected to reordering into themes, commensurate with the continuous process of reflection, investigation of hypotheses, elimination of some avenues of inquiry and pursuit of fruitful ones. The software permitted manipulation of large amounts of data making it easier to locate examples within texts through search and filtering procedures, resulting in greater freedom to draw interpretations (Tesch, 1991: 25). Finally, the data gathering and analytic process being completed the resultant interpretations became the textualised and constructed text, grounded in narrative and observation, informed and made transparent through the self-reflexive analytical process.

4.4 Language and linguistic barriers

Competence in the language of informants is usually perceived to be part of the 'mystique' of ethnographic work, to paraphrase Charlotte Aull Davies who goes on to expand on the limitations imposed by reliance on translation (Aull Davies, 1999: 76). Accordingly Agar comments on the uncomfortable feeling associated with having insufficient control during fieldwork when obliged to use interpreters but comments that this is probably not an uncommon sensation for fellow researchers (Agar, 1996: 51). Equally Ardener notes how 'alienating' it can be to rely on translators and that time spent attempting to learn the language is well used (Ardener, 1995: 106). Martha Macintyre comments ruefully on the anthropological assumption of linguistic competence and her initial despair at her complete inability to speak Tubetube (Macintyre, 1993:46).

To put the language problems in this study into context it should be noted that in Sarawak, as in Peninsular Malaysia, the national language is *Bahasa Malayu* and all Malaysian civil servants, including medical staff, are expected in theory to reach a high level of proficiency if they wish to secure permanent posts. The Peninsular uses a refined version, but in Sarawak a shortened, simplified version is the common argot. This is not to suggest however that *Bahasa Malayu* is understood and used by everyone, the cultural diversity of people has meant that for many it remains a foreign tongue. The Dayak language Iban, for instance, has many similarities to *Bahasa Malayu* but Bidayuh has a completely different structure and many obscure dialects. It is not uncommon to find that the older generation, specifically Chinese, Indian and Dayak families, speak English with greater fluency (due to the region's colonial history) than the official language. In the

early sixties Dr K.E. Schmidt, described the problems caused by linguistic diversity in the following way:

The chaos of languages in Sarawak constitutes the main difficulty for anyone concerned with mental health in this country. Among its bare three-quarters of a million people, at least twenty-one different languages (not dialects) are spoken. This situation obviously militates strongly against hospitalization, which is avoided as much as possible, since even normal people are unable to converse freely with each other. (Schmidt, 1964:155).

At Hospital Sentosa therefore a combination of languages and dialects are used, but most members of staff are familiar with English having been trained in that medium. Few patients however are competent in English and will use a mixture of Malay, Iban, Bidayuh and Chinese dialects, such as Foochow or Hokkien. Despite the plurality of languages staff and patients manage to verbally interact reasonably well and there is usually someone to hand who can translate.

Yet as with Dr Schmidt, communication for me was also highly problematic as my Malay was very basic and my ability with other commonly used Sarawak languages was non-existent. Painfully aware of my incompetence in this area I found myself obliged to use translators some of the time. Fortunately I was able to recruit some multilingual translators to help with the focus group discussions and several semi-structured interviews. Being my own final-year social work students these translators were well known to me and consequently I was able to discuss problems of translation and interpretation with them in detail before interviews. Their understanding of the study, awareness of confidentiality issues, as well as basic grounding in mental health issues

proved invaluable, although I remained very much aware that however detailed and accurate their translations were, nuances would inevitably be lost in the process and that this represented a certain drawback. Nonetheless our drives home were filled with fascinating discussions about the interview and our different interpretations of events and phrases, which assisted me to develop a closer idea of how our assumptions and beliefs had coloured our impressions and were duly recorded in my research diary.

The bulk of the study however was undertaken alone and involved an immersion into the linguistic environment, which improved my language competence considerably. Translations with patients were still required at times of course, however these were often spontaneously provided by other participants who might also be translating the general meaning to others. Once I appealed to a patient standing by and apparently listening to the monologue of one particular person, asking 'what is she saying?'. To which the unconcerned but affable reply was, 'I also do not understand, never mind'. Generally however I did understand much of what was being said, the gist was usually caught without too many problems, words falling into specific meaning at a later date, although sometimes irascible Maya, a long-stay patient, would crossly tell me I was *bodoh* (stupid) for not understanding her. With some patients, such as Maya who had much to tell me but was hampered by my linguistic incompetence much of the time, a strategy evolved whereby she and others would be encouraged to write down their thoughts for me to take away and have translated later.

Due to my slow and hesitant use of language I was heavily reliant on the circumstances in which utterances and gestures took place and who responded to speakers or who ignored them (Fabian, 1996). It was some time later that I came across Unni Wikan's comments on her own very similar position, whereby she utilises a postmodernist debate about whether language is able to fully represent and express the relationship between the self and the external world. Wikan dismisses an ethnographic preoccupation with words, such as is the basis of discourse analysis and argues for a more 'empathic' attitude, commenting that it may instead be necessary to

Transcend the words, we need to attend to the speaker's intention, and the social position they emanate from, to judge correctly what they are doing. (Wikan, 1993: 193).

I would entirely agree with Wikan's point as what I noted frequently was how little weight and attention were given to patients' words by staff and fellow patients. By contrast the statements of staff were weighty and authoritative. English was used by staff as largely *the* language of medical authority and nearly all nursing staff spoke a formalised English to the ward doctors, but returned to the locally flavoured English garnished with Malay when amongst themselves (Spradley, 1979: 71). Finally, while physical distance was the norm between the medical staff, and myself as well, as in contact with men in general, physical proximity and touch was used as another dominant and most eloquent medium of communication by many of the women patients. I experienced having my hand held, embraces, pats and strokes and at the other extreme threatened slaps or spitting conveyed a wealth of meaning, which often made verbal communication redundant.

4.5 Some ethical considerations

Ethical considerations permeated the fieldwork experience and are therefore alluded to throughout this thesis. In this section therefore I attempt to draw attention to some of the ethical issues that coloured the ways in which my presence and role were interpreted and demarcated. These examples serve as a means of illuminating the ambiguous nature of my position in relation to what was perceived and consequently do not act as an exhaustive list of instances.

One of the main dilemmas I experienced throughout fieldwork was related to how far I should involve myself in those events taking place around me which I interpreted as being of a dubious nature. On some occasions I felt that I should intervene, whilst on others I remained uncertain and kept silent, inducing in me anxieties about tacit collusion, which remained unresolved. Two short examples serve to illustrate this dilemma quite well. The first took place during an informal chat with a medical assistant who was talking about his job in an animated fashion. Close by a male patient was aiming vicious kicks and blows at another who was cowering without retaliation. It is very likely that this would have continued if I had not quite quickly drawn the medical assistant's attention to what was taking place a few yards behind him. My interference at this point I felt to be perfectly proper behaviour, however on another occasion during the early days of fieldwork I witnessed a woman patient approach a nurse to ask for a sanitary towel. A brief wrestling match ensued while the nurse attempted to expose the woman's naked genitals in public to verify that the patient's menses had really begun. Judging from the

patient's reaction this was a humiliating violation of personal privacy, but one in which I did not intervene but instead carefully noted.

The first example shows me in a paternalistic light as the two men were patients and also suffered from learning disabilities, as I knew. I also assumed at the time that the medical assistant seemed to be momentarily neglecting his duties perhaps because I was distracting him and that therefore this accidental omission gave me license to interfere. In the latter case, the emancipatory aims of this feminist study notwithstanding, I was uncertain of how much authority I could bring to bear on the situation and whether my primary role was to observe or to intervene. Whilst naturally the thought flickered through my mind that interference between a nurse and her patient would also jeopardise my tenuous standing on the ward and consequently my study.

Subsequently I witnessed other episodes involving staff and patients which worried me but more often I was presented with low-key dilemmas; for example one woman that I got to know quite well asked me to intercede with the staff on her behalf. Once or twice I did bring these kinds of matters to the attention of the staff but most of the time I tried to encourage patients to voice their own concerns to the appropriate authority. I wanted to avoid being seen as either an unorthodox member of staff or alternatively as an adopted advocate on patient issues. Thereby finding myself neatly caught in quandaries and dilemmas regarding the role of a feminist researcher faced with actual instances of oppression in the field. I reasoned that either situation would probably interfere with developing relations with groups of informants as well as probably contravene my agreed

role in which it was agreed that I would confine myself to research only, feminist politics regardless. Therefore at other times I believed that I should confine my role to simple observation and did not interfere with events taking place around me, yet the issue remained, perplexing, distressing and irresolvable.

In relation to these kinds of issues, albeit not from an overtly feminist perspective, Mary Nettle describes how she was able to draw clear boundaries between her brief as a researcher and deeper involvement in the concerns of psychiatric patients (Nettle, 1996: 205). Melissa R. Gilbert warns against the imposition of the researcher's own values onto the subjects of research as being an arrogant betrayal of trust (Gilbert, 1994: 93). While Shirley Kleinman points out the difficulties of managing negative emotions towards events and participants in the field, and that these feelings express personal values through which a process of deeper reflection and analysis is usually distanced from by time and place (Kleinman, 1991: 185). Kim Lützén however acknowledges that 'holding values in suspension' can be morally ambiguous during times when we should intervene and such situations remain problematic for researchers in terms of ethics and methodology (Lützén, 1996: 79; Robertson, 1996: 293).

Given that a feminist study purports to be a moral enterprise and weighing up the contingent status of research my response to this kind of dilemma was clearly a pragmatic one. In order to initiate any level of change I usually resorted to questioning staff about the rationale for policies and practices. This served a dual purpose of firstly attempting to avoid prejudging behaviours without understanding the context in which they took place.

Secondly, I hoped through these means that my questions would spark a process of reflection in my respondent that would challenge established attitudes on the ward leading to change at this point in the hierarchy of power.

CHAPTER FIVE

THE TRANSFORMATION TO PATIENT-HOOD

5.1 Introduction

This chapter draws on a variety of themes based on research findings that attempt to define the parameters of life on the ward. These cover an analysis of the spatial configuration of the hospital environment and admission and discharge procedures. The classification of patients in relation to their psychiatric 'career' from acute to chronic status is considered (Goffman, 1993). An introduction is made to the socialisation of patients to the hospital environment through issues raised by participants, with a view to exploring these themes in greater depth in subsequent chapters. The themes utilise patient and staff accounts, as well as self-reflexive field notes, in an effort to describe and illustrate life on the wards.

5.2 The ideal asylum: physical boundaries and demarcated values

Hospital Sentosa occupies an ambiguous position in public perceptions in that primarily it embodies in concrete form the connotations of stigma that mental illness represents in Malaysia (Lau & Hardin, 1996; Trad, 1991; Wintersteen *et al.* 1997). At the same time it attempts to counteract this image through public relation exercises aimed at informing the general public, resulting in exhibitions, public talks and media statements. The hospital's appearance works to its advantage in this endeavour, as is not unattractive and is far less forbidding than many of the Gothic psychiatric establishments built in nineteenth-century

Britain epitomised by the gigantic London County Asylum at Colney Hatch (Shorter, 1997: 34).

These days one enters Hospital Sentosa through a main door that is decorated with floral murals and is then presented with the view of a long, low, whitewashed quadrangle of administrative offices, open-plan wards and recreational workshops built around a central square lawn. Two arms of corridors extend at the end of this quadrangle leading respectively to the private wing and at the other end to the general wards. In this way the layout of the hospital typifies a fundamentally pragmatic if value-laden design reminiscent of Saris descriptions of the ideal asylum, albeit on a much reduced scale (Saris, 1996: 543).

Class differentials are carefully built into the geographic space of the hospital, in that the fee-paying first and second-class wards are based at one end of the hospital in a pleasant area of brightly planted containers. To reach the single-bedroom units of the first-class wards the visitor is obliged to walk uphill to a small oasis of greenery. By contrast the majority of the congested non-paying 'public' wards are reached by walking in the opposite direction heading downhill. Equally, and in common with many British hospitals of the same era, the hospital is segregated in terms of sex where men and women occupy exclusive spaces, reinforcing notions of gender difference and the presumed hazards and attractions of mixing freely with the opposite sex (Clark, 1996; Gittins, 1998). In this vein Foucault draws a somewhat abstract observation of psychiatric institutions,

(With their) large populations, their hierarchies, their spatial arrangements, their surveillance systems (these are) delineated areas of extreme sexual saturation. (Foucault, 1976b: 46).

As Foucault conveys, this segregation serves to conspicuously underline the very issues of sexuality and gender that such spatial strategies attempt to evade in the first place.

Furthermore, just as men are firmly separated from women at Hospital Sentosa, there exists a further category of men who are separated from their own sex. These are the men of *Mei Kui* ward, a place that stands apart from the rest of the hospital, in an isolated block. This is the forensic ward, the 'Broadmoor' of Hospital Sentosa to quote Dr. Schmidt, which houses criminally insane male patients (Schmidt, 1961: 157). It has no female counterpart in this hospital and is a unique environment that is both a part of and yet stands apart from the rest of the hospital. Here female visitors are a rarity and female staff rarely enter unless accompanied by an escort. A pervading air of notoriety and danger is associated with *Mei Kui* and consequently I was reluctant to visit this part of the hospital for a long time. When I did so, I was very surprised to find it at quite different from my expectations and far less forbidding.

5.3 Categorising patients: the ‘salvageable’ and the ‘irredeemable’

The ‘acute’ wards for male and female patients are visible from each other as dormitory blocks separated by high chain-linked grounds. Such is the symmetry of the wards that public wards at ground level are placed one behind the other across a partially covered corridor. The major part of fieldwork was spent on these two wards which are, in comparison with the ‘chronic’ wards, relatively busy environments and where the small but resident long-stay population of the acute wards is varied by a background of admissions and discharges of first-admission and multiply admitted patients.

While staff use the terms ‘acute’ and ‘chronic’ with the matter-of-fact attitude of those comfortable with accepted definitions, I was unclear about what was meant in each case. Consequently I questioned staff on most wards about how *they* used this term and which patients might be considered acute and which chronic. The outcome of this line of questioning was insightful but nonetheless raised more questions than answers. A person such as fifty-five year old ‘Margot’ on Female Ward 2, whom I knew well, would be classified as a chronic patient and as such has lived at Sentosa since being admitted as an unruly teenager. An extract from field notes provides a thumbnail sketch of Margot and the kinds of interactions we experienced when Margot was feeling cheerful and well.

Field notes. Female Ward 2.

Saw Margot who was as usual carrying round a child’s bucket filled with an odd assortment of items that represent her worldly possessions. Margot was feeling friendly and wanted to chat and once again I tried to get a coherent story out of her without luck. Margot is often lost in forlorn, confused thoughts about her former family, with many anxieties about ‘misbehaving’.

Today I discovered that her name is an alias. In fact, as a Chinese woman she carries a Chinese name and she was given the nickname of 'Margot' by an aunt due to her childhood love of dancing - a *veritable* Margot Fonteyn. Margot doesn't do much dancing these days though and sometimes I come across her in a frozen posture, apparently unable to speak at all. Today she is also preoccupied by her need to 'talk, talk, talk', for which apparently she has been scolded by nurses in OT. This is very sad, as when she feels well Margot is an animated and charming person, which stands in contrast to the mute and utterly bewildered figure on the ward at other times.

In her study of psychiatric service users in the community Sue Estroff notes that the term 'chronicity' is generally used to define the duration of illness, but is also used in relation to 'psychiatric, social, behavioral, attitudinal and interpersonal characteristics'. An individual such as Margot would probably be seen as a typical example of the chronic patient in her inability to communicate her thoughts adequately combined with her obsessions, her odd habits and peculiar appearance (Estroff, 1985: 44). Roger Gomm suggests that 'chronicity' is more generally used to describe the effects of 'institutionalisation': the petrification of individuals into a 'mental illness role' and again Margot would appear to fit this description as well on her 'bad' days (Gomm, 1996: 81).

At Sentosa, staff found it fairly difficult to precisely pinpoint the nature of 'chronicity' but described it in terms of practical considerations governing classification in a somewhat nebulous and circuitous way. To clarify the explanation then, on the 'acute wards' Female Ward 1 and Male Ward 1 the tempo is livelier and 'acute' patients are regarded as being in certain ways 'salvageable'. Once they are no longer suffering from a psychosis or any other condition affecting orientation or lucidity, patients on these wards are more likely to be responsive to visitors such as myself and are therefore popular

places for visiting nursing students and doctors. On these wards multiply admitted 'acute' patients form the largest group. Some veterans have been admitted on scores of occasions spanning decades in a 'revolving-door' cycle, managing nonetheless to avoid a permanent admission, almost always due to continued family support in the community.

Once this family support is seen to fail, however, and patients spend longer and longer periods at the hospital, their status becomes redefined even though their actual diagnosis may remain unchanged. Eventually this is liable to the new, demoted classification of the irredeemable 'chronic' patient, with an entirely different level of professional expectation attached to their condition. The point at which the practical hope is lost that a patient can be discharged back to the family 'home' is seen as a significant turning-point, where a patient is transformed into a 'chronic' patient and an almost inevitable downward path is charted, from which only a rare occurrence can prevent permanent custodial care and exile from life beyond the hospital walls. This general description, rather than specific identification, conforms more closely to Arthur Kleinman's discussion of the term in which,

Chronicity is not simply a direct result of pathology acting in an isolated person. It is the outcome of lives lived under constraining circumstances with particular relationships to other people. Chronicity is created in part out of negative expectations that come to be shared in face-to-face interactions – expectations that fetter out dreams and sting and choke our sense of self. (Kleinman, 1988a: 180).

Chronic patients at Sentosa therefore are those who have been hospitalised without discharge for years on end. They are therefore seen to be hopelessly 'institutionalised' regardless of the status of their illness, and therefore incapable of surviving outside of

custodial care without family support. This stands in direct contrast to the defined status of 'acute' patients who can and do survive beyond the walls of the hospital.

The incarceration and waste of potential of so-called chronic patients is not unappreciated by the staff on the wards who refer to the plight of their human flotsam in various emotive ways. I repeatedly heard of chronic patients being described by staff as having been 'dumped' and 'abandoned' to hospital care, as a further extract from my field notes illustrates.

Field notes. Male Ward 3

The staff seem generally pleased to see me and they are friendly and interesting; perhaps they are suffering from boredom. They show me one hapless Chinese patient of around 30 or 40 years old with wasted, bent limbs curled up on a plastic chair and cheerily goes to show me his case file. 'He's a rich man!' The Malay MA bursts out with a grin, 'yes, a rich man. His father owned many acres and died leaving it to him, but then the uncle took it because he (the patient) is a mental sub (mentally subnormal). But the hospital said he (uncle) must pay for 2nd class for this fellow, so at least he gets something. He doesn't have to be here – he could go home if someone feeds him with a spoon, but no they don't want him at home, so he must stay here.'

In the opinion of the staff, therefore, chronic patients are victims not so much of society, their illnesses or a psychiatric system which fails to find alternative means of care, but are instead victims of uncaring families, who are seen to be abrogating their duty to take care of their mentally ill relative for life (Ashencaen Crabtree, 2001: 149-150).

Finally, since a large majority of in-patients at Sentosa are long-stay individuals there are four times as many general wards for the chronically ill as there are for acute cases. Quite a few long-stay veterans on the acute wards are destined in due course for the chronic wards. While they can cope adequately and are youthful and active in most respects they will stay on the acute wards for as long as possible.

The years in institutional care often leave an indelible mark on psychiatric patients, which militated against my overtures to develop a conversational relationship. For many such patients, like Margot, it was not possible to maintain a conversation long enough for me to be able to extract a coherent account from the fragments of information seemingly arbitrarily strewn. This said, my presence could be greeted with enthusiasm by patients on some of the wards, particularly Female Ward 2 and Male Ward 2, which either by design or accident were home to a fairly gregarious set of people eager to shake hands and say hello, even when little that could be gleaned was deeply illuminating. Under these circumstances it was not the verbal responses but my observation of the every-day behaviour of patients and staff and the routines implemented and submitted to, that provided most of my understanding of what the chronic wards were like to live on.

5.4 The cycle of patient-hood through admission and discharges procedures

In interview it was often quite difficult to obtain much insight into how patient respondents perceived their admissions. Most had been openly escorted by family or through some form of guile, while some had been admitted by the police under dramatic and possibly more traumatic circumstances. Although respondents normally indicated an awareness of a transgression somewhere, this was not usually discussed in specific terms. Rather it remained a vague and uncertain set of circumstances, although some, of both sexes, admitted that violence or destruction of property had initiated action. Dimbuad, a Dayak patient, described how his original admission followed from a psychotic and aggressive episode after a period of drinking *langkau* (an extremely powerful and toxic ‘moonshine’). While newcomer Ai Lan, a seemingly passive and depressed young woman on her first admission, said that she had threatened to kill a member of her family in a family row before turning her aggression on herself in an abortive attempt at suicide.

Based on feminist critiques that claim a preponderance towards female admission to psychiatric services universally, my initial assumptions on commencing fieldwork were predictably, that this would prove to be the situation at Hospital Sentosa as well (Busfield, 1996; Chesler, 1996; Miles, 1988; Russell, 1995; Wetzel, 2000). Contrary to my expectations however, and without purporting to offer evidence beyond the boundaries of this particular study, statistical records from Hospital Sentosa suggest that a significant bias towards the admission of women over and beyond that of men may not be the general trend. Instead statistics revealed that admission figures broken down into gender variables over an admittedly limited two-year ‘snapshot’ of admissions,

demonstrated that the sexes were fairly equally represented during this time, with a slight bias towards the number of men. In 1997 for example, men represented 57% of multiple admissions at Hospital Sentosa and by 1998 the number had risen slightly to 58% of all admissions. Additionally in 1997 men still outnumbered women in terms of first admissions by a ratio of 68% but by 1998 this had dropped to 62%. Evidently, for this particular hospital, during this brief historical period at least, the sexes appeared to occupy an equal footing in terms of diagnosis and custodial care, albeit that the reasons given for admission did not offer a gender-neutral territory, as will be discussed further.

Patients under compulsory admission orders are usually brought to Sentosa under an antiquated piece of legislation built on the foundations of colonial legislation, which has remained in a virtually static state in independent Malaysia. This legislation is known as the 'Mental Health Ordinance Sarawak 1961' and like its UK counterpart, the Mental Health Act 1983, the Mental Health Ordinance Sarawak 1961 states that compulsory admission to hospital can only be made in order to protect the patient or others from harm. There is an added clause however that states that admission can be undertaken on the grounds of the protection of property from damage by the patient.

The Sarawak legislation does not offer a definition of mental illness, unlike the UK 1983 Act, but refers to mental illness or mental 'defect' as being of an 'unsound mind'. Consequently no distinction is made between mental disorders, illnesses and learning disabilities. That this *does* mean that detention at the hospital is made of people with epilepsy, Down's Syndrome and other disabilities loosely categorised as 'mentally

subnormal' is made apparent through statistical data pertaining to Hospital Sentosa. Finally, in Sarawak the process of admittance empowers a magistrate to order the apprehension of 'any person reported to be of an unsound mind or to be behaving in such a manner as to suggest that he is of unsound mind' for a period not 'exceeding one calendar month' (Mental Health Ordinance Sarawak No. 16, 1961: 4 (2.1): 2). At which time a medical report must be prepared and following this period an inquiry held; however as the Act goes on to say, the detainee has no right to be present at an inquiry if the Magistrate 'is satisfied that, by reason of his lack of understanding, no good purpose would be served by his attendance' (No. 16, 1961: 9 (1): 3).

By comparison in the UK the statutory Approved Social Worker role is premised upon the need to preserve the rights of psychiatric patients in admission procedures, and while this is in the process of revision in Britain, a corresponding role has never evolved in the Malaysian system (Butler and Pritchard, 1983; Hudson, 1982; Pringle and Thompson, 1986). Heavy paternalism tends to dominate proceedings in the admittance of patients in Sarawak and once in the custody of care the coordination and the statutory observation of the processes of admittance and review can frequently be haphazard. According to the prominent former State Chief Psychiatrist Dr. Abdul Kadir, who was also the former director of the hospital, it is not uncommon for the maximum period of confinement to be overlooked by busy staff or unconcerned relatives.

'(Compulsory) Certification to hospital is currently unstandardised throughout the country, which is a problem. A more rapid admission procedure is also needed as currently this all goes through a magistrateAnd furthermore protection of patients' rights needs to be looked at. The current situation, especially in

Sarawak, is that a family can have a patient compulsorily admitted against their will and even against the medical opinion of a doctor, who may feel that they can be cared for as an out-patient. These admissions usually take place under section 13, of the Mental Health Ordinance '61, which is actually for temporary admissions only, but the time of detention is usually poorly monitored.'

Under this system there is no specific right to appeal, and the boundaries of voluntary and compulsory admission are blurred, whereby individual circumstances of admission and rights to discharge remain unclear to patients. The resulting situation is that all admissions act in effect as mandatory and indefinite periods of custodial care, in which patients are subjected to a forcible socialisation into conformity, without any professional or legal acknowledgement that they may legitimately, in the case of so-called voluntary admissions, 'opt out' or demand a review tribunal.

5.4.1 Life problems and hospitalisation

I had few opportunities to make a direct comparison of official rationales for admission compared with the views of patients on the subject. In general conversation with patient participants and staff however, the views of the latter towards sanctioned professional intervention were often discordant with how patients saw their lives and hospitalisation (Cooper, 1970; O'Hagan, 1996).

These accounts from patients resonated with some of the theoretical positions of the so-called 'sociology of deviance', whereby transgressions of social norms are controlled through the labelling of transgressors as 'mentally ill' (Scheff, 1996: 65). To this well-known point, the 'myth' of mental illness, is a convenient way of pigeonholing the troubles of the poor, the excluded and the oppressed in society (Szasz, 1974: 24-5;

Fernando, 1995: 16). Labelling individuals as mentally ill thereby serves to compound the original so-called problems in living (Gomm, 1996; Rosenham, 1993). Goffman, in accord with Scheff, describes the 'moral career' of the psychiatric patient once labelled, as one of continuous professional discrediting of the patient's social self and mortification of their integrity (Goffman, 1993).

In this way the narratives of the patient participants I studied could be seen to be accounts of life problems. These problems were seen as part of the individual's pathology and were then reframed as representational delusions and obsessions, confirming to staff, if need be, the diagnosis of mental infirmity. The original problems of individuals, grounded in gender stereotypes or in general poverty for instance, were obscured and distorted through the enforcement of the 'deviant role' of the psychiatric patient as depicted in the following accounts (Scheff, 1976: 67; Lemert, 1993a).

Abang was a multiply admitted man on Male Ward 1 and although a fairly capable individual was destined to join the legions of the 'chronic' eventually. At that time the hospital represented an easy existence, one that he did not rail against and in fact seemed to have adapted to as a place of permanency. Abang's day revolved around sleep, meals, working in the occupational therapy unit and in particular smoking. This mundane existence was one he was resigned to living because his family had effectively consigned him to the care of the hospital on an indefinite basis as he was seemingly unable to pull his weight at home and was evidently considered an expensive and dispensable liability.

‘It was my father who suggested I be here. He says I only eat and sleep at home but at least I can work here. If I am at home and suddenly my eyes roll up again I need to come back on that day itself. We don’t really have enough money to pay for the bus fare. So since my father asked me to stay here I can work in the carpentry, I stay here, *lah*. Financially it is quite tight for my family and my father cannot afford to feed me. Besides my father is a heavy smoker and he is old and cannot earn much.’

On the private ward Foo, a quiet, earnest Chinese youth in his late twenties, regarded the hospital as a semi-voluntary retreat from the intolerable hurly-burly of life at home in the family-owned ‘shop-house’, to which he returned on ‘home leave’ every few weeks. Foo was preoccupied with guilt over his inability to help his widowed mother, for being the ‘eldest son’ in a Chinese family the expectations to shoulder the main burden of care for the family would normally be very high and consequently his failure to do so was all the more painful. At home the pressure made him feel ill and quickly precipitated a semi-voluntary return to the undemanding environment of the private ward, as he was an additional and unwanted burden to his family during times of relapse. On the other hand being in hospital was far from ideal. The ward ‘has no freedom, the nurse there always direct you to do this and do that’. Foo considered the dilemma insolvable and concluded that it is better all round that he continued to regard the hospital as his real home with occasional, emotionally fraught visits back to the family home.

As physically fit young men Abang and Foo were socially expected to take up the role of main breadwinners and protectors of their family. A diagnosis of mental illness had prevented them from discharging these duties adequately and they were both now regarded as liabilities, to be discarded to an indefinite and emasculated exile at Sentosa. For women patients at Sentosa however, in further comparison with feminist analysis,

their inability to meet socially expected obligations was perceived not in terms of being *de-sexed* by their competencies or squanderers of limited resources but rather as moral and sexual deviants, contaminators of the *status quo* and corrupters of their children (Barnes and Bowl, 2001: 72; Cogliati *et al.*, 1988: 100; Ussher, 1991: 71). While most men on Male Ward 1 were single men, on Female Ward 1 many of the women there were mothers in keeping once more with observations from the West of the increased risk factors correlated with a diagnosis of mental illness and the state of maternity (Ramon, 1996: 86; Ussher, 1991: 166). These women were understandably particularly traumatised by their diagnoses and admissions, with their thoughts continuously revolving around the welfare of their children, and for the most part were not resigned to their custody. Maria, a regular admission to the relative comfort of the private wards was one of the few exceptions and talked of the strains of being a wife and mother, in contrast to her youthful ambitions as a physics graduate. 'I was beautiful, I was clever ... the top of the class, every time!' Maria believed that 'stress' and a highly anxious, unassertive personality had deprived her of the opportunity of making more of a life, which was otherwise characterised by financial dependence on her husband and the trials of caring for her disabled child as well as the loss of achieving her intellectual potential. Maria evidently missed her family a lot and telephoned them frequently, worrying considerably about her young child but feeling too overwhelmed to return home. Such was the stigma of her shameful inability to cope that her whereabouts were kept a secret from her child who was duly told that his mother was away shopping on an indefinite and baffling spree.

Linda, like Maria, had been in and out of the hospital for years and was now held here against her will, as she has no home left in the community. Linda mournfully engaged my attention and pouring out a pitiful litany of sorrows. Linda usually talked about her lost son with palpable longing as she was forced to give up contact with him after her diagnosis and the consequential collapse of her marriage.

‘I hasn’t seen my son for seven years. I write so many letters asking photo. But he doesn’t want to write to me... I went to my house when my boy was ten, but my husband he said “don’t speak to Mummy”. I think a woman was inside, his new woman...’

Elynna, a newly arrived first-admission patient, horrified by her incarceration, seemed very relieved to be able to talk about her experiences to me. She described how she was recently brought ‘unconscious’ to the hospital (by which she means an out-of-mind or psychotic state) after an attack of disorientation on the public street. Elynna recounted a tragic and typical tale of gender oppression and loss, in which her marriage failed when her husband left to set up home with another woman and then refused to support his former family. Elynna later migrated to the city with her children in order to find work and while life continued to be hard for her, the family survived. One day, she says, her husband suddenly appeared and took the children from her, depositing them with one of her distant relatives, on the grounds that Elynna was earning a living as a prostitute, an accusation she absolutely denied. A year passed without her being allowed to see the children and to add to her injuries she was cast off by the rest of her family. Forcibly hospitalised she was now distraught with worry and frustration, especially as she had

been informed that there were moves afoot to formally adopt the children within the family against her wishes.

Elynna powerfully conveyed her belief that it was the accusation of immorality that had unlawfully, but not uniquely, deprived her of her children driving her temporarily and understandably out of her mind (Ramon, 1996: 89). While, (as has already been discussed) this study does not seek to objectify the narratives of participants with a stamp of factual 'proof', they do serve to provide insights into how participants understood their condition. As such, these narratives commanded attention as accounts of oppression but were also almost entirely ignored in the hospital environment. Ward staff usually brushed off attempts by patients to engage them in a shared understanding of their perceptions, dismissing these perceptions as 'delusional' and the individual typically as 'psychotic'. Instead a highly medicalised, demeaning jargon served to disassociate the lived experiences of individual patients from their agonised state of minds. This manoeuvre provided a close example of what Claire Baron, following Erving Goffman, regards as the 'tragedy' of mental illness through the professional relegation of 'every expression of alienation and dissatisfaction' to being symptomatic of their illness (Baron, 1987: 145).

Moral laxity, as in Elynna's case, was considered on the female wards, at least in terms of staff attitudes if not through stated policy, to be a reasonable reason for the enforced admission of women. As such it operated as the 'sociosexual' control of women, which is exemplified in the following scenario (Showalter, 1981: 326):

Field notes. Female Ward 1

Two patients, Geranting and Tuyah are moving chess pieces on the board, imitating the movements of the game but without following the rules. One of the players, Geranting a young woman turns to me when she sees me and stops playing, clasps my hands, tears starting to her eyes. I gather she thinks I am a doctor and is telling me she wants to return to her *kampung*, '*balik kampung*', she says weeping. Tuyah her opponent looks grave and says to me, 'you must tell her "be patient. You will go home when you are not sick"', evidently parroting what is told to the patients by the nurses.

Geranting's story is given to me in an off-hand manner by busy nurses and is a confused and fractured account. The brother brought her to the hospital because of the things she was doing at home. These 'bad things' involved 'going with men at night'. Another nurse amends this to one man.

Researcher: So it was because she was having relations with men that she was brought here?

Nurse S: Maybe, that is what the family say.

[Geranting weeps and falls on the ground trying to kiss the Nurse S's feet begging to go home]

Nurse C: The family situation will have to be assessed - the case will be referred to the social worker. [She walks off to the treatment room]

Nurse L: It is her 4th admission already. You also have to feel sorry for the family: if they cannot control her then they have to bring her back to the hospital.

Researcher: But this 'bad thing' is about her going out at night with men?

Nurse S: That is what the family say...

Researcher: So are the family trying to protect her by bringing her to the hospital?

Nurse L: No. They think she is sick because she does bad things ...

[Geranting still crying and asking to go home]

Tuyah: [off-side] She goes with the man because she loves him, that is why she is engaged to him

Nurse S: I don't think she is engaged. [Goes off to deal with another patient]

Nurse L: [Resignedly] The family say she does bad things ...

Researcher: Can you explain what it is meant by that?

Nurse L: You see, she denies that she does anything (bad)... she cannot discuss her problems with us [shrugs] She must stay here until we find out about the home situation but the social worker is on holiday, she must wait until the social worker returns... You know some families give us the wrong address because they are frightened to take the patients back

- Researcher: But she is not violent?
Nurse L: Oh no.
Researcher: Breaks things?
Nurse L: No, but the family always bring her back when she does something wrong.
Researcher: So it seems that every time Geranting does something the family don't like, it is put down to her illness and she is brought back here. Would you call this more of a social problem than a medical problem.
Nurse L: No. (Pause) You know she is 'schiz'¹?

These accounts from women left me feeling very angry, agitated and depressed without knowing what I could actually do to relieve their suffering or my feelings. Without trivialising the suffering of male patients their accounts did not resonate for me with the same qualities of pathos, oppression and dispossession as those of these women. While I was often moved to indignation and sadness on the behalf of male patients, this was a different and more distanced response and rarely did I find myself identifying closely with male participants as I did with women. The interlocking patriarchal systems that created oppression in marriage and medicine seemed to conspire cruelly against women and I found myself identifying deeply with these women in what felt for me to be the undifferentiated consciousness of an oppressed sisterhood. No doubt, this feeling of a bond of sisterhood was an emotive one created specifically by surface similarities, nonetheless I believe that the accounts given by Elyna and Maria were offered to me on the partial hope of eliciting something more than just a facile and token sympathy.

¹ Barrett (1996) makes an interesting point in his ethnographic account of psychiatric patients in Australia where service users are faced with the contradiction of being encouraged to see themselves as 'persons with schizophrenia', a concept compatible with a *person first* ideology, yet staff freely refer to them as 'schizophrenics', which effectively de-emphasises personhood and relegates them to a generic and homogenous category. This kind of contradiction is less apparent at Hospital Sentosa, where the derogatory shorthand term 'schiz' is a commonly used term amongst staff, uncomplicated by references to the ideology of personhood.

5.4.2 Discharge procedures: custodial care and gender

The discharge process at Sentosa, as in other hospitals, is reliant on the ward doctor's verdict, but without the option of voluntary discharge. For chronic patients, the lack of alternative facilities militate against their ever being able to achieve a discharge from hospital premises and a similar situation exists on *Mei Kui* ward. Ward staff pointed out one individual from an indigenous nomadic group now mandatorily 'resettled' by the Government for the purposes of a dam-building project. This man would in all likelihood remain permanently at the hospital despite his pardon from the State's Chief Minister, as his community had effectively exiled him for his crime by refusing to accept him back. A return home to a hostile community struggling to survive a completely new way of life stacked the odds too heavily against success, in the opinion of the staff who continued to hold him on the ward.

In general the hospital policies dictate that psychiatric patients need to be discharged with an escort who will nearly always be a member of the family. Consequently discharges may be delayed until such an escort is available and delays of hours, days, weeks and even years are by no means uncommon as is indicated by the following conversation:

Field notes. Female Ward 1.

It's evening on the ward. The night shift has arrived on duty; they are sitting around taking a breather while the ward settles down for the night. A young Chinese woman is anxiously asking the Sister in charge for permission to leave the ward to use the public telephone box at reception.

Patient: I want to go out. I want to call home. My heart is like a rocket - I want to go home.

Nurse L: How many times have you been out to telephone today? Five times? You stay on the ward now.

[Patient appeals to another nurse]

Patient: I want to go out to call my brother.

Nurse P: You must listen to the Sister, if she says “no” then *we* can do nothing.

Nurse L: You’ve spoken to your brother, what did he say?

Patient: He said that he had to ask my sister-in-law.

Nurse L: What did she say?

Patient: I didn’t speak to her, only my brother, he said to wait, they would come later. But I want to call ... can I use the telephone here?

Nurse L: No, that phone goes through to the operator. If they do not come by 9 o’clock, I will call them myself.

Patient: I don’t want this *baju* (hospital jacket) when I go home.

Nurse P: You can wear your own *baju* - the yellow one you had when you came here.

Nurse L: You wear that *baju* tonight and the yellow one to go home.

Nurse P: You stay on the ward tonight. [Cajoling] One more night.

Patient: Can I pay the hospital transport to take me home?

Nurse L: No, the rules have changed. No transport. You would have to pay overtime.

Patient: I want to call them.

Nurse L: [Getting annoyed] You behave! You behave!

Nurse P: One more night. Then you see the doctor tomorrow and he will decide for you.

Patient: Can I go home then?

Nurse P: Yes, a nurse can escort you - if you know the address. Where do you live?

[Patient hesitates over the address, nurses exchange a look]

Nurse L: [To me] She has been waiting all day to go home but no one has come to take her home yet. [To patient] Wait till tomorrow now – it’s night-time now.

Researcher: It must be very upsetting for her to wait for so long.

Nurse L: [Aggrieved] She must not phone so much, they will think she is *still* ill. Once is enough.

[Patient gives up and wanders off.]

The main assumption informing this general policy towards escorted discharge appears to relate to the assumption that a psychiatric patient, and particularly a female patient, must remain under the custodial care of one carer or another. She is consequently not seen to be independent or autonomous by virtue of her recovery and her discharge is therefore contingent on the cooperation of others, a situation, which as has been illustrated, may cause a considerable amount of distress. While male patients are known to leave the hospital without an escort on occasions and more often resort to 'absconding' given the opportunity, this level of independence is considered an unacceptable hazard in relation to women under hospital care. Consequently patients in general, and women patients in particular, are expected to be totally reliant on the coordination of families and staff to affect their discharge.

5.5 Ward existence and the process of socialisation

Upon arrival at the hospital probably the first thing that I noticed was the locked-up appearances of the four wards I had decided to focus on. Locked grill gates from the main corridors to the entrance of Female Wards 1 and 2 via their attached verandas forced me to ask for permission to enter on nearly every occasion. My presence was virtually always spotted by one of the women patients who tended to hang around the gate peering at the occasional passer-by. She would then alert a nurse who would leisurely and elaborately unlock the large padlock on the door, permit me to enter, and then lock the gate up securely once again. The 'turn-key' operation was also in place on Male Ward 2 which, apart from *Mei Kui* ward, was the most isolated on the hospital by virtue of being the only ward located on a first floor. By contrast, there was usually free access to Male

Ward 1, which was less often locked, and consequently gave an air of being one of the most liberal wards. This however was belied by its formidable, overcrowded lock-up section, a feature of every public ward.

Due seemingly to a fondness for symmetry, ward design was very similar on the acute and chronic wards. On Female Ward 1, Male Ward 1 and Female Ward 2, a large veranda lead to the 'open-ward' area, which was flanked by the ward garden. On the verandas of Female Wards 1 and 2 were long trestle tables, often covered in plastic sheets, which were used for eating and general utility purposes as well as work for the women patients. On Female Ward 1 large flower pots of camellias and bougainvillea were used for decorative effect, while in the latter months of fieldwork a small, rarely used badminton court was the main feature of the veranda area on Male Ward 1. The garden of Female Ward 2 was more utilitarian in appearance and graced with basic washing-up facilities of large plastic bowls, dish racks, scrubbing implements and a hose-pipe close to the view of passers-by. The veranda area of Male Ward 2 was the grimmest of all, being a balcony netted over with wire, lined with plastic chairs and with a floor littered with cigarette butts.

On these four wards, regardless of sex or duration of stay, the general appearance was one of sparseness, with an antiseptic quality created only in part by the smell of cleaning fluids, but mostly conveyed by the sheer bareness of the room and lack of decoration. The main ward on both units is a big open dormitory where a dozen or so metal-framed hospital beds were lined against each of the longest walls under the glassless, barred

windows. At the far end of the ward was a barred and locked nursing room equipped with an examination bed, sinks and medicine units, where my interviews with patients were often conducted for want of a more conducive environment. At the other end of the room stood the 'locked' section, which was divided off from the rest of the 'open' ward by bars and acted as a self-contained unit, with its own beds for patients and a latrine.

By some of the beds on both 'open' wards an occasional, rickety bedside table was seen, but this was a rare piece of furniture, which on Male Ward 1 was often to be found with the drawer awkwardly pushed against the wall in an ineffectual attempt to deter theft, but making access a tricky business. Here there were practically no signs of the personal possessions of patients: no clothes or shoes in sight, no books, games or family photographs on view. Personal items were for the most part kept under the bed-mattresses for convenience and these were usually items lacking in value, such as plastic sandals. Valuable items, primarily money, were safeguarded by the hospital authorities and although the staff did assure me that patients could use security lockers for other possessions I did not see evidence of patients using these during my visits and concluded that few possessions were brought into the ward upon admission.

Personalisation of space was made additionally problematic in that although beds on the acute wards were nominally allocated to patients they were in practice held in common, so that other patients might casually occupy beds as required. For some patients, particularly on Male Ward 1, this did not seem to overtly bother them. On Female Ward 1 however the following rather fragmented discussion took place with Wei Hua, a young

Chinese woman on her first admission, and Noor, a Malay ‘old-hand’, in which both women clearly express disgust at the communal bed practice due to the contamination of their sleeping areas by other patients who were voluntarily or involuntarily confined to bed.

- Researcher: So, what do you think about sharing beds with other people here?
Wei Hua: Sleeping ... the bed sheet (searches for word) ... blood...
[makes a gesture indicating her vagina].
Researcher: Period? Menstrual blood?
Noor: Unclean.
Wei Hua: And here [gestures towards her rump].
Researcher: Faeces? Shit?
Wei Hua: Don't like other people to sleep on your bed – smell.
Researcher: So you cannot say, ‘this is my bed’?
Noor: No, they (the nurses) restrain people on beds – you cannot say ‘this is my bed’.

For Noor and Wei Hua, the implication was that sleeping in the beds stained by the bodily fluids of other women was a deeply mortifying and stigmatising ordeal. In referring to menstrual blood as ‘unclean’ Noor was clearly making a reference to a dominant and religious patriarchal view of regarding this as an area of taboo and shame (Davison and Sutlive, 1987: 163; Northrup, 1995: 104). Consequently Noor implied that for her the fact that women patients were obliged to lie in each other’s menstrual blood was a deeply degrading and contemptuous practice in the dehumanising process of turning individuals into patients.

5.5.1 A 'typical' day: life on the wards

My early interviews with patients on the acute wards involved soliciting questions concerning what constituted a 'typical day' on the ward in due accordance with Spradley's formula of probing for comparisons and dissimilarities (Spradley, 1979). The only comparable feature that was particularly noteworthy was the lack of general interest this question evoked in my informants. I learned through narrative and personal experience that on Female Ward 1 and Male Ward 1 the day started before dawn, from 5.00 am onwards there was movement on the wards and some patients would already be sleepily showering and getting dressed. The majority however remained slumbering through this activity until they were obliged to rise to take their first daily dose of medication a short while later; they might then return to bed until rallied again for breakfast, following which some would inevitably attempt to sleep again. The routine revolved around the taking of medications, meal times, chores and sleep and this set the monotonous tempo for the coming day.

For Jacob, a highly articulate, socially isolated, multiply admitted Chinese man in his early thirties, the most important question revolved around which medical assistant would be on duty that day. Those who had the ability to break the inertia of life on the ward were highly valued in comparison with those who are content with the soporific, unregulated passing of time.

'Zulhan (MA) is the only one who makes a real difference for me, and he's the only one who has been trained ... in Singapore for 1 year. He sets tasks, which may look simple from the outside. We wake up early, take medicines and make our beds very nicely. His standard is very high. We shift tables, cut grass, wash

and dry the dishes, do the laundry. And we do other things, like role play - like a father and his son or daughter passing by the shops and the child is ... not behaving. Zulhan sets up the scene and the things he wants to see happening. Sometimes we play netball or run round the compound. With the other MAs time passes monotonously. They do their tasks but do not organise patients into any activity particularly - very boring. Other MAs have a very low expectation of the patients and a rather limited view of their duties. Some MAs seem more like a policeman or a detective when he gets angry.'

Jacob interpreted the organised routine set by the energetic, motivated Zulhan as indicative of his interest in the patients and furthermore, his respect for their potential. The lack of stimulation provided by other members of staff was seen as a form of neglect rather than liberalism and quite insulting in the practical implications that psychiatric patients are incorrigibly apathetic and that their main requirements are simply met through tending to their animal needs and pacification as provided by medication.

My responses to the same question posed on Female Ward 1 were rather different, in which the tedium of life on the wards was a noted feature and a more or less expected one. More animation was expressed on the topic of food, which was usually listed as one of the main aggravations of ward life typified in the following quote from one woman, 'It is hard for me. I have no money! The food here is no good! Cannot go out!'

Aini, was a witty, eloquent, popular Malay woman in her early middle years, and like Jacob, had much experience of the hospital over the years. She was suitably disenchanted and scathing in her appraisal of life on the ward compared to life at home.

- Aini: The good and brilliant place for people is home. This is not a place for people, for animals!
- Researcher: In what way is this place for animals?
- Aini: The people (other patients) are very angry ... snatching at food like savages. ...The food is bad. I like cow meat ... sometimes the food is bad!

Mealtimes therefore were an important theme in the narratives of patients, the three early mealtimes and two snacks broke the monotony and measured the time of a 'typical day'. Teo, a veteran patient on Male Ward 1 ruefully commented that so far as he was concerned meals were about the only thing to look forward to. As Aini observed however the food on the public wards was unpalatable and unvaried and seemed to be the worst of institutional cooking, grumbled over by Chinese patients occasionally, for being *halal* to boot, regardless of the preponderance of Chinese patients at the hospital (Ashencaen Crabtree, 2001: 151).

A stodgy diet consisting of mounds of steamed rice, stewed vegetables and a small helping of protein, meat, fish or eggs formed the basis for meals. Food arrived in large tureens from the hospital kitchens and was slopped into bowls or army-style tray containers to be eaten in rapid privacy by patients. Meals were not used as a time for socialising but on the contrary, privacy and solitude were emphasised more at these times than at other times of the day, as the following extract from field notes conveys.

Field notes. Male Ward 1.

Lunchtime begins at 11.20 am. A member of staff and Boon Chieng (a patient) serve out the food, which today is minced beef stew with cubed potatoes in it, steamed rice and mixed bean sprouts and greens. Tepid coffee to drink. The staff take plates of the food to those in the locked section. Open-ward patients carry food to the table or sit on the veranda floor to eat. Food is a solitary experience it would seem, with little talking going on but great concentration on the food, heads bowed over bowls or bowls lifted up to faces. In the locked section I notice that to gain privacy everyone sits with their backs to the bars facing the veranda - a curious sight of rows of backs is seen. Within 10-15 minutes the meal is over and clearing up by patients begin. Plastic dishes are stacked up in a huge bowl on the floor and hosed down by squatting patients.

For male patients at liberty to leave Male Ward 1 poor food could be supplemented by a visit to the canteen situated just inside the hospital's front gates and for a fee of money or cigarettes were brought back to men confined on the wards. The canteen was nominally for the staff but patients were known to use it, as did the general public, particularly soldiers from the nearby barracks. It was predominantly patronised by men, albeit of very different status. Women patients were rarely able to use its facilities due to the tighter restrictions placed on their movements, although evidently some attempted to get nurses to buy extra food for them, judging from this admittedly somewhat paranoid sounding account from newly admitted Maslia on Female Ward 1. Without being able to verify her claims, I understood her account to be a counterattack on the context of marginalisation in which she struggled to survive (Lemert, 1993b: 110).

'But the nurse here is not honest. They (the nurses) simply cook the food and it's not tasty and well-cooked. Also, sometimes patients will ask nurses to buy food for them and the nurse lie to the patients saying that they bought the food for them but actually the nurse cooked it themselves and sell it to the patients who wanted to eat those food. Besides, if there are additional food in the ward, the nurses didn't give it to the patients but instead, they eat it themselves.'

If gender played its part in the nutrition of patients, so too did class in relation to financial resources, whereby those in the private wards received a much improved diet, higher in protein, varied, well cooked and well presented. Although I have no evidence that women patients who occupied a lower social class were subject to overt distinctions in relation to diet, the system ensured that their access to a superior level of nourishment, as enjoyed by other categories of patients, was effectively denied or made highly problematic.

5.5.2 Uniforms as symbols of identity

At Hospital Sentosa patients were allocated a hospital uniform, although exceptions to this could be seen on both acute wards. Occasionally patients might be seen wearing a curious assortment of various-sized clothing, which were items of communal property left behind by previous patients and these were worn more in the spirit of 'dressing-up', and as such were tolerated by staff. Normally however the vast majority of patients wore the ubiquitous uniform, and this procedure took on overtones of ritualised initiation or indeed 'mortification' upon entry to the wards (Goffman, 1991: 25). As such, the implications behind the wearing of a uniform formed a recurrent theme, although one that was almost exclusively discussed by women patients. Here an extract from my field notes gives an illustration of the ritualistic and punitive socialisation into ward conventions of a Dayak woman from a remote area of Sarawak.

Field Notes. Female Ward 1.

The nurses are engaged in an exasperating attempt to educate a new patient in the locked ward into the niceties of behaviour. This patient, apparently comes from a remote rural location, the staff say, and I have the impression that this is used as a way of explaining her unorthodox behaviour. She appears to be a wizened,

diminutive woman, maybe only in her late forties to mid-fifties, who appears to be disabled, with a malformed hip resulting in a curious staggering, stooping gait as she drags herself angrily around the locked section. The nurses say they had an awful job trying to clean her up when she was first brought in.

Now they are trying to get her to wear a hospital *baju* (jacket) as well as the regulation baggy shorts, which are so large on her small frame that she has pulled them right up to cover her chest. This at least, for the nurses is a step in the right direction, as up till now she insisted on being bare-breasted, which is a normal state of dress in her traditional Dayak *kampung*. This is very much disapproved of by the nurses, Malay, Dayak and Chinese. The nurses make it clear to me that her obstinate nudity is a clear indication of her generally benighted, backward state; and every attempt is made to cajole her or demand that she conforms to the conventions of wearing the hospital uniform. I am given to understand that until she starts to behave in a 'reasonable' fashion, in other words compliant to ward rules and docile in manner, she will remain on the locked ward.

The whole issue of uniforms at Hospital Sentosa was in turn strongly and depressingly reminiscent of Clark's dismal description of the impersonal allocation of communal, hospital clothing at Fulbourn Hospital in the England of the 1930s and 1940s.

All clothing belonged to the hospital. It was regularly gathered and dispatched to the hospital laundry and there boiled. There was no individual clothing, not even underwear. In some women's wards a basketful of knickers would be dumped on the floor and the women would then scramble to get into something that might fit. The apathetic invariably ended up with clothes that did not fitAll this was seen as an indication of their mental disorder and self-neglect. (Clark, 1996: 55).

At Sentosa patients were issued with robust and androgynous outfits consisting of anonymous and shapeless jackets and baggy culottes with the hospital initials printed on the breast pocket. A token nod at gender differences could be seen in the colour of uniforms rather than the shape, with most male patients dressed in grey or green, and most women in faded red gingham or navy blue. These durable uniforms fulfilled two roles: being subjected to communal wear and laundering, they had a practical necessity

and, as Gittins (1998) and Goffman point out, they acted as a symbol of a more profound personal dispossession (Goffman, 1991: 28).

The uniformity and harshness of hospital clothing constantly reminded patients of their loss of status, freedom and identity. (Gittins, 1998: 135).

Although the staff seemed largely oblivious to the attitudes patients had towards wearing the uniform, at least amongst some women respondents the implications of the uniform were understood and accordingly deeply resented.

Field notes. Female Ward 1.

Aini joins us at this point, sits down and we proceed to talk about clothing. Soo Mei, soon to be discharged isn't wearing a uniform as usual but instead looks clean and dapper in tailored shorts and sports shirt. Aini says of course the patients here don't want to wear the uniform. I decide to draw her out on the subject.

- Researcher: So how do you feel about wearing a uniform Aini?
Aini: Very depressive. Very bad feeling. You see the label here – 'Mental Hospital Sarawak'. People know you are mental.
Soo Mei: (inquiringly) Mental? Something wrong?
Aini: Yes, something wrong in the mind. People scared of you. When they know what you are wearing, they are scared of you.
Soo Mei: And if you don't want to wear it they lock you up.
Aini: [Looking at Soo Mei's outfit thoughtfully] You are not mental.
Soo Mei: But if I am not mental why I here, *bodoh* (stupid)? [general laughter].
Aini: (Referring to Soo Mei's clothing still) ... No one will suspect anything.
Soo Mei: I getting slowly and slowly well
Aini: (Disagreeing) Mentally retarded.
Soo Mei: Yes, and she [pointing to me] is mentally retarded too [more laughter].

On another day, I talk to Aini again about uniforms, a subject she feels strongly about.

Aini: When we go home we change clothes ... (the uniform) showing we are mentally retarded people ... not good, badly, desperate! Wearing a label 'HSS' - Sarawak Hospital Sentosa - all the people know who we are.

As Aini rightly pointed out, the uniform was a deeply stigmatising label making a clear public statement of the wearer's deviant status in society. While men were hardly better dressed they tended to present an indifferent attitude to the situation, but women seemed to find this a more painful issue. Women, in Malaysia as in the West, are expected to look attractive and attempt to 'make the best' of themselves: women patients, especially in contrast with the dapper nurses, appeared all the more conspicuously dowdy therefore in their unbecoming uniforms. This was clearly a situation that others were aware of, as demonstrated by one male patient who said to me confidently, 'but the women they look so ...awful, all their prettiness gone'. Uniform therefore served to desexualise women patients, which symbolised a further fall in status, as this did not in any way appear to level the unequal playing field between the position of men and women patients.

My findings additionally indicated that as a powerful visual symbol, the uniform is a more significant loss of status than simply being on the ward. On one occasion during a discussion about uniforms, Aini suddenly turned to Soo Mei and questioned her status as a patient due to her sporty 'civilian' attire, was she in fact really a patient? Soo Mei reasoned the matter out and asked rhetorically why on earth anyone, other than a member of staff, would voluntarily remain on the ward. That to do so was clearly an indication of mental illness, and so therefore, that might also explain the anomaly of my presence too!

By this time the women of Female Ward 1 had become familiar with my odd visitations and even stranger questions. Here however I had a clear indication that I had been to some extent embraced in a discourse that could rightly be seen as subversive. My position as the butt of the joke indicated that I had achieved a new stage in my relationship with them and had managed to step out of the role of absolute outsider in this mischievous and humorous reversal, where I was evidently labelled as the mad one (Goodall, 2000: 106). The bantering tone teasingly questioned my motives and my sanity; this hinted that further reassurance was needed by me to establish why I had chosen to be amongst them. Furthermore this provided deep insight into the perceptions of my participants in which questions were raised about the endless ambiguity of defining what *is* madness. To Aini and Soo Mei, there were a lot of people in the hospital who seemed to be mad but were not, and alternatively a lot who were not seen to be, but probably were, myself included (Rosenhan, 1993).

CHAPTER SIX
ROLES AND RELATIONSHIPS: POWER, DOMINANCE AND
RECIPROCATATION

6.1 Introduction

In the closed confines of the ward environment the structure of hierarchy inevitably looms large for patients in relation not only to staff, but also to their peers. Ward life, as Goffman points is the definitive example of the ‘total institution’, in which all functions of life are carried out within the institutional setting and according to its definitions, requirements and mandates (1991: 11). As such the ward tends to magnify peer relationships as inescapable webs of influence that encompass and dominate the social existence of patients to a high degree. This chapter therefore seeks to explore a number of different relational patterns in reference to patient participants that are embedded within emerging themes. Consequently relationships are explored within the context of phenomena to bring them into sharp relief and in so doing, aspects such as profiteering and organised patient labour are also considered.

6.2 Reciprocal relationships

The notion of friendship amongst patients provoked some interesting responses. First-admission patient respondents were usually still in the painful process of adjustment and therefore other patients on the ward were often dismissed as being merely a motley collection of *orang gila* (mad people). As such the implication was that they were of no direct consequence to anybody and consequently this derogatory term could be also be used by established patients in discrediting former friends.

6.2.1 The conditions for friendship

For those patients, men and women, on the acute wards who had experienced multiple admissions, the ward however was more likely to represent a sociable environment where they might encounter a relatively high level of acceptance and camaraderie in comparison to the isolation and rejection that often characterised life 'at home'. This patient 'sub-culture' appeared to act as an important buffer between the self-esteem of the individual and the social rejection that the role of mental illness imposed upon them within their own communities (Barham and Hayward, 1996: 234).

Friends, for example, were a big issue for Dimbaud, who has been admitted more than twenty times over the last ten years and confessed that he was lonely back at his Dayak longhouse. This was a significant issue considering the traditional close-knit nature of such communities (Mashman, 1987: 233; Schmidt, 1964). Abang, who once lived in a Malay *kampung* (village), agreed, adding that his friends those here in the hospital and that there was no one he can really call a friend outside of the hospital anymore.

‘My friends (in the hospital) very nice, very friendly. I don’t have friends at home...Been here for 4 to 5 years, but I do go back for home leave about one week. I just gone back on 25th March (1999) but this time I come back earlier, not really one week... Last time (undefined past) I have friends but now they already working. They don’t worry about me. If they work they don’t care about me anymore. They did not find me to play hockey, football....’

Due to the loss of common ground, relationships with ‘normals’ tend to deteriorate over time until connections between individuals and their communities are ultimately too attenuated to bridge gaps in erstwhile friendships (Estroff, 1984: 250). Respondents were strongly aware of this situation and several indicated that they did not find this a welcome topic to discuss and therefore a deeper insight into loss of personal connections was not easily obtainable.

Some people like Jacob on Male Ward 1 were particularly isolated, as he had no real friends on the ward, and seemingly none in the community either. The business of just getting along with others was seen as very poor substitute to finding a close friend, something Jacob yearned for, but in this attempt he seemed doomed to frustration.

‘The majority of people on the ward are of low education – they haven’t finished Form 3 (primary education). Only about 10% have the kind of education I have. It’s impossible to make good friendships on the ward because people are so sick. and sometimes I haven’t had a very good response when I’ve tried to ask them questions.’

Unfortunately for Jacob, despite his obvious intelligence, he had little insight into the feelings of others and therefore the kinds of questions he asked were often inflammatory, such as 'do your family visit you?' This was a fascinating issue for Jacob in view of his stormy and alienated family relations, but a very tactless question to ask in a context where so many had been estranged from their families for years with dire results for their future. Consequently Jacob attempted to define his relationship with his favourite medical assistant, Zulhan, as a 'friendship' of sorts because of the lively and caring interactions he received from this particular professional. This by the nature of things could not be a 'symmetrical' relationship, as Estroff puts it, and therefore the most basic condition for friendship could not be realised (1984: 250).

Friendships on the ward amongst patient peers clearly represented an important source of emotional support but also acted as a necessary social lubricant in a congested communal space characterised by large numbers of diverse individuals. To this end casual friendships and general bonhomie were in fact the conditions necessary for survival on the wards and therefore cordial and reciprocal relations were by far the most prevalent types of relationship found amongst participants. These types of relationships however could also be viewed as temporary alliances rather than genuine friendships and were quite often built on a brittle foundation of expediency and mutual benefit and that could quite quickly turn to enmity (Wigoder, 1996: 155).

Tuyah, a cheerful veteran on Female Ward 1, took a sanguine attitude to life pointing out that under these conditions the individual is obliged to rub shoulders with all manner of individuals without the luxury of too much discrimination.

‘(This ward) holds all sorts of people. Many are very sick. They have no control over their bowels; they wander around, their eyeballs roll up; they shake or drop their heads down. Here are all kinds of people: Malay, Bidayuh, Iban, Melanu, Chinese.’

Consequently people like Tuyah were careful to ensure that arguments were kept to a minimum and a general network of good relations was fostered with most people on the ward. The confined and claustrophobic universe that the ward represented meant that enmities could not be allowed to flourish unchecked. It is all the more important therefore to ensure that one had friends who could be relied on to share an odd cigarette or snack. In fact *sharing* is what makes a friend, added Mariam, Tuyah’s chum.

6.2.2 ‘Sharing’ networks among patients

Reciprocation amongst patients represented a common theme uniting patients on all the wards I studied. A few members of staff interpreted sharing behaviour as being examples of an altruistic gesture or as one nurse put it, ‘patients are very generous to each other’. On the male wards a medical assistant observed that some patients had to be prevented from giving coveted items away. Based on interviews with patient participants of both sexes however it emerged that those who do not share risk exclusion from the vital network of mutual support that raises the conditions of merely surviving on the wards to a higher level of comfort and enjoyment. Some patients like the aloof Tan Siew could afford to opt out of the reciprocal network due to private means, which although relatively limited nonetheless represented quite a sizable sum on Male Ward 1. ‘A cigarette’ said Tan Siew, ‘is like a wife’. Which in other words you do not share, although evidently Tan Siew could be generous with his cigarette butts when he chose,

thus maintaining cordial if subservient relationships commensurate with his lofty status on the ward.

Through chats with Mariam and Tuyah, I learned that staff sometimes present themselves as friends to the patients for reasons of their own, but since they do not share their belongings this is just a false camaraderie. Without it being explicitly said, the message is that this was of course also true of me. On at least three occasions I received gifts from individuals, one, as discussed in Chapter Four, being from a nurse, while the other two were from women patients, who gave me respectively a tiny sachet of instant coffee and a much-used personal ornament. Unfortunately as I did not understand the significance of these overtures at the time, I did not return these favours and therefore presumably I failed to create the necessary conditions for genuine friendship. Nonetheless patients of both sexes saw me as a figure of some influence in the hospital and often referred to me by the powerful title of 'doctor' either by mistake or through ingratiation.

Women and men quickly identified me as a probable source of help and I was subject to frequent petitioning by patients to exert myself on their behalf. In this way I found myself reluctantly placed in a role that conformed closely to that of the 'rescuer' as defined by Asher and Fine (1991: 202). As a 'rescuer' I was regularly asked to intervene on the behalf of patients to obtain a rapid discharge, or to provide them with money or other covetable items. Occasionally I was asked to find employment for patients once

discharged, as exemplified by Linda's plea, 'Talk to the *towkay*¹ for me ... I don't think they want to employ individuals from here'. Now and again I was even asked to employ a patient participant myself. Margot for example, asked me if I would consider taking her on as a personal servant, but without waiting for my answer responded despondently that no doubt I was looking for someone much younger and fitter than she was.

While I found these petitions and the assumptions that lay behind them extremely embarrassing I was also aware of having been hoist by my own petard, in that evidently my colonial baggage had finally caught up with me despite any pretensions to the contrary, at least so far as patients were concerned. As a white person, however drab my appearance, I was perceived to be powerful, wealthy and privileged and therefore easily able to grant favours and use my influence should I so wish.

Many long-serving patients could recall a time when the medical hierarchy at Sentosa had been dominated by colonial powers and therefore it was quite logical to identify me with these figures of authority. Margot's assumption that I was in the business of recruiting domestic staff was in this context a reasonable supposition given that colonials would of course employ local staff in this way and that it is likely that some ex-psychiatric patients might find employment through these routes. The field study implied that I was indebted to the participants involved and therefore, on a *quid pro quo* basis at least, the implication was that I was expected to return the favour. The uneven situation that I found myself in, whereby I was unable to reward participants in the tangible ways they suggested resonated uncomfortably with Judith Stacey's point (1991) that the

¹ Generic term for a Chinese shopkeeper or businessman.

research encounter is essentially an exploitative exercise. That said, these kinds of petitions actually underlined the inherently unequal status between myself and patient participants in which to comply with them, had it been in my power to do so, would only have served to perpetuate these inequalities rather than rectify or even address them.

Finally, as a woman and one who had worked hard to forge good relationships with both women and men on the wards it was not unreasonable for patients to assume that this indicated an inclination on my part to share tangible benefits with others less privileged. The assumption by women patients that I would be particularly empathic towards women was correct and by some strange extension was at the basis of my relationship with *Miss Hui Ling*. This patient on Male Ward 1 had adopted a transsexual identity and frequently engaged me in conversation bemoaning of the horrors of being incarcerated in a ward full of coarse men and therefore ‘as a woman also’, I could surely identify with her predicament and secure her release.

6.2.3 Profiteering in the marketplace

The ‘sharing’ of goods operates in at least two different ways, firstly as a way of securing friends and improving one’s quality of life. Secondly, items can be used as a means of making a profit, usually through a system of barter and payment in kind, rather than through ready cash, although the latter is a feature of ward life as well.

Cigarettes, to reiterate, form the primary goods in this informal marketplace of profiteering, with food and sweets seemingly taking a less prominent position, due perhaps as one nurse suggested to problems of access. For many patients male and female, chronic and acute, the main activities revolve around smoking, which in common with other psychiatric institutions is rife at the hospital (Goffman, 1991: 183; Urdaneta *et al.*, 1995: 74). Staff accounts variously point out that cigarettes, as opposed to food, are easily obtainable from friendly or perhaps somewhat intimidated visitors to the hospital and that smoking acts as a form of initiation for new patients, even those who are non-smokers at the point of admission. One nurse put the prevalence of smoking down to 'boredom' and peer example. In addition a long-serving nurse pointed out that it was commonplace practice from prior to the hospital's inception to hand cigarettes out to patients 'as an incentive for good behaviour'. Cigarettes therefore formed the main commodity in the market place, in which commercially made cigarettes were bulked out by the even cheaper homemade variety made of a toxic combination of the contents of cigarette butts wrapped around *atap* leaves. If an opportunity presents these were fairly discreetly hawked around male and female wards as an acceptable and affordable substitute for the real thing, when it could not be paid for, begged, borrowed or stolen.

Men appear to dominate as entrepreneurs with a tiny minority of women participating in these activities, such as the resourceful, independent Catherine on Female Ward 2. Culturally Malaysian women of most ethnic groups have always had a foothold in mercantile activities and have not been excluded from producing and profiting in the marketplace (Davison and Sutlive, 1987: 163; Karim, 1995: 39-40). The low profile of

women in marketing activities at Sentosa suggests that there are other causes at work to account for their exclusion which is discordant with ethnic and gender expectations in this multicultural society.

Wily Mathew from Male Ward 2 was an excellent source of information on the activities of the opportunistic male dealer and through extrapolation provided some good insights into the absence of women entrepreneurs. Once given permission to leave the ward Mathew often took advantage of the situation to go *jalan jalan*, or in other words strolled into town through the simple expedient of sneaking out of the hospital grounds. Once free, Mathew made his regular rounds of the local cafes, visiting proprietors in order to scrounge whatever he could. He was usually successful in this venture, since to submit to his fairly modest demands was probably the easiest way to get rid of him. On his return to the hospital Mathew hawked his goods amongst inmates on the different wards, if necessary carrying out transactions through the barred grill gates or alternatively might confine his activities to his own ward for added social lubrication.

Fortunately for Mathew he was first and foremost a male patient and a harmless one at that, for while male patients could occasionally be seen in town and were conspicuous as such by their hospital uniform, much greater vigilance was employed in the care of women patients. The access of women patients to the general hospital grounds was subject to much greater restriction and therefore women patients were practically never seen beyond the walls of the hospital. Restricted access to sources of supply, as well as the difficulties involved in accessing customers on other wards effectively and heavily

curtailed the activities of women dealers. Female patients were thereby relegated to the less profitable role of passive consumers of cigarettes, whilst due to the repercussions of trading restrictions and other means of increasing personal revenue, they were more likely to be able to afford only the cheapest and most harmful type of cigarette available.

‘Sharing’ and profiteering carry with them the inherent danger of being involved in conflicts over possession, and this was a main cause of fights on the ward. For as Tuyah and Mathew pointed out, there were characters on the ward who enjoyed victimising others and stealing their goods, because there was ‘something wrong with their brains’. While ‘old hands’ were aware of these hazards and took steps to avoid unpleasant encounters, for newcomers, such as Elvis, a bewildered teenager enduring his first incarceration at the hospital, these fights were a frightening event.

Field notes. Male Ward 1.

Elvis makes a violent, throat-grasping gesture as he describes the kind of fights, which break out amongst patients. Quarrels break out over small things, such as cigarettes, bullying or bragging. But says Elvis, ‘the worst thing is that they go on until they are stopped – or *kill* someone’.

Elvis’s notion that murder and mayhem are a feature of ward life was in fact based more on fantasy than reality. As such this represented the extreme anxiety he felt at being diagnosed as mentally ill and being misplaced in a Bedlam of unpredictable violence. For Elvis, insanity *was* precisely this kind of alarming, immoderate behaviour, to which he was currently struggling to attach meaning and motive. Although Elvis’s fear of murder was an exaggerated one, the fear of being involved in a violent episode is a completely understandable one, in view of what Rose *et al.* calls the ‘small but serious

risk of violence' on psychiatric wards (1998: 5). Just as fights and violence feature on the psychiatric ward in Britain, at Sentosa this was an ever present if not necessarily a highly hazardous situation for most patients on the wards.

6.3 Dominant relationships

Acts of violence on the ward might break out as seemingly spontaneous aggression that was usually swiftly broken up by ward staff. Violence by patients was also used covertly as a means of ensuring discipline on the wards, while staff assaults were an infrequent but by no means unknown event, according to the discreet hint given to me by one house doctor. In this case aggression by patients towards patients did not conform to the more commonplace strife that was subject to staff control. Instead staff appeared to collude in aggressive conduct that was demonstrated by individuals who despite being patients themselves were placed in a position of power over their peers:

We had already learned that those wearing striped clothing were prisoners like us... This made it all the more difficult to understand why they treated us so viciously... (Kielar, 1982: 6).

A good deal of fieldwork elapsed before I began to differentiate the few acts of violence I witnessed into type, nature, motive and most importantly, consequence. Eventually I began to appreciate more fully the dominant role played by several patients on both the acute and chronic wards. For want of a better expression, I adopted the term 'prominent' as used by Primo Levi in writing of his Auschwitz experience to describe those prisoners raised above the ordinary lot (Levi, 1979: 96). I use the term advisedly as I certainly do

not want to imply that conditions at Hospital Sentosa are in any way comparable to life in a Lager. Nonetheless it seems to me that the general role of control of peers by an appointed elite amongst the patient corps is central to the phenomenon, as I understand it, enacted on the ward.

If the drowned have no story, and single and broad is the path to perdition, the paths to salvation are many, difficult and improbable. (Levi, 1990: 96).

To generalise then, the ward *prominent* occupied a privileged position in relation to other members on the ward and this position was endorsed through action or omission to act by the real authorities on the ward, the staff. Not all wards appeared to have an obvious coterie of *prominents* yet this was noticeable on many. Evidently this was a useful role on the ward, as it was not uncommon to find individuals like these helping out with all manner of tasks, rarely menial, but more often supervisory, managerial and disciplinary in some fashion or another. Some *prominents* were fairly innocuous individuals and were rarely if ever involved in bullying others, at least physically. Others and these of both sexes could be seen to be outright bullies and openly aggressive in their behaviour towards others. On Female Ward 2 force was used to maintain the authority of Martha, a sullen and menacing woman, who had few words to spare for anybody but plenty of spirit to punish perceived transgression. Martha was a capable individual on a ward characterised by a majority of disabled individuals. She frequently acted literally as 'door-keeper', keeping a close eye on those who wanted to enter and leave the ward and was often privileged with locking and unlocking the gate herself after a dour scrutiny when visitors such as myself wished to enter or leave. Personally I found Martha an

unpleasant and unpredictable individual with overtly bullying habits gratuitously inflicted for seemingly the sheer pleasure of maintaining her fearsome reputation, as the following brief example illustrates.

Field notes. Female Ward 2

Martha Chung has a permanently sullen expression. Her name is down on several rotas for cleaning floors, making beds etc. Obviously she is seen as one of the most capable patients but she also has a very unpleasant side. I see her pass by the locked ward containing a very confused Chinese patient and pokes her in the face with a fist (pulling back so that it is less than a punch) but getting no real reaction Martha then slaps her in the face and threatens her with a scowl and a fist before moving off in her independent swaggering gait.

Violence was far from unknown on this ward despite the general stereotypic belief at Sentosa that violence and aggression are not typical characteristics of women. This was demonstrated by the fact that there are no resources for violent female offenders at Sentosa although there were such women here, while women are generally regarded by staff as more 'compliant' and easier to manage than men (Orme, 1994). Aggression on Female Ward 2 was usually punished with a spell on the locked section, however I never saw Martha incarcerated in this fashion, much as she might deserve to be in all fairness. Additionally although Martha had comparatively menial tasks to do on the ward, yet in a ward where so few were as capable as she, her chores marked her out as one of superior abilities. Martha's cooperation in this respect rewarded her with more important tasks and a privileged status, free from much interference by the ward staff.

6.3.1 Achieving prominent status

Catherine as a veteran patient and successful entrepreneur achieved the status of a *prominent*. In common with Martha, Catherine exercised a lot of power but this was strictly confined to the pursuit of her own ends, these being predominantly connected to personal comfort and autonomy. Because Catherine was considered to be a very competent individual, at one point it was hoped that she would be able to thrive in NGO-run supported accommodation. This however was not a successful placement and Catherine was returned to the custodial care of the hospital as it was found that she refused to develop the necessary independent living skills. Instead Catherine used a variety of unpleasant forms of coercion, including physical intimidation, to force other residents to support her.

On the ward Catherine continued to exploit others through similar tactics and seemed quite content to be back in the hospital environment, being one of the few women permitted to leave the ward more or less as she pleased. This enabled her 'businesses' to flourish and in addition she enjoyed the support and protection of her well-connected and involved family in Kuching. Her general appearance was strikingly fashionable in comparison with her peers on the ward and she exuded an air of complacent guile. Catherine's power apparently lay in her ability to shirk chores and delegate these to others, leaving her free to enjoy an almost unequalled level of freedom and leisure amongst women patients, leaving open the question of how staff were duly compensated for these valuable privileges.

On Female Ward 1 Tuyah was also engaged in seeking prominence. Her approach was to make use of her wide experience of the malign supernatural. Tuyah told me with some relish that she had been the victim of an *orang buat* (a witch or sorcerer) since her adolescence. During this prolonged possession she has been multiply raped by an *antu* (a spirit being or incubus) and miniaturised animals, including a crocodile, were seen to emerge from her vagina (I assume this latter to have a sexual as well as cultural reference). Additionally Tuyah's arms and legs were covered with a multitude of old and half-healed scars that look self-inflicted. Tuyah however had managed to acquire some status on the ward, although not as much as she would have liked, and was confident to the point of egomania at times. She announced herself to be a fully fledged *dukun*: a shamanistic healer, of some consequence, able to detect and cure illness as well as communicate with the spirit world (Winzeler, 1995: 115).

The shaman's role...is one of curing sick people using a range of supernatural techniques. Shamans are drawn into this role because of an experience considered by them to be an illness, an affliction, and a victimization by a spirit-being. (Bernstein, 1993: 171).

To claim to be a *dukun* carries important connotations for patients at Sentosa, in a cultural context where traditional healers practice care parallel to biomedicine (Loustaunau and Sobo, 1997: 3; Razali, 1997). At Hospital Sentosa the majority of patients have sought help at one time or another from a wide diversity of traditional healers amongst the Malay, Chinese and Dayak communities (Ashencaen Crabtree and Chong, 1999; Barrett, 1993; Bentelspacher *et al.*, 1994; Bernstein, 1993; Fidler 1993; Kleinman 1980; Kleinman, 1982; Razali, 1995; Razali, 1996 *et al.*; Razali, 1997; Walsh, 1994;

Wintersteen *et al.*, 1997). Although tormented by her symptoms, Tuyah did not regard this as excluding her from the role of a *dukun*, in fact quite the opposite applied:

Knowledge comes to him (the shaman) during events of tremendous feeling – pain, ecstasy, and seizures, illness and trauma, at times self-inflicted.... In trances or in other altered states brought about by self-inflicted suffering, the shaman experiences ‘torture’, ‘being cut to pieces,’ which lead to death and resurrection. (Romanucci-Ross, 1997b: 216).

While the staff attributed a catalogue of distressing symptoms to mental illness, Tuyah knew that these were clear manifestations and indications of her shamanistic destiny and as such were to be flaunted amongst fellow patients rather than denied or played down.

On Male Ward 1 Boon Chieng held a position that combined aspects of these seemingly polarised positions. Like Catherine, Boon Chieng was a man who stood aloof from most patient interactions, and accordingly was smartly turned out in his own fashionable wardrobe. In comparison to Martha he was a responsible and dependable supervisor of others and had specialised in the allocation of meals. His duties also encompassed access to the keys of the locked section, distribution of patient uniforms and bedding, as well as assisting in administering medication to others under the supervision of a member of staff. Fortunately, unlike Martha, Boon Chieng was a non-violent individual who managed to enforce his authority through other means and probably those directly connected to his duties.

Having observed Boon Chieng for some time I was rather taken aback to hear a litany of very bizarre outpourings from him in a private interview situation. For Boon Chieng seemed totally preoccupied with the literal fear of being poisoned and roundly accused relatives and ward staff of persistently trying to kill him. This then was the reason for his chosen and favourite duty of food attendant: he could keep a close eye on proceedings as a means of self-protection. With the status that this situation had brought about, seemingly Boon Chieng had gone on to consolidate his position of power by taking on greater responsibility.

Boon Chieng's official diagnosis labelled him a paranoid schizophrenic and his obsessions certainly seemed to confirm this. Fortunately however, as in Tuyah's case, his mental illness had not proved to be a handicap to him on the ward but rather the reverse: in that in many ways this had enabled Boon Chieng to make the most of available opportunities in achieving a high level of rank. For ward staff the outward appearance of 'mental stability' is a prerequisite for any credibility, and Boon Chieng's conduct demonstrated this stability even though staff were fully aware of his innermost paranoia.

Like Boon Chieng, Jani the *prominent* ward entrepreneur on Male Ward 2, did not need to assert his position through physical aggression. Jani occupied a similar position to that of Catherine, in that he had a 'business' that he attended to which took him out of the ward regularly, while an air of single-minded self-preservation undeniably marked him out from the crowd. A hopeful retinue of patients frequently formed around him on his return in the hope of 'cadging' a cigarette that he might condescendingly pass over, as

evidently most of his 'business' took place on other, probably more profitable, wards. Jani was clearly well linked into the underground system of procurement of coveted items and probably this, as well as his undeniable sense of himself and general coping ability, had helped him to attain this comfortable position.

Not all who would assume the position of *prominent* are accepted as such, despite attempts to emulate the appropriate behaviour. On Male Ward 1 Alias, an inarticulate Malay youth, showed many of the traits found in the successful *prominent* but lacked the ability to attain the position. Alias resorted to standard tactics to elevate himself, such as attempting to undertake responsible jobs as well as doing his best to physically threaten other patients.

Field notes. Male Ward 1

On the open ward Alias is up to his odd antics. With a permanent and somewhat menacing scowl he glowers at me [I pretend not to be looking at him]; he unplugs the operating lights and fan; he prods at a plastic bowl under the nursing station and moves it a few millimetres with his foot; he picks up a bundle of folded towels and with precise violence bangs them down again on to the same spot; he picks up the remote control of the television and puts it away in a drawer. Then wanders off and shouts something at the patients on the locked ward, who ignore him.

Researcher: [to MA] He seems busy helping tidy up the place.

MA: No, he is looking for something ... [moves off]

The fact is Alias isn't looking for anything but is going through the ritual of acting like a medical assistant: organising, inspecting and maintaining order amongst the patients. But the medical assistant denies this and does not see what is being enacted. Later I see him out of his old hospital uniform and wearing a lurid, flamboyant outfit but ill-fitting and improperly fastened.

Unfortunately for Alias, his behaviour was very unpredictable in that he often behaved like a buffoon and cavorted playfully with patients when he chose. His whimsical behaviour on the other hand often caused him to overstep his mark as a bully to no good purpose or alternatively he would go too far in the aping of ward staff. In fact, despite how totally conditioned Alias was by the ward system, he was not a candidate for any real authority as staff could not exploit him adequately as an extra and dependable pair of hands for he was seen to be incompetent due to Down's syndrome, his limited comprehension and generally erratic behaviour.

In conclusion, gaining status through these various routes is usually a fairly long-term strategy and therefore prominent individuals were almost exclusively found among long-stay patients, who had a vested interest in achieving the best possible place in the 'pecking order'. Occasionally a particularly charismatic and assertive first admission patient might attempt to gain a higher position in the ranking order. Usually however newly admitted patients were more likely to be overwhelmed by the need to make a rapid adjustment to the routines and rituals of the ward and did not therefore represent a real threat to the established *prominents*.

In consequence long-stay patients and staff were well known to each other and this familiarity did at times breed if not contempt amongst patients, a willingness to push the boundaries of authority as far as they could. While elitism amongst patients on the ward could be very useful, the problem for ward staff lay in maintaining the demarcation between their rank and that of the *prominent*, as *just* another patient. This resulted in a

certain tension at times, whereby a *prominent* could be temporarily punished or even permanently demoted for stepping out of line by being reduced to the ranks. As an insolent and ‘pushy’ individual (in relation to staff) Tuyah spent a good deal of time in the locked ward. Likewise Frankie on *Mei Kui* Ward lost a coveted long-term position of rank that he worked hard for after arguing with the staff over the publicly acknowledged extent of his powers.

Conferring rank and privilege amongst select patients could therefore be seen to a useful strategy for relieving workloads for staff. This is also a highly effective means of control through the sowing of a divisive seed amongst patients, where the person most likely to be in a position to draw attention to subversive patient behaviour was the *prominent* rather than the staff.

We are aware that this is very distant from the picture that is usually given of the oppressed who unite, if not in resistance, at least in suffering. (Levi, 1979: 97).

Not surprisingly therefore, to maintain privilege it was important that *prominents* upheld the rules of the ward and valued the ethos of the system, if not totally, at least sufficiently to maintain prestige and position as demotion was by no means unknown. Such a situation was liable to lead to rivalry amongst patients and acrimony, creating a necessity to rule by tyranny, as exemplified by Martha’s behaviour or by influence and beneficence, as exemplified by Tuyah’s approach. In any event the repercussions of privilege were unlikely to lead to the relinquishment of power by individual *prominents* in view of the advantaged offered by the system.

6.4 Familial relationships and the connection with patient labour

Asylums have as a general rule utilised the labour of patients to maintain the institution, sometimes attempting to generate a financial return on institutional care through the unpaid or poorly paid labour of patients. As Black and in addition Barham point out psychiatric hospitals have long regarded patient labour as an essential commodity (Black, 1988; Barham, 1992) and in this respect Sentosa was no different. By and large however the work undertaken by patients was divided into two general types of which ward chores might be supervised by *prominents*. This stood in accordance with one of the major roles undertaken by *prominents*, which in the context of the Lager is to assist in the exploitation of fellow inmates through their labour. Other forms of labour at Sentosa were reframed as ‘therapeutic’ and managed by staff, thus camouflaging any vested interest the hospital may have in patient labour as is discussed further in the final section of this chapter.

Findings strongly indicated that there existed a causal link between labour and a further type of relationship amongst patients, these were *familial* relationships and were adopted on wards as both as a specific cultural response to the social situation as well as being a mode of interaction that operated to the advantage of ward staff. On most wards at Sentosa it was not difficult to find examples of pseudo-family relationships, such as that on Male Ward 1 where anxious teenagers sought out the protection of older males as paternal figures. Similarly on Male Ward 3 a well-known patient senior in age, experience and ability ‘fathered’ many of his younger peers while similar examples could be found on the female wards. As such it is not suggested that these types of relationships

were exclusive to Hospital Sentosa and indeed are no doubt replicated in some form or other on most psychiatric wards globally.

In Malaysia however the development of 'familial' types of relationships represent a specific cultural strategy for creating connections of rapport amongst non-related individuals, as described by Wazir Jahan Karim:

In Malaysia and Indonesia a manifestation of this is the metaphorical naming (through terms of address) of people beyond the local grouping by kinships terms, as if to recreate the intimacy and familiarity of consanguinal and affinal ties in local groupings in other spheres of life. Everywhere patron-client and employer-employee relations in economic and political affairs are neutralised by terms like *pa'cik* (uncle) and *ma'cik* (aunty) in Malaysia. (Karim, 1995: 37).

Indeed so strong can these 'affinal' ties become that some members of staff develop very close 'familial' response to patients in their care. On Male Ward 3 a medical assistant described how a patient was reunited with his community after several years, and was then discharged home only to be rapidly readmitted following difficulties in adjustment. 'He wanted to come back here - this is his home, and we are like his family' was the emotive explanation given. Although these types of relationships had an emotional role to play, on the chronic wards and particularly the female chronic wards, familial relationships were premised upon labour and as such were encouraged by staff.

Field notes. Female Ward 2

Patients are busy caring for others. This seems to be an important role for many patients - I see several helping older, incapacitated ones on the commode; taking them to the bathroom; changing their clothes. An older woman start to undress a diminutive, youthful figure that lies hopelessly curled up, her legs have to be rearranged before the shorts can be removed. Underneath she wears no underwear. She is half carried, half dragged by the older woman and a nurse to the bathroom. This is the severely disabled and probably brain damaged young patient I have seen in the past. It is hard to guess her age but maybe in her early 20s. Later I see her propped in a chair, her face looks smooth, blank and expressionless.

The nurse tells me that this help is regarded as therapy, another says that originally the ward was so understaffed that patients had to help each other, now it has become a valuable feature of this ward. For instance, I am told, that one patient regards an older one as a mother figure who cares for her pretty well totally and the younger one describes herself as her *anak* (child).

The chronic wards held a comparatively large number of patients who were unable to care for themselves due to their mental and physical disabilities and these people were therefore dependent on basic nursing skills. While the female nursing staff were engaged in undertaking nursing tasks for these fundamentally incapacitated individuals, many were cared for by other patients, in a sort of informal 'twinning' programme. Commonly more able women were expected to care for others, assisting them in washing, dressing, toileting and feeding activities on a daily basis. This was achieved through the forging of personal relationships between patients by staff which were described by them in filial and parental terms.

While staff evidently benefited enormously from the caring relief provided by patients it could also be argued that these nurturing alliances between patients could well have been extremely valuable to long-stay adults who were otherwise barred from developing intimate relationships in society. The nurturing role is of course associated primarily with women stereotypically, and while it is true that this could be found on the male wards, it was far less commonplace. Another aspect of the heavy burden of care provided by female patients was that these chronic wards held a larger number of incapacitated patients than the male chronic wards, although ages and duration of stay were similar. This tended to suggest that incapacitated male patients were less likely to be cared for in the same way as female counterparts. Findings bore this out in that invalid male patients were more likely than women to be sent to Sentosa's sick ward, which was notably run by female nursing staff. This suggests that the intimacies and obligations of familial ties were heavily reinforced by gender stereotypic considerations that care work was particularly appropriate to women and in this context to women patients.

6.4.1 Patient exploitation through 'therapeutic' work and gender disparities

In addition to ward-based chores, occupational therapy was offered to long-stay patients at Sentosa, although this felicitous wording suggests that patients could freely choose to participate without coercion, which I would certainly not suggest was the case. Long-stay patients were in fact targeted for occupational therapy due to the perception that this could be of little value to recently admitted acute cases, who were expected to merely sit out the duration of their stay on the wards. Occupational work at Sentosa therefore was

traditionally seen as an important way of keeping otherwise idle hands employed while contributing to the hospital revenue. This being the case, chronic patients would normally be allocated whatever work was available, as this medical assistant pointed out,

‘(There is) insufficient analysis of social needs - no matching of interests to the work ... Chronic patients have no say in what they do ... they obey the staff ... What choice do they have?’

At Hospital Sentosa occupational therapy was divided into work considered suitable for men and women respectively, with the former being able to participate in carpentry, basket weaving and farming activities, which took place on a small scale in the hospital grounds. Women were occupied solely with handicraft work, which consisted basically of repetitive work using fabric and given handicraft tasks to do dependent on their skills and levels of concentration. The majority of women were given the least-skilled task, which involved extracting threads from scraps of material. The ‘thread-sorting’ activity was incredibly tedious work that usually took place at long trestle tables on the ward. The end result was that the piles of individual threads were used as stuffing material for a small range of household goods manufactured by staff and other patients in the occupational therapy department.

By contrast with the predominant activity for women, male patients were given the opportunity to apply their skills in carpentry, producing sturdy and creditable pieces for sale. The basketry department produced an array of smaller items and larger pieces of rattan furniture; most of these items were usually sold to kindergartens in town, which

held a contract with the hospital. Finally, male chronic patients were also involved in small-scale gardening activities with the chronic wards producing leafy vegetables, most of which was sold to staff. *Mei Kui* ward had taken advantage of the expertise of many of its rural-born patients and had developed an enviable specialist activity, providing a good deal of independence for those involved in the activity. This was livestock farming, predominantly a business in breeding quails, chickens and goats, and which appeared to provide a small but steady income. Like that from all other such activities this was ploughed back into the hospital revenues under the 'Patients' Fund' from which patient salaries were deducted. Earnings on the forensic ward were some of the highest obtainable in this system and the work was comparatively stimulating and autonomous. Skilled work undertaken by men therefore could potentially command a relatively good income by the standards of the hospital, as Abang pointed out,

- Abang: Yes, I am hardworking. Last time (before an admission) I was farming over there, digging holes, clearing grass, building houses and moving a gas stove.
- Researcher: What about in here?
- Abang: At the time of Dr Abdul (previous director of the hospital) he didn't ask me to go to the carpentry. I just stay here all the time but when Dr Siong took over, he asked me to go there. Maybe it's good because I can earn some money, even if not much.
- Researcher: And you learn new skills?
- Abang: No, I just polish the wood.
- Researcher: Do you make furniture?
- Abang: Yes, it is hard work. I don't make furniture, I polish the wood and sometimes I take the tools that we need from the store. I get a salary from going to carpentry. At first they said they will give us RM 8.00 a month but we get around RM 20 each month. I was surprised!

Occupational work undertaken by men and women differed not only in the levels of skill required, with women relegated to largely unskilled and highly monotonous activities, but this was also reflected in the token earnings that patients achieved based on sales. The most lucrative line of work lay in livestock farming, followed by basketry and carpentry and other forms of farming. Handicrafts paid the least under the present regime resulting in women patients being subjected to a replication of the economic inequalities inherent in conventional patriarchal, capitalistic societies as well as being rife with gender stereotyping (Wetzel, 2000; Witz, 1992).

Occupational-therapy programmes gave many patients a sense of dignity, with a renewed interest in life, but they also reflected a rigid and Victorian stereotype of gender perhaps more than any aspect of hospital life. (Gittins, 1998: 107).

Ah Ming, for example, was a multiply admitted woman who had unusually been given a factory-type punch card by 'Dr Jerry', one of the few psychiatrists at the hospital, that ensured that a certain number of hours were devoted to the work. Ah Ming's role at home was that of an unpaid if somewhat unreliable domestic servant to her family, a not uncommon situation for the 'poor relative'. Her anger at being effectively excluded from family participation resulted occasionally in violent quarrels in which Ah Ming tended to come off the worst, followed by a prompt readmission to hospital. At Sentosa the rigorous training Ah Ming was subjected to through the punch-card system seemed designed to discipline her into uncomplaining, ill-paid, unfulfilling and mind-numbingly tedious work compatible with her stigmatised station in life as a woman with a psychiatric history. When this was accomplished to the satisfaction of staff, she would be considered fit for discharge back to the dubious care of her family.

To conclude therefore, rehabilitative work for women at Sentosa was undoubtedly remarkably lacking in stimulation, as well as being financially and personally unrewarding. This raises some serious questions about the nature of such 'therapeutic' activities and what kinds of messages were being reinforced to patients through forms of exploitation premised upon sexist and capitalistic practices. On the wards however through the normative employment of familial connections between patients, women's labour became an equally valuable commodity to be utilised. In this respect however, exploitation was to some degree allayed, as by the nature of things this tended to compensate some patients through offering the personal benefits of bonding with another.

CHAPTER SEVEN

CONTROL OF PATIENTS THROUGH REGIMES OF CARE

7.1 Introduction

In this chapter a number of themes are discussed with regard to the perceived control of patients on the wards; these are in turn related to the complex and interconnected system of inequalities that impact heavily on the lives of women patients in particular. The chapter commences with accounts relating to the use of medication and treatment programmes, and concentrates on the use of electro-convulsive therapy as recounted by patients of both sexes in interview. The use of locked sections on wards is further discussed as a means of physical control of patients generically. This strategy and the ideology that underpins it are in turn considered in relation to staff reinforcement of gender norms that have an especial resonance in relation to the 'sociosexual' control of women patients (Showalter, 1981: 326).

7.2 Medication, 'compliance' and resistance

As discussed in Chapter Four, participants were encouraged to raise and discuss issues that they found personally significant within the broad parameters of the study in general. These topics did not always conform to my expectations and for example one area that I regarded from the outset as potentially holding critical insights into care procedures at Sentosa was that of treatment and medication. I was therefore keen to explore this with patient participants in interview although found that the subject did not lend itself easily to open discussion. In consequence the implications of medication in relation to patient

attitudes and conduct was one that remains to some extent unresolved but useful information could be finally pieced together over an extended period of time through inference built on hints and clues.

7.2.1 The 'compliant' patient

Initially I found that few patient participants were particularly interested in discussing the issue of medication in any real depth and appeared, on the surface at least, to view this as a normal and mundane part of their daily routines. In support of this disinterest I noted that, at least in my presence, very few patients of either sex offered anything approaching resistance at medication time. On the locked ward in Male Ward 1 for instance, given the command people presented themselves at the bars to seemingly compliantly ingest pills or offer arms ready for injections without even inconveniencing the staff into unlocking the grill gate. Eventually however I began to uncover indications that some patients were in fact quite suspicious of the perceived deleterious effects of medication upon their metabolism, as Geranting on Female Ward 1 commented.

‘It’s weird that everyone here is sleepy and weak after taking medication. It may be good but it makes people so weak, and always sleeping.’

On the private wards by contrast, ex-serviceman Abdul Mohammed, rather relished the spaced-out feeling created by medication, which he described as a pleasant *berkhayal* (daydreaming). In interview Boon Chieng, the *prominent* on Male Ward 1, was flatly opposed (although outwardly ‘compliant’) to taking his medication due mostly to these debilitating side effects and was understandably highly suspicious of the way his medication was altered now and again without any explanation. Ironically although

medication was being used to tackle his paranoid schizophrenia this situation inadvertently served to feed his paranoid fantasies further. These views collectively are reflected in turn by those of service users in the UK, where Rogers *et al.* (1993: 122) and separately (Barham and Haywood, (1996: 61) note concerns regarding the loss of energy and unpleasant side effects brought about by the use of tranquillisers and anti-psychotic drugs. In turn however, Jonathan Gabe comments on research that indicates the value users placed on the soothing 'peace of mind' created through the use of medication (Gabe, 1996: 188).

A level of acceptance of medication on the wards was demonstrated to the extent that patients for the most part accepted pills and injections as a routine that they had to adjust to, even if this was not much liked, as obliquely indicated in this comment by a long-stay patient.

'Getting up? There's no particular time, nothing is fixed except taking *ubat* (medication) and chores maybe. People don't always get up at the same time because they may be knocked out by *ubat*.'

Patients who had been 'knocked out' by medication were accordingly a normal sight on the ward to which little attention was generally paid, as indicated in the following observation taken from field notes.

Field notes. Male Ward 1

Today, unusually for this ward, I found a patient tied to his bed - this is a large Chinese man snoring soundly and secured firmly, absolutely oblivious to the noise on the ward. Apparently a new admission and not yet seen by the ward doctor, according to the MA on duty. He (the patient) has spent the first night

screaming and shouting, necessitating tranquillisers and now restraints, to stop him falling off the bed.

Coercion was another recognised fact of life on the wards and the pragmatic acceptance of medication by patients tended to conceal the repercussions that awaited a show of real resistance. On one occasion I personally witnessed an incident of patient resistance in which a woman in the locked section had been refusing to take her medication for hours and so it was decided that it would have to be given by force. Four nurses entered into the locked section and pinned her face down on the bed, whilst another injected her in the buttock despite her screams and then quickly withdrew.

Under these circumstances then patients were more likely to openly accept medication rather than suffer the oppressive consequences of refusal. Tuyah, as a self-appointed *dukun*, and Jacob, as a proclaimed Christian, were resigned to taking medication, whilst actually dedicating themselves in private to their own personal healing rituals (Lewis, 1996). The working compromise these patients offered was to pay a nominal lip service to the reputed benefits of biomedicine for the sake of peace whilst in fact having a far greater faith in their own therapeutic regimes. These personal regimes towards health were plans that the ward staff appeared to either generally unaware of or did not accept as credible strategies (Oldnall, 1996: 139; McSherry, 1998: 687-8; Younger, 1995).

7.2.2 Resistance through 'non-compliance'

Historically the advances in medical treatment in the area of psychiatry have been read in terms of social advances for the greater benefit of the public (Shorter, 1997). Yet treatment and medication are not neutral activities and for many psychiatric dissenters have been viewed as issues of hegemonic control as well as of individual resistance (O'Hagan, 1996; Szasz, 1874). Fennell, for example, draws attention to the means by which non-voluntary psychiatric treatment has been sanitised and brought into a general public acceptance through appeals to the common good.

The common feature of these medical breakthroughs was that they were often performed for the greater good and greater glory of medicine, on patients who were incapable of consenting or who adamantly refused them, and who were certainly never told of the likely effects. (Fennell, 1996: 139).

The implication is that the beneficial effects of medical care must occasionally therefore be imposed for the good of the patient through control. Busfield points out that if the discourse of 'control' is counterbalanced by that of 'care' then this constitutes a false dichotomy.

Care and control in mental health services.... are not, however, mutually exclusive alternatives ... for control is integral to caring. (Busfield, 1996a: 233).

Resistance to treatment however was often interpreted in terms of pathology in psychiatric patients, which in turn defined them more clearly as being in need of *management* for *appropriate* care to be administered (Estroff, 1981: 83-5). Although at Hospital Sentosa one nurse told me of some of the tricks patients used to dispose of their

tablets, staff largely regarded treatment as devoid of political or ideological nuances. Instead it was seen in a matter-of-fact light, to the extent that medication administration as well as medical assessments and resulting discussions on the subject took place publicly on the open ward.

The implementation of the community nursing programme at the hospital has, for instance, been justified primarily in terms of being an effective weapon in the prevention of medication defaulting amongst out-patients and only secondly as providing an empowering community service (Lau and Hardin, 1996). Hospital staff frequently talked of 'non-compliance' amongst patients as constituting a major problem which resulted in 'revolving-door' admissions. How compliant a patient was seen to be became a measure by which to judge an individual's personal worth, as well as prognosis. Rarely however was this used as a means of evaluating the method of treatment itself, a move which Arthur Kleinman interprets as implying the 'moral hegemony' of medical science over that of personal meaning and autonomy (Fadiman 1997: 261).

Over time however, I found that the responses given by participants became more complex and insightful as in my interviews with Petrus, a teenage first-admission male patient enduring his first spell in the locked section of Male Ward 1. Initially when we discussed the subject of medication in a semi-formal interview his comments seemed blasé and superficial and he professed to have no particular antipathy towards the unknown injections and pills regularly administered.

Some weeks following his discharge, I managed to track Petrus down for another conversation at the golf course café where he was doing casual work. He seemed amused to see me and positively elated by his new-found freedom and this time had a very different account to give.

- Researcher: Did the hospital give you medicines to take when you were discharged?
- Petrus: Yes, three packets, and I was to come back for more when I was finished. But I haven't finished them yet.
- Researcher: Were you meant to take them every day?
- Petrus: Yes, but I only take them when I've got a headache.
- Researcher: Do you know what they are for? Did they (staff) explain what they for?
- Petrus: They only said that if I take them I'll be well. But I am well now so I only take them when I feel ill.
- Researcher: Although you are meant to take them every day, aren't you?
- Petrus: Yes
- Researcher: So ...
- Petrus: I don't like taking *ubat* (medicines).
- Researcher: Why is that?
- Petrus: Why don't I like taking them? (Pause) Maybe because I don't want to be part of that system. If you take *ubat* then everyone thinks you must be ill – I am not ill. (Pause) It's good to be out of that place, I don't like being told what to do.

As Estroff points out, this kind of argument contains its own logic, only sick people take medication, therefore to constantly take medication is to constantly advertise sickness to oneself and others and therefore suffer the deprivation of a hope of recovery (Estroff, 1981: 112). Petrus felt well at that time, effectively he felt 'cured' of some distressing symptoms and therefore there was no need to take medication, despite staff providing the usual information, namely that his condition was only 'treatable' not 'curable'. Furthermore Petrus did not really know what the medications did biochemically and did

not much care, but made it clear that he was unwilling to accept a life of being constantly defined as sick with the subsequent control by health authorities that such status implied. Needless to say Petrus's attitude would be censured by the hospital staff as 'non-compliant' and be seen as an indication of his lack of insight, which in itself is seen as symptomatic of schizophrenia.

The fact is however that 'medication defaulting' was seen as *the* major reason for multiple admissions of men and women and indicated that many patients at Hospital Sentosa were not willing to take medication beyond the enforced environment of the psychiatric hospital. Unpleasant side effects caused by tranquillisers, anti-depressants and anti-psychotic drugs apart, the stigma and the sense of hopelessness caused by continuous use of medication also appeared to be good reasons for refusal. At Sentosa patient anxieties about the side effects of drugs were not frequently acknowledged as a serious concern by ward staff, but was one duly noted by Dr Tiong Mee Siew the hospital director. He was candid in describing the more serious side effects caused by anti-psychotic drugs, such as tardive dyskinesia as well as the lesser effects of drowsiness, constipation and a dry mouth, as a definite disincentive. Since in his opinion so many patients must take these medications for life, the side effects of medication were practically never discussed with patients beforehand for fear of alarming them and their families, an omission that, as he said, is practised 'in other countries'. Presumably the assumption by staff was that the evidence of side effects manifested by other patients around them would be passed off as an individual peculiarity rather than the sad consequence of side effects. This presumption would it seem be an optimistic one in that,

judging from patients' comments, side effects were not merely a known but feared outcome of compliance.

7.3 ECT as an instrument of control

On Female Ward 1 relationships with some informants were marked by an increase in the depth and types of confidences shared, which gave me further insight into medication and treatment that patients found particularly disturbing. Of more consequence to these women than the general administration and side-effects of the usual kinds of *ubat*, notably, tranquillisers and anti-psychotic drugs, was the routine administration of electroconvulsive therapy (ECT), as suggested in this extract from field notes.

Field notes. Female Ward 1.

On the ward, nothing much happening except that I see a woman in the locked section with a large gauze plaster on her chin being escorted out of the ward by some nurses. Behind them a nurse wheels a wheelchair - it's obvious she is on her way to ECT. I ask the patients and they confirm this - it's amazing that so many of them have had ECT repeatedly

Later, on the way out I see a nurse wheeling the woman I saw earlier back to the ward. The nurse is moving briskly and in the chair the woman doesn't look much the worse for wear except for a fixed and wide eyed stare. We pass each other without any change in her frozen regard.

Jane Ussher contends that women in modern Britain have been subject to ECT in increasingly high numbers and are in fact, more likely to be subjected to this form of treatment than men (Ussher, 1991: 163). Hospital records at Sentosa are unable to quantify the use of ECT in the patient population or to corroborate a ratio in relation to gender variables, yet ECT does seem to be in common practice at the hospital based on

the accounts given by patients and staff (Rack, 1982). Thus given the helpful cue from women patients I was then able to take this issue back into the male wards for further discussion with male patients and seemingly stumbled on a topic that generated a good deal of anxiety and indeed fear, amongst patients.

ECT has of course received a notorious press, although there are many service users in Britain who have equally found it to be highly beneficial (Keseey, 1962; Perkins, 1996; Rogers *et al.*, 1993; Taylor, 1996). ECT at Hospital Sentosa was used for a diverse range of patients, rather than being dedicated to the treatment of 'serious, intractable depression' to describe its conventional use by Rogers *et al* (1993: 123; World Health Organization, 1997). In interview Dr Tiong Mee Siew was very candid about the use of ECT in the hospital saying, that it used to be applied 'indiscriminately' in the past. In these enlightened times it was used more specifically; however it was not retained just for its conventional usage but operated on a wider client group. Due to staff shortages and the lack of individual secure units, ECT at Sentosa was used on those patients deemed to be exhibiting problematic behaviour on the ward, such as general disruption and aggression and therefore:

'This settles their behaviour very quickly and makes them more manageable. So ECT in this way overcomes our nursing problems.'

For Dr Tiong Mee Siew this use of ECT was far from ideal, yet the overcrowding on the ward coupled with insufficient numbers of supervisory staff ward dictated that a fairly draconian level of control would be in operation at times. How liberal a regime this is in

comparison with the procedures of twenty and thirty years ago can be gauged by the following extracts from field notes.

Field notes. Male Ward 1.

T.P. a long-serving, authoritative MA is happy to discuss changes he has seen in the hospital during his long career here. He describes various horrors such as the condition in the locked wards and ECT as it was conducted in the past where the patients were fully conscious and terrified.

‘They (patients) had to be dragged to the machines and the staff would go around the ward shocking them, sometimes about 20 people all around the room. It was terrible. It was torture - torturing the patients ... But then I think it was the Americans stopped that - ECT without anaesthesia - some rules were made... It was also terrible for the staff as well of course’.

Frankie from Mei Kui ward has spent most of his life in psychiatric care and recalled the past clearly. Frankie was a useful source of personal information on ECT treatment and was able to provide a personal account that fit the descriptions provided by the medical assistant, albeit from a very different position:

‘I had it (ECT) many times, many times. Terrible experience – ECT. Terrible experience! Like fire in my head – electric current’.
[Frankie holds both sides of his forehead with his fingers] ‘So fast. Terrible.’

Frankie indicates that he was awake at the time but that the sessions rendered him unconscious. He goes on to explain why he received ECT.

‘To calm me down. I was always standing up ...But thank the Lord all well, so calm now ... it’s not practical in a hospital to stand up like that. Yes, I was calmer afterI was unconscious for hours. During those times yes, I was very ... nervous.’

It remains unclear exactly how long ECT was practised in this kind of fashion, and it is therefore just as difficult to ascertain when more humane procedures were brought in at Hospital Sentosa, and understandably ward staff are reticent about being seen to criticise previous management. Yet although it is quite clear that things have improved considerably at the hospital, some patients interviewed were far from happy about being subjected to the procedure. Dimbaud received ECT once and was so appalled by the subsequent memory losses that he experienced sporadically ‘for five months!’ that when ECT was suggested to him once again upon a further admission he broke out of the hospital somehow and made his escape. Patrick on Male Ward 1 was full of trepidation, as on the following day he was scheduled to receive his first course of ECT at his mother’s instigation, which he quite clearly resented deeply. As a Catholic he had asked his local priest for guidance and since his priest concurred with his mother, Patrick was willing to reluctantly submit to the feared treatment. Patrick evidently attempted to view this in a spirit of Christian humility arising maybe from a mixture of anger, hopelessness, helplessness and maybe a desire to please.

‘Some people sacrifice their bodies, but others also choose to sacrifice their minds’.

On Female Ward 1 Aini gave a lyrical yet graphic account of her experience of ECT treatment.

Aini: When not well - when mind is chronic - your speaking not a structure – imagine things – hearing voices. ECT - with a current all over your head and a wire in your hand - a needle in your hand.... Vibrations of sound make us giddy - it radiates the mind in circulation... First an injection is given, half asleep, half aware -

feeling of something afloat - drifting slowly and slowly – fast asleep. Like a thunder moving with a storm. Like a sea breeze with the wave.... Very painful and giddy [holding temples] vomiting - under our chest got pain... When I got my 3rd ECT this year, when I was 36 (years old) - I was awake 25 minutes...

[I am uncertain what Aini means when she says she was ‘awake’ as she also says she was under anaesthetic, i.e. ‘asleep’].

- Researcher: Can you remember afterwards?
Aini: Not yet actually ... We remember things, slowly remember.
Researcher: Do you think ECT is a good sort of medication?
Aini: Not very good, ECT. Sometimes destroys our organic systems.
Soo Mei: If I am unhappy, it makes you feel more happy, but cannot help you.
Aini: Sometimes you remember - sometimes you forget - like waves.
Maria: Bad memory. ECT no good, bad memory. 6 times! (Received ECT). Pills better.
Tuyah: Whole body shaking – electricalised.

In conclusion, whether staff were aware of how their patients felt about the treatments available at the hospital, the position of staff on the benefits of medication was, as would be expected, largely unanimous. While force was seen as an inconvenient and unpleasant duty it was nonetheless regarded as necessary to retain order. Although medical assistant Tua regarded ECT as being a ‘cruel’ sort of treatment yet he continued to administer it and said in its defence, that there was no doubt that some people appeared to benefit from it therapeutically, whilst other patients certainly become more *manageable* following it.

Many patients regardless of sex evidently did not feel that they were in a position to protest against treatment following admission and it is arguable how far patients could be seen to have given their genuine consent to treatment in the first place. Whether staff felt that treatment given by force damaged their day-to-day relationships with patients is unclear, although evidence from a survey of British service users conducted by People

First indicates that patients perceived this as causing a serious breach of trust (Rogers and Pilgrim, 1992; Rogers *et al.*, 1993). In terms of ward control at Sentosa however the use of medication and ECT in particular played a vital role in maintaining order whilst being upheld as benign and therapeutic.

This role however was beginning to be questioned from within the hospital itself. One doctor framed a different area of concern in relation to the quality of psychiatric treatment. To summarise, these concerns lay in the view that medication prescribed on the wards was rarely reviewed throughout a patient's psychiatric 'career' and that consequently polypharmacology of obsolete prescriptions continued to be common practice. Dr Abdul Kadir, the former director, agreed with this criticism but went further in expressing his concern that outpatients were frequently overmedicated and/or were receiving inappropriate medication.

- Researcher: Are you saying that people come into the psychiatric hospital with psychosis and are given very high dosages, but that they continue to get the same level when they are better?
- A.K: Yes, because they are not being reassessed in their communities.
- Researcher: What are the repercussions of such high dosages?
- AK: *Zombie-ish* types of behaviour. Other effects as well. The illness role continues, you know, the illness behaviour is maintained. Other effects, like tardive (dyskinesia) which is more handicapping than the problem (illness). And those who really need medication don't get it – due to insight problems and rejection by others.
- Researcher: It's a real paradox.
- AK: Yes, the ones that don't need it are given it....
- Researcher: How? By repeat prescriptions?
- AK: By the clinics (rural clinics) and these people usually have very supportive families who get them the prescription. They (the family) are very helpful because they (the patient) are no bother. But people who are difficult, well people are scared of them and

reject them, so they get no more treatment. And going to the clinic is difficult because of poverty and so on.

Given all these issues it is somewhat strange that the 'non-compliance' of patients was not more fully accepted by ward staff in general as holding meanings other than that of a form of sickness behaviour. To do so however would no doubt mean not only an open dialogue with patients regarding the pros and cons of treatment but also a revision of treatment and how medication was prescribed, as well as reviewing the whole concept of consent to treatment. Even if such a scenario were to be seen as an eventual goal, it would seem a remote one under the current circumstances.

7.4 Open and locked wards: gender norms and physical control

The acute wards offer a particularly illuminating insight into the complexities of the open-ward system as it was practised at Hospital Sentosa. Although almost identical in layout and general procedures, the male and female wards reflected policies of heavily paternalistic gender stereotypes. A comparison of the locked-ward systems in Female Ward 1 and Male Ward 1 offers a particularly compelling example of how the 'care and control' dichotomy was interpreted and practised upon gendered lines.

As described in Chapter Five both wards contained a locked section for psychotic and generally unruly patients, which on Male Ward 1 held the majority of patients at any given time and as such was a very overcrowded and sordid environment. Facilities on the locked section in this ward reflected in part that of the open ward yet were conspicuously older and more dilapidated. Thus the beds were old and rickety with poorer or even no

bedding, which in any case consisted only of a plastic mattress, sheet and pillows. The walls were quite stained especially near the bathroom with what looks like faecal matter and were obviously less hygienic than the open ward. Altogether the locked sections of Male Ward 1 and its female counterpart were unpleasant, odiferous and crowded, with several patients having to use the adjacent cramped and squalid bathroom. The following description taken from field notes illustrates the general environment of the locked section on Male Ward 1 on a typical day.

Field notes. Locked section, Male Ward 1.

The MAs described the locked ward as being less crowded today but nonetheless patients were lying down in various places - on the mattresses or the floor. Some beds are without mattresses at all and patients lie on springs. On one bed with a mattress two patients were sleeping back to back. Under this bed a man sleeps on the bare floor, and next to him another. I notice the locked ward particularly today: the pale blue faded paint, the suspicious streaks of dirt and maybe faeces on the walls, especially near the toilet. The strong stench of excrement and the sheer barrenness of the environment. People sleep, as there is nothing else to do, one man sits staring into space. A deranged and giggling patient spots me and follows my movements through the bars, whatever he is saying completely incomprehensible.

The locked section on Male Ward 1 was marginally more squalid than that on Female Ward 1 where conditions were similar in terms of confinement in overcrowded conditions, while many patients of both sexes were evidently psychotic and often aggressive. This made the locked section on male and even female wards a particularly risky and highly disruptive environment to be in as the following extract indicates.

Field notes. Female Ward 1.

By 8.10 (pm) the lights are turned out in the locked section, but people like Tuyah and Roslia (the rather sullen woman who spat at me) still stand at the bars talking and pacing around. A woman inside is screaming periodically. Earlier I saw her pulling, slapping and shouting at a prostrate patient.

Researcher: There seems a lot of noise going on in there.

Nurse T: Yes, she thinks someone is having sex with her. If you ask her, she'll tell you someone is trying to have sex with her.

Researcher: Can the patients sleep with all that going on?

Nurse T: Sometimes they are disturbed. Some patients will pull their sheets off, or pour water on them.

Researcher: Pour water? Oh dear, that sounds pretty bad. What do you do?

Nurse T: Tie them up maybe or separate them.... The problems at night-time are different from those in the day.

Whilst the locked sections on the male and female acute wards resembled each other in physical geography, the ways in which they were run were very different and reflected assumptions and stereotypes related to gender norms. The locked sections of both wards were however a dominant feature of ward life and one which most patients, would experience to a greater or lesser extent. The demarcation between open and locked sections on Male Ward 1 was clearly defined and whereby there was little opportunity for close interaction between the two different categories of patient, short of the occasional chat or exchange of small items, such as cigarettes and snacks. Even during visiting hours male patients were not allowed out of the locked section to talk to their families in private but contented themselves with sharing intimate moments separated by bars with the rest of the ward as involuntary witnesses. Virtually every man would have experience of the locked section in that for the vast majority this was the first experience of ward life they had following admission. As Peter, a young Dayak, first-admission patient, authoritatively informed me, 'everyone new is locked up'. Confinements like these could

go on for days and Teo and Chua, both disgruntled veterans agreed that, 'the worst thing on the ward is no freedom'. Once liberated from the locked section however, there was usually more scope for visits beyond the confines of the ward for recreation purposes.

The staff rationale behind the confinement of men lay in the need to prevent 'absconding' and 'escapes', for the assumption was that patients would certainly do so given the least opportunity. Escape prevention was identified by staff as a very important role in nursing supervision and methods of control were reframed as responsible measures demonstrating staff accountability. The discourse used by staff in relation to male patients and their freedom of movement was suggestive: the use of the term 'escape' in relation to men denoted a view of male patients as being very different from their female counterparts. As Ussher, and additionally Pilgrim argue, in the West male madness is deemed to be more dangerous than that of women's and consequently requires the use of a predominantly penal-type environment (Pilgrim, 1988: 149; Ussher, 1991: 171-2). This resonates with the view of male patients at Sentosa by staff, where they were also regarded as being more aggressive than women, as well as being more independent and opportunistic. By contrast although women were also subject to the careful vigilance of staff, this was based on an entirely different criterion, and which served to perpetuate a view of femininity that stood in contrast with that which denoted the masculine.

7.4.1 Reinforcing the virtue of feminine passivity

The relative liberty of male patients on the open section of the acute ward was not shared to anything approaching a similar degree with to that of their female counterparts on Female Ward 1. Here the open/locked geography of the ward was subject to a different demarcation and flow of movement. Women on the acute ward were all confined to the ward except during periods of work undertaken in occupational therapy, exercise sessions or other escorted forms of recreation. The demarcation between open and locked was less clearly drawn and those relegated to the locked ward for periods of the night and day would also be allowed to join companions on the open section at selected times. The movement on the ward between these two distinct zones was fluid in the case of women patients, whilst the boundaries between the ward and access to the rest of hospital were carefully guarded by staff.

Male patients once liberated onto the open ward were much more likely to find themselves placed back in the locked section for antisocial behaviour. By contrast on Female Ward 1 while 'aggressive' women were uniformly disliked by staff, in keeping with Chesler's point, they were not solely confined to the locked ward but were free at times to mingle with others on the open section, which was of course not open but also locked (1996: 51). At Hospital Sentosa however the boundaries between aggressive and placid behaviour in women were blurred through a general policy of confinement that made prisoners of female patients on the ward. The outcome was that violence by women patients could not be adequately curbed by similar strategies to those of male patients and

other forms of control had to be created that were compatible with the idealised and helpless passivity of women (Redfield Jamison, 1996: 122-3).

It would seem then that women patients were regarded by nursing staff as requiring more supervision in general than their male counterparts and reasons given for the strict confinement of women were commensurate with this assumption. Women patients were viewed in terms of vulnerability and social responsibility and their sexuality was seen to be a commodity that needed to be controlled by staff (McGinty, 1996: 93). In direct comparison with Italian psychiatric hospitals in the 1960s and 1970s, women patients at Sentosa were strongly identified within their biological roles (Cogliati *et al.*, 1988: 101). Significantly the majority of women patients on Female Ward 1 were of childbearing age and accordingly their liberty was habitually circumscribed, reminiscent of Elaine Showalter's description of nineteenth-century institutional care.

For as the Victorian asylums became more overtly benign, protective and custodial it also became an environment grotesquely like the one in which women normally functioned e.g. strict chaperonage, restraint of movement and limited occupation, enforced sexlessness and constant subjugation to authority (Showalter, 1981: 321).

At Sentosa the position of young fertile women patients stood in some contrast to the position of obviously post-menopausal elderly counterparts on the chronic wards, who were more likely to be permitted greater latitude to wander the adjacent corridors provided they did not go beyond the hospital boundaries. Furthermore by subsuming the concepts of gender/sexuality/fertility these then become subject to further refinement on the grounds of class distinctions, as these constraints applied specifically to women on

the 'public' wards. Pre-menopausal women on the private wards were 'supervised' by staff but this was more likely to be restricted to judicious chaperonage rather than to literal confinement. Although equally subject to patriarchal definitions of the 'feminine' this was applied according to more genteel standards in keeping with the social status of the bourgeoisie. Regardless of class however, as Cogliati *et al.* note, 'women of all classes' are essentially 'reduced to being only bodies' (1988: 101). In this vein Phyllis Chesler (1996) goes on to argue that women generically in asylum care have traditionally been subject to very close supervision in which the notion of women's essential and childlike dependency on pseudo-professional parenting is reinforced through control and the punishment of 'wayward' behaviour.

The gender of women with psychiatric histories at Sentosa can be therefore be interpreted as subject to the post-structuralist analysis of binary opposition, whereby women with mental illnesses were seen as virginal, childlike and potentially vulnerable victims of unscrupulous men (Beasley, 1999). This can be read as an identification of women patients with the mad woman in her innocent Ophelia mode (Kromm, 1994). On the other hand, as typified by the Bertha Rochester image from Charlotte Bronte's *Jane Eyre*, women patients can be simultaneously seen as predatory and promiscuous, inclined to solicit sexual intercourse without discrimination.

Jenny on Female Ward 1 exemplified the concept of the simple and deceived innocent. Jenny was a quiet individual with mild learning disabilities who had been recently readmitted onto the ward ostensibly due to a pregnancy, her second by the same man. She

was instantly categorised by staff as a 'rape victim' or at least as a victim of seduction by a wily opportunist, which was seen as much the same situation. Jenny herself seemed pleased about her pregnancy and referred to her impregnator as 'her boyfriend', this being passed off as a sign of her naiveté and inability to care for herself. Because Jenny was seen as a particularly vulnerable woman staff decided that she would not be allowed to keep her baby and sought to 'protect' her by arranging for a non-voluntary sterilisation at the general hospital and the enforced adoption of her baby through the welfare services.

The rationale behind such close supervision of women patients conformed to the notion of women as essentially weak and corrupt, to paraphrase Cogliati *et al.* (1988), as the following section of interview indicates:

Researcher: So you think they (women patients) may be abused if they go out?
Nurse L: Maybe... We have a deaf one, maybe she has - and some *like* it.
Maybe their trade and they go back to it!

While on a different occasion another nurse confirmed this view in the following way: 'women can be raped, men can't, but some women *even* go out and invite it!'. Accordingly the open-ward system was criticised by some members of staff on the grounds that this enabled women patients to enjoy a dangerous freedom. Yet the complex nuances behind this use of an 'open' but actually locked system was sufficiently incongruous for some members of staff to try and justify it to interested listeners, such as myself:

Field notes. Female Ward 1

It's the end of the day. I want to leave but first have to find a nurse to let me out of the ward. As she does so for some reason Nurse S feels the need to explain about the locked grill gate.

Nurse S: Years ago it (gate) was open ... but a patient had a baby.

Researcher: You mean she got pregnant by another patient?

Nurse S: Yes - relations with another patient. It was a baby girl, delivered in SGH (Sarawak General Hospital). I think she was adopted.... The hospital was short-handed then.

Researcher: Is the ward short-handed now?

Nurse S: Not so much.

The inference drawn therefore was that even if the public were unable to 'abuse' women patients, they were still vulnerable to the attentions of male patients who might impregnate them, as *had* already happened. In actual fact despite this allegation being repeated to me by two different parties, this event was denied by other long-serving nurses familiar with the female wards. In addition I found no real evidence that this event took place and suggest that it may have formed a useful piece of staff mythology that worked against the free movement of female patients.

In either case women, whether reluctant or active participants in heterosexual encounters, were seen in terms of biological functions that were subject to moral codes and therefore in need of close surveillance (Cogliati, *et al.*, 1988; Ussher, 1991). Consequently strict sexual segregation at Sentosa was viewed not as social control but more as a means of protection of women in custodial care. This reflects measures in contemporary Britain where isolation of sexually 'disinhibited' women away from male 'exploitation' is defended as a safety measure (Mental Health Act Commission, 1997: 10; Standing

Nursing and Midwifery Advisory Committee (SNMAC), 1999: 12). Furthermore this is commensurate with Gittins' rather more sympathetic interpretation of similar procedures in pre-Second World War England in that sexually segregated areas for women could be viewed as a place of sanctuary rather than oppression in that they

Provided shelter, protection and 'asylum' from an outside world in which violence and abuse by men could be, and frequently had been terrifying (Gittins, 1998: 127).

On the female wards at Sentosa however, notions relating to the passivity, vulnerability and chastity of women were reinforced as feminine ideals that counterbalanced the view of women patients as sexually predatory and therefore equally in need of segregation from men. In reality the consequence was that this policy tended to generate behaviour that subsequently justified its continuation. On Female Ward 1, based on my direct observations, women often responded to youthful visiting male doctors with a lusty lack of inhibition that one would normally associate with a certain type of juvenile, machismo, in-group behaviour overtly designed to sexually humiliate women. Ironically in the course of their duties these young doctors found themselves placed in the inverted and ignominious position of becoming an object of sexual gratification to a whooping, bar-rattling, audience of harpies shooting lewd remarks in their direction.

As Showalter points out, removed from the social constraints of normal society women psychiatric patients are liberated to express themselves in rowdy behaviour which challenges the female stereotype ‘...that women should be quiet, virtuous and immobile’ (Showalter, 1981 320). This however did not serve to overturn notions of gender norms prevalent among staff but instead mandated that these norms should be reinforced, if necessary by punitive measures. Commensurate with this was the practice of tying patients to beds with cotton restraints that was still widely used at Hospital Sentosa and particularly on women of all ages, including the infirm elderly¹. The use of restraints on women was noted to be a facet of Italian psychiatric practice in the recent past in keeping with the hostile professional attitude towards women in asylum care (Cogliati *et al.*, 1988: 99). At Sentosa restraints were used on women generally for ‘behavioural problems’, such as acts of disobedience and aggression. The whole notion that physical passivity was normal for women and that confinement was an appropriate management technique compatible with gender difference was one that could be seen to be powerfully reinforced on the female wards (Showalter, 1981).

The following dialogue, which took place with Wei Hua and Noor from Female Ward 1, offers a perspective of how confinement was experienced and understood by women patients.

¹ Restraints on elderly and infirm individuals of both sexes are used as a means of ensuring immobility that is overtly seen by staff as a risk management procedure to prevent injury or *inappropriate* movements.

Researcher: [To Noor] Have you been in the locked section?
 [General laughter]
 Noor: Of course! We've all been in the locked section.
 Wei Hua: I go to locked section!
 Researcher: What was it like?
 Noor: Bad. There are bad smells from the *jangan* (latrines), when you sleep, when you eat, very bad.
 Researcher: Why do people go to the locked section?
 Noor: When you scream, when you shout, when you behave badly you go to the locked section. When you fight – fighting for freedom you are restrained. (Gloomily) I was restrained yesterday.
 Researcher: Why was that?
 Noor: I put my gold ...[indicates neck and searches for word] pendant down the *jangan*. They tied my hands [puts her arms crucifixion-style] and tied. My hands hurt.
 [She shows me faint bruises on her wrists].
 Researcher: How did you feel about that?
 Noor: I cried, I felt so bad. 2 hours on the bed. Legs are tied very tight. That is not the law to restrain when they are sick. Knocked my head on the bed, nurse Sister X. Very harsh treatment.
 Wei Hua: (Vaguely) My sister's baby, it screamed and screamed and she put it ... tied it in... a sarong and put it in the bed and gave the baby her *susu* (milk/breast)... and the baby... (tails off)

For Noor confinement on the locked ward was a deeply disagreeable physical experience, but being tied to her bed was, she conveys, worse in being a psychological and physical assault of the deepest degradation. Although Wei Hua's interjection seemed rather bizarre and unconnected with the topic discussed, she was at the time listening attentively to my conversation with Noor. Whereas Noor viewed restraints as no less than utterly brutal, Wei Hua appeared to draw an association between confinement and protective containment and parental care. This to some extent reflects Chesler's analysis of psychiatric nurses acting out the role of 'ersatz' authoritative and smothering/mothering figures: in that the bondage of women was apparently seen by Wei Hua as in some way analogous to the swaddling of infants by loving figures of authority (Chesler, 1972; Chesler, 1996).

The disciplinary nature of forcibly immobilising women, through the general policy of the locked section and the discretionary practice of using constraints, becomes apparent as crude methods of reinforcing patriarchal definitions of gender, as well as acting as a means of social control. Just as the suppression of heterosexuality of women gives rise to exaggerated displays of sexual consciousness as well as frustration on the wards, the efforts to enforce passivity and modesty on women served to emphasise their sexual identity as primarily that of objects of male sexual gratification. Even this role however could not be gratified due to their status as psychiatric patients, and consequently the women held this objectivised, sexualised self in indefinite suspension. Unsurprisingly therefore expressions of sexuality became an introverted preoccupation with grooming for a forbidden role, while narcissistic occupations were equally encouraged as appropriate leisure pursuits on the female wards.

7.4.2 The female sex object in suspension

Traditionally male patients have been regarded as naturally and obviously benefiting from outdoor activities and at Sentosa men on both the acute and chronic wards could look forward to leisure activities beyond the confines of their ward where they could play football at the entrance to the hospital for instance (Gittins, 1998: 127). Women's leisure pursuits by contrast almost solely took place in the ward environment itself and here gender-appropriate recreation was encouraged. On Female Ward 1 women were encouraged to listen to pop music or endlessly leaf through women's magazines liberally littered with advertisements for beauty aids for the lightening of dark skins. Alternatively on Friday mornings on Female Ward 2 there were newly implemented make-up sessions to look forward to.

This latter recreation was a recent and highly popular innovation, with donated used make-up from the staff and a few other props like old handbags. Even the most confused patients appeared to get a lot out of these sessions and could be found applying make-up with enormous care and devotion to detail, showing a rare and often exceptional concentration. In contrast to the seriousness with which these women took these activities many of the nurses appeared to find these sessions a source of entertainment and sat in groups looking on, commenting and laughing at the antics and pretensions so openly displayed. Yet as a spectator myself, the nurses' amusement did not seem to me to be just callous mirth, but a reaction to a fundamental discomfort with the proceedings, as certainly there was something touching but macabre about the spectacle as this extract from field notes conveys.

Field notes. Female Ward 2

Mae, a rather alarming and severely mentally disabled woman who carries the battered, broken-nosed face of a convict, applies a heavy dusting of talcum powder to her face. On top she adds two large rings of lipstick onto her cheeks and also applies this to her lips, grinning with pleasure and showing half-rotted teeth. Later she works and reworks the palette of her face with bright pink rouge and so on, until she looks quite frightful. At the next table the nurses keep an eye on the patients, having a bit of a giggle at the mess they are making. Margot applies makeup carefully and with dignity: green eye shadow, face powder, muted lipstick. I have rarely seen her look so nice. I compliment her and she laughs. 'No, no - I look like the devil!' she says in her half-amused, half-mournful self-depreciating way. A serious, elderly stooped patient stolidly paints the face of another elderly patient incompetently but caringly. Another has painted her face into a travesty of a Japanese geisha, all white powder and bright pink cheeks and eyes, with dark eyebrows and red lipstick. She scowls at me watching her.

These sessions seemed to act as a tangible reminder to women patients of their sex as well as some of the expectations attached to gender, whereby concern for appearance, narcissism and decorum is inculcated in women from an early age. Furthermore female staff epitomised through scrupulous dress and careful grooming the ideals of feminine beauty that women patients could aspire to but could never attain. However although the end result often looked like a travesty of femininity, the chance to recreate oneself and the concentration required in creating these geisha-like masks were undeniable and remarkable in this stultifying environment. On Female Ward 1 if a woman attempted to overcome the *desexualisation* of generic, regimented, unkempt patient-hood through acts of self-ornamentation staff would reinforce this through such verbalised approval as, ‘*cantik!* (attractive) you look pretty today’. This situation in turn is reminiscent of the observation by Rowett and Vaughan in their study of women offenders in the UK where inmates are seen to be moving towards ‘recovery’ by the controlling authorities if they adopt overtly feminine interests that are compatible with gender normative behaviour (1981: 137).

Additionally pictures of predominantly white glamour models and a faded photograph of fetching blonde Aryan children reminded women patients of the accepted hallmarks of beauty as belonging primarily to the fair-skinned races. As one nurse commented to me with bland irony, ‘all white people are beautiful’. Consequently I received more than my fair share of compliments and duly received a long love letter from a woman starting with the words, ‘to the first *orang puteh* I have loved’ from which it was apparent that my

ethnic appearance alone had managed to conjure up fantasies for my admirer that were otherwise devoid of reality and could not therefore be realised.

7.4.3 The viability of a lesbian alternative

In the strict confines of an environment in which sexuality was both highlighted and denied by the system it was predictable that patients sought gratification through homosexual alliances. Most of my information on this subject was gathered from observation and interviews with female patient respondents. By comparison although clearly some male patients had adopted a 'gay' identity, these men practically never alluded to this aspect of their lives. Equally male staff were unwilling to discuss this directly although some did admit that homosexual acts regularly took place on the wards but that these were somehow 'prevented' although how was not clarified. The reluctance to discuss this topic is commensurate with general social attitudes towards gay lifestyles in Malaysia, which are informally practised and have given rise to an active street industry of rent-boys yet are rarely discussed or socially acknowledged (Ashencaen Crabtree and Ismail Baba, 2001).

On the female wards my investigations into lesbian relationships were treated with less circumspection than on the male wards. This was probably because although equally proscribed in Islam, in Malaysia lesbianism is barely recognised as a legitimate phenomenon (Ashencaen Crabtree and Ismail Baba, 2001). It therefore has no accepted social reality and does not pose as threat to cultural values in the same way as the male gay lifestyle. In opposition to this view Wazir Jahan Karim asserts that in fact normative

sex roles are not as strictly demarcated as they are in the West and that some Asian women enjoy greater liberty to explore their sexuality, as indeed do their male counterparts.

Numerous Southeast Asian cultures allow both men and women to explore their sexual differences freely, without inhibition and without shifting the natural attributes which both sexes have to offer one another (Karim, 1995: 36).

My findings suggest however that at Sentosa a conventional attitude of disapproval and discrimination was applied to women who did not conform to behaviours that in the West would be seen as gender normative. The resulting reactions and attitudes of those in authority towards these breaches were again similar to that which traditionally one would expect in a Western context, as described by Cogliati *et al.* (1988: 99) and additionally Chesler (1996), in which lesbian conduct is subject to earnest repression in institutional care. Consequently not all nurses admitted that lesbian relationships did exist on the wards and some categorically denied this even in the face of evidence. On one occasion I saw two inseparable women patients cuddling intimately but playfully in bed, the nurse I was with looked on stonily without interference, except to say to me eventually with disgust and resignation, 'Look at them – just like animals!'. What I found particularly interesting was this was the same nurse who had earlier told me that lesbian relations did not take place on this ward; clearly this represented more than just a problem of definition for this person. On another occasion a nurse attempted to be particularly helpful by pointing out an alleged lesbian couple and then paraded them in front of me as a supremely ridiculous example of a butch/femme stereotype. Fortunately despite staff

reluctance I was able to discuss these events with women patients with more success, such as in the following conversation with Soo Mei and friends.

- Soo Mei: I love my friends ...[passionately grabs my hand]. But I don't like some ... We were in bed And I was like this - in the middle ... and she touched my...*susu* (meaning breast) ... and I said "no" and ... [gesture of hitting out]. Now she is afraid of me.
- Researcher: What do you mean 'in the middle'?
- Soo Mei: Like this ...
[Draws a picture of 2 beds pushed together with three people lying in it]
- Researcher: And that happened here? On the ward?
- Aini: Yes, here!
- Soo Mei: Yes, I scolded her!
[Points out one of the patients walking near us]. I don't like her.
[Tuyah comes up and joins us but is feeling withdrawn and unresponsive today]
- Researcher: Do you have a boyfriend at home Soo Mei?
- Soo Mei: Yes, I had a boyfriend one time but he wanted -
- Aini: Sexuality!
- Soo Mei: Make love. So I said 'No! do not... do not...' [lost for words]
- Researcher: *Tidak masuk* (do not enter/penetrate)?
- Soo Mei: *Tidak masuk*. I do not look like a soft ... soft lady.
- Aini: A soft lady, a gentle lady – you are a tomboy!
(‘Tomboy’ carries certain connotations)
- Soo Mei: I'm not a tomboy!
- Aini: [To Tuyah laughing] A lesbian! A lesbian! [Tuyah nods sullenly].

Although Soo Mei actively sought sexual gratification she refused to be predated upon by others and felt able to reject, violently if necessary, those lesbian advances that did not appeal to her. Although evidently ambivalent about being publicly labelled a lesbian herself, in her own forthright, assertive way Soo Mei projected a positive image of the lesbian alternative to the enforced chastity and sexual inertia of the ideal female hetero-orientated patient in *purdah*. The 'tomboy' reference in its implication that lesbian sexuality emulates the active male role was one that Soo Mei shunned due probably to

stigma, but also demonstrated through the adoption of boyish, uninhibited mannerisms and her smart masculine dress.

Aini, as a Muslim however, could not bring herself to condone lesbian behaviour and in fact indicated that an element of sexual violence permeated the ward system, in which she implicated both patients and staff as well.

- Aini: [Turns to me and drops her voice]. Sometimes the nurse touches us [holds her breast] here.
- Researcher: Why does she do that?
- Aini: [Looking cautiously back to the nurses station] I don't know. (The patients) show their body - no shame. That is an issue of morality. The nurses come to take off my long pants, I think it's sexual - you say sexual? They touch [indicates breasts].
- Researcher: The patients show their bodies?
- Aini: I don't want that - that is lesbian and bad thing by God. Lesbian behaviour... [Roughly grasps her breasts and vulva in clawed hands]. Some here - not a lot, during the day-time when I am bathing ... people are naked, bodies open to all.
- Researcher: What do the nurses do if that happens?
- Aini: The nurses scold but nothing. I pushed her off. The nurses locked her up and the nurses said something bad about me - I didn't hear them but heard them mumbling something.

In this extract Aini is evidently describing an attempted sexual assault by a fellow patient, although it remains unclear how common such events were on the ward. Nonetheless Aini's point stands, that sexual assaults were not necessarily recognised by staff, who appear to equally condemn sexual assaults and consensual sex amongst women. Given the accounts by patient and staff participants the attitude of nurses towards anyone engaged in or suspected of lesbian behaviour was highly condemnatory. Under ideal circumstances the lesbian alternative could represent a way of subverting the 'cloistered'

existence of women on the ward through sexual gratification that precluded the physically real or implied male presence (Mohanty, 1991). In opposition to this strategy, the ward environment was one where women patients in general were frequently obliged to adopt the posture of passive objects that could be publicly stripped of their clothing and exposed in their nakedness to the voyeurism and even brutality of others. While through their condemnation of lesbian conduct but their general complacency towards sexual assaults on women patients by other women, nurses failed to adequately protect women in their care (Chesler, 1996). Regardless of the nature of any potential sexual contact, whether this was construed as heterosexual or lesbian, coerced or freely sought, women psychiatric patients at Sentosa were regarded as morally culpable and therefore in need of surveillance tactics and heavy measures of 'sociosexual' control (Showalter, 1981).

CHAPTER EIGHT

ROLES, CAREERS AND OPPORTUNITIES: STAFF ACCOUNTS OF PSYCHIATRIC WORK AT SENTOSA

8.1 Introduction

This chapter and the subsequent one are devoted to staff perceptions of their work at Hospital Sentosa. Interviews with staff of both sexes and at all levels of rank raised some interesting themes regarding work conditions and collegial expectations as well as prevailing attitudes towards patient care. Significantly these could be related to the position of the individual member of staff in the general hierarchy as well as being subject to gender differentials. These accounts are considered against a backdrop of current plans for the future direction of Hospital Sentosa which formed the main areas of consideration for those in the upper hierarchy of the hospital system. My findings indicate disparity between these perspectives and expectations and those from lower down the hierarchical chain and in so doing provide a useful focus for the exploration of individual accounts of personal experience against rhetorical projections of ideal psychiatric care.

8.1.1 The experience of research in the medical hierarchy

In Malaysia the male-dominated medical profession retains a very high status and an authority that is largely unchallenged by the public or allied professions. Psychiatry accordingly carries these gender biases as well the privileges of medical status, although arguably to a lesser extent due to the perceived stigma of mental health, as discussed later in the chapter (Selig, 1988: 91). Consequently the power of the profession in Malaysia

remains unquestioned by allied professions, such as psychology, occupational therapy and social work, as is seen to have occurred in relation to non-psychiatrists in the contemporary British context (Ramon, 1988: 10). At Hospital Sentosa most of the doctors are young male house officers with female counterparts being quite a rarity numbering only two individuals at the time of fieldwork.

In the process of fieldwork I found that hierarchical considerations were a dominant feature that impacted on how staff related to me in terms of acceptance of my role and willingness to assist. Consequently although I frequently found myself in the role of petitioner when attempting to interview established doctors, house doctors of both sexes were usually amenable to an approach and indeed seemed well disposed, and even on occasion relieved, to confide during interviews. With some notable exceptions, doctors of all ranks were approachable and some even took pleasure in adopting an instructive role. This pedagogic attitude however could take on the form of bullying behaviour, exemplified by Dr Jerry, an overbearing and strangely antagonistic senior doctor who took a delight in baiting me by evading my own questions and instead posing others that were designed to highlight my ignorance. Naturally this was a frustrating and not very illuminating process, but evidently not entirely uncommon, as Robin Brian notes of his own similar experience as a researcher in a sociological study of psychiatrists in Britain (Brian, 1986: 115-6).

In general, and understandably so, lower-status individuals such as medical assistants and nurses were often uncomfortable offering comments on the behaviour and attitudes of higher-status staff, specifically the doctors in charge. It was therefore highly problematic gathering information on what nurses and medical assistants thought of doctors, short of inferred nuance and veiled implication. On the other hand, doctors were more likely to feel able to comment on similar issues in relation to lower-status colleagues, with some reservations, although obviously wary of seeming to criticise those above them and hospital policies in general. Findings however indicated some interesting similarities could be found amongst the themes emerging from doctors and nursing staff, by which I include staff of both sexes.

These emerging issues offered valuable insights that tended to confirm views gathered from patient respondents with regard to conditions at the hospital and the general attitudes of staff towards them. Findings gathered from senior doctors however served to place the hospital in a wider context of service delivery. The future of the hospital formed some of the main preoccupations of those at the highest level of the hospital hierarchy, in addition to the headaches involved in the governing of the institution.

8.2 Paradigms of care and modern colonialism: ideology and dissent at Sentosa

Hospital Sentosa is currently positioned somewhat uncomfortably at a cusp of change in mental-health provision that is slowly taking place in Malaysia, in that ostensibly the theoretical direction of mental-health services in Malaysia has seemed to embrace moves towards the decentralisation of psychiatric hospitals (Ashencaen Crabtree and Chong, 2001). Whilst this direction is generally reinforced as the prevalent one, in conversation with the higher echelons of power, this is by no means a unanimous view. Many members of staff at the hospital were sceptical of the projected vision of the community psychiatry in the State, whilst others appeared quite oblivious to these concepts that formed a bone of contention 'upstairs'. Yet, whilst nominally plans for decentralised services in Sarawak are driven by people like the hospital director, the implementation of such a large-scale project lies primarily through the coalition of the 'coal-face' nursing staff. Unfortunately it was these individuals who seemed the least informed about or involved in plans afoot. This then presented me with some difficulties in that I was privileged to hear information regarding the agenda for decentralisation, in interview with Dr Tiong, whilst being uncomfortably aware that this was not an agenda that nurses and medical assistants on the wards generally discussed as having any real significance for them at all. This situation was not aided by the fact that there was a conspicuous lack of specific and accountable guidelines published and disseminated by government agencies on the matter (Ashencaen Crabtree and Chong, 2001: 27).

8.2.1 A projected vision of community psychiatry for Kuching

In interview Dr Tiong spoke with animation about Sentosa's future and described an exciting community-based service that would take place under the 8th Malaysia Plan scheduled for the coming five years (Malaysia, 1991; Malaysia, 1993). Ambitious projected plans would involve the building of a new acute, two-storey fifty-six-bed block at the general hospital. This anticipated that one floor of the block would house a day hospital and community psychiatric nursing facilities, whilst the other would be turned over to general psychiatric wards. The grounds of Sentosa itself would house the siting of a new polyclinic covering out-patient appointments thus allowing downsizing of the hospital to accommodate chronic and other long-stay patients only, a practical plan in view of the predominantly chronic patient population. Unfortunately snags hindered these exciting developments, the first being to obtain permission to proceed from the Sarawak State Government, a major problem in itself¹. Whilst the other lay in the general difficulties of taking the first steps into the unknown unaided by government advice, much to Dr Tiong's despair.

'Nobody seems to know how to go about it, *lah*. It means more than just decentralising the hospitals ... (it) means providing services in the community: day care, day hospitals, community services like halfway home. Unfortunately promoting mental-health issues rather than community psychiatry as such ... although promoting is part of community psychiatry, but it doesn't provide services for those who are mentally distressed!'

¹ The Sarawak State Government subsequently rejected the plans without giving formal reasons.

Dr Abdul Kadir, an active proponent of the decentralisation move in Malaysia, expressed impatience with the attitude of designated frontline personnel. These were seen as being already engaged in dealing indirectly with community mental-health needs but viewed as shying away from casting these activities into a formal and directly interventionist role.

‘They won’t handle the mental-health cases but will refer out. In terms of mental health, they are doing it (psychiatric work), but the personnel don’t recognise it. When this programme came in (decentralisation), there is a lot of dissatisfaction: fear of extra work. If the mental-health programme is being established - implemented properly they are scared that they won’t have time, training. But they don’t need extra time, it is no extra work to them, they have these cases anyway. They believe that it is extra work: “My work is this!” They want this (mental health) to be specialised, to be handled by special doctors, but there are many other diseases which are not handled by specialised people’.

The recalcitrant professionals that Dr Kadir spoke of with irritation are the public-health medical assistants who were employed in a variety of care sectors including, for instance, the male wards at Hospital Sentosa. This however only reflected some of the problems for the implementation of community-based care, which required a concerted, co-ordinated approach from the health authorities and social services, as noted by this affiliated NGO worker:

‘The Welfare Department regards mental illness as a medical problem, there’s no perception of psychosocial needs at a practical social-work level. There’s a very poor alliance between health and welfare. In theory they should be involved but ... There is a community mental health policy but nothing concrete. Critical services, accommodation support, sheltered employment crisis intervention teams – none of that being done through the Government sector; NGOs are providing in that area on a very small scale, you know’.

Turf boundaries then could be understood as a common obstacle towards providing satisfactory community support, which Government plans and proclamations appeared to do little to tackle (Ashencaen Crabtree and Chong, 1999b). The general response of the social services to-date is a refusal to acknowledge any real role in the care of psychiatric patients in the community, while NGOs take up the slack in service provision². In this somewhat chaotic situation it is hardly surprising that hospital personnel were portrayed and, as will be seen, portrayed themselves as unmotivated to do other than keep Sentosa ticking over much in the way it has done for years.

8.2.2 Dissent and critique in the ranks

In the meantime dissent high in the ranks was articulated by Dr Jerry who disapproved of the entire endeavour and scathingly dismissed it as yet another tired example of post-colonialism paradigms inappropriately imposed on developing nations (Bhugra, 2001; Littlewood, 2001; McCulloch, 2001).

- Dr J: Community psychiatry is rubbish! I've told them that in Kuala Lumpur. It was all started by the British - and in Malaysia we have to copy everything Britain does, even if it's wrong.
- Researcher: What kind of model of care would you like to see instead?
- Dr J: Where you'd get large numbers of psychiatrists and trained staff, all trying to compete with each other and learning from each other. Instead of this situation where you get a psychiatrist here or there, doing as they please, with no one looking at what they do. This is the way other health practices are managed, like the Cardiac Centre in KL (Kuala Lumpur). This is where all the knowledge and technology is concentrated, and not just heart problems, most other

² Problems run deeper however, where the abrogation of responsibility by the social services is hardly open to effective challenge while a more fundamental structural problem exists in which while all psychiatrists belong to the health sector, community mental health comes under the public health sector, leaving it unclear which Government departments are responsible for implementing community care.

medical specialities. We should be doing the same with psychiatry.
It would be much better for the profession.
Researcher: And the patients?
Dr J: Them too.

For those who still adhere to a basic belief in community psychiatry, Dr Jerry's vision of centralised services represents a nightmare return to the vast asylums of yesteryear, on the pretext of improved service provision and psychiatric excellence. Ironically in reality this would barely move away from the models of care, that Dr Jerry regarded as defunct and exhausted as well as inappropriate for modern, independent Malaysia (Acharyya, 1996; Barham, 1992; Deva, 1992; Shorter, 1997). Narratives such as these point to a continuing tension that exists between ideologies that are predicated on polarised models of care. These nonetheless retain a grip on values and practices influenced by the West, but which are mutually incompatible (Campbell, 1996; Caplan and Caplan, 2000; Forrester-Jones, 1985).

Finally, in the European context, the move towards community-based care can be seen as describing a uneven continuum that has generally moved towards greater democratisation of psychiatry, articulated as a civil-rights and humanitarian move (Campbell, 1996). At Sentosa by contrast, paradigms from seemingly quite incompatible eras of Western psychiatric care were imposed simultaneously and imploded into a confusion of rhetorical stances that appeared to keep progress immobilised and the condition of patients' static. This is a situation that is accordingly noted Rostom and Lee (1996) in their study of major psychiatric service providers on the Peninsular.

We were informed that the recent policy in decentralisation only extends to the concept of relocating services outside the hospital for care in the community projects, it does not appear to encompass the wider issues of service-user empowerment. (Rostom and Lee, 1996: 25).

The low-key rationale for decentralisation in Malaysia has in part, like the UK, been subject to budgeting concerns, where it was hoped that this would be a cost-effective approach to care (Ashencaen Crabtree and Chong, 2001). However it might be more to the point to see decentralisation in Malaysia as an attempt to keep abreast of contemporary developments in psychiatric-service provision but subject to ideological qualifications far removed from emancipatory goals (Campbell, 1996; Scheper-Hughes and Lovell, 1986). Furthermore, as Forrester-Jones points out in her study of community care moves in Britain, the unpalatable fact is that doubtless there will always be some individuals who will require semi-permanent residential care. This was the perception towards the largest majority of patients at Hospital Sentosa and consequently required little in the way of fundamental changes to the current system (Forester-Jones, 1995: ii). Yet, as Sue Estroff points out, de-institutionalisation in itself does not remove the fundamental barriers of social exclusion faced by psychiatric patients.

De-institutionalisation has, for the most part, been simplistically effected through movement away from the architectural embrace of hospitals. But institutions, of course, are complex, extending beyond walls to the articulation of traditions and values as a societal level. In this sense, the institutions of chronic mental illness have been little affected by the escape from institutional buildings. The roles, expectations, stereotypes, and responses that accompany being a back-ward patient or a long-term community outpatient have changed little. (Estroff, 1981: 253-254).

Consequently the plans to integrate acute psychiatric-service provision with general hospital services required a certain evangelism on the part of its proponents. Although as will be seen, this was a message that had yet to filter down to the lower echelons as a viable alternative to the present system.

8.3 Community psychiatry and ‘coal-face’ staff

One major problem for community-based services for Sentosa lay in the simple fact that it required other members of staff than the architects of these plans to carry out the services. The hospital plans consequently hinged on the nursing teams in their various capacities based in part upon gender normative roles, to realise these ambitious plans, and these roles in turn could be seen to handicap staff in the efficient execution of their duties.

8.3.1 The role of the community psychiatric nurse in community-based services

One dominant branch of the nursing resource that is essential to community-based care is the hospital’s community psychiatric nursing (CPN) team. It has been argued that their intervention is critical to the success of the hospital in managing out-patient care, demonstrated by the fact that their workload doubled in volume over the extended fieldwork period alone (Lau and Hardin, 1996). The CPN team consisted of two nurses and a medical assistant who were reliant on a driver and at that time, a rather dilapidated vehicle. Unfortunately due to budgeting constraints it was not seen as possible to increase the number of staff from its original team size of three people, as this would also require additional transport that the hospital could not afford. The pressures of the job consequently grew and while members of the team audibly approved of the pivotal role

they would be playing, in interview one of the nurses pointed out some of the difficulties ahead, particularly in relation to the benefit of medical assistants over that of nurses in the nature of their official capacity.

CPN: Only Michael (CPN) can prescribe medication, *as* a medical assistant. We can't because we are nurses, we cannot even prescribe Panadol! If Michael is on leave then we must find a doctor able to prescribe ... and this takes so much time with so many patients and appointments.

Researcher: Would you say this was an example of sexism in the services; the way nurses and medical assistants have different duties like this?

CPN: Maybe. But the system has always been like that.

Although nurses and medical assistants undertake similar duties on the ward, their motives for this line of work are characteristically somewhat different. In the general health setting in Malaysia nurses and medical assistants occupy specifically designated gendered roles, whereby 'nurses' are always women and are largely assigned a skilled but supportive role and are normally unqualified to prescribe medication to patients, of even the most mundane variety, as stated by the CPN in interview.

The medical training of medical assistants being men reflects the dominant view that it is men who largely occupy the elite profession of medicine, and the training of medical assistants conforms to that stereotype, and as such stands in some contrast to the situation in Britain whereby

The right to make a diagnosis and prescribe a form of treatments is a core element of the professional power of doctors, jealously guarded from encroachment by other clinical staff such as nurses. (Barnes and Bowl, 2001: 60).

The incorporation of medical knowledge with a view to prescribing medications demonstrates, in this way at least, that medical assistants are inherently expected to carry more responsibility than the nurses, and more closely affiliated with the kudos that is attached to doctors. It is medical assistants therefore who run the rural polyclinics prevalent in Sarawak. This is considered a challenging and responsible post, where initiative and independence are demanded at a high level. Accordingly at Hospital Sentosa selected medical assistants and doctors work alongside each other in the out-patient clinic examining, prescribing and admitting patients, with the doctors assessing new and/or complicated cases. Nurses, including female CPNs, were therefore not considered professionally competent to undertake the responsibility of prescribing even basic medication by virtue of their different training and roles (Witz, 1992: 142).

8.3.2 Medical assistants and care management on the wards

If the conditions of work differ for nurses and medical assistants a logical hypothesis would suggest that the rewards and reasons for choosing work in a psychiatric institution also differ for men and women respectively. Findings indicate that that this was indeed so on a number of grounds, although, unlike the number of long-serving nurses and medical assistants now approaching retirement age, the majority of recently appointed nursing staff of both sexes had not specifically entertained ambitions to work in psychiatric nursing. Of these latter individuals, most had been transferred to Hospital Sentosa from

other parts of Malaysia and not necessarily with their consent, while others had chosen to come for a variety of reasons both personal and professional.

Hospital Sentosa is a resource that is continuously short-staffed to a greater or lesser extent and in Malaysia medical staff can be transferred to wherever they are needed with little regard to people's preferences, hence staffing levels fluctuated around a core of established members, depending on the migration and departure of staff. Fortunately the hospital is located in a desirable city with good living standards and reluctant staff can usually find that they are compensated in terms of quality of life for working in an environment which otherwise may not have been their first choice.

Several of the medical assistants had opted to transfer to health vacancies in the city after spells working in clinics in rural backwaters. That the running of these rural clinics was evidently a tough occupation is made clear in the following account from a medical assistant.

Field notes. Male Ward 1.

'I like it (the job) – much easier than in the clinic before ... Then there was only me and one other fellow to do everything, *lah!* People would come any time – night, day, it was very busy. Here we just look after the patients and follow doctors' orders and you can talk with patients! But sometimes you cannot. I just follow orders here and the patients obey us when we tell them to do things, *lah*. No, I did not choose to come here, I wanted to go to SGH (general hospital) but - I will stay for a little while, maybe I will go for training like Zulhan (another MA). It is good here and close to Bau, where I live so'

Zulhan was an outstanding example of a competent, trained and more importantly *enthusiastic* individual, and much appreciated by Jacob on Male Ward, as discussed in Chapter Five. Zulhan's type of psychiatric nursing was therefore seen by some patients to be a dynamic and skilled role model for other members of staff that went a long way in improving the lot of the patient population (Barnes and Bowl, 2001: 113). Zulhan's methods however were not seen as a norm of nursing standards for Sentosa that medical assistants unanimously cared to aspire to. A further account given to me by a different medical assistant confirmed the view that the nursing tasks at Sentosa did not represent a particular challenge compared to his previous duties.

'This is like a holiday after the clinics. I am talking about the small rural clinics not the big polyclinics. I used to do everything - the cleaning, the grass cutting, the diagnosis, treatment and then being on call at night. Very tough work, you can work all night and then all the next day. At Sentosa we do the same work as the nurses and just follow the doctor's orders – more relaxing.'

Rural clinics are the backbone of primary health care in Sarawak, where rugged terrain separates small, isolated communities (Ashencaen Crabtree and Chong, 1999c). Medical assistants assigned to these clinics are responsible for their day-to-day running and are therefore likely to see a wide variety of cases, referring on to general and specialist resources when patient conditions exceed their professional competencies. The medical assistants who had transferred to the hospital from these difficult working environments seemed to a man to be delighted to find themselves in the relatively unpressurised, and indeed in some respects, even 'cushy' berth, after the humdrum, exhausting life of the rural clinics.

Ward life for male patients however could not be regarded as a holiday and particularly for those on the chronic wards, this tended towards the regimented. Medical assistants adopted a supervisory role that seemed based on the mundane existence of the military barracks in peace-time:

Field notes. Male Ward 2.

The ward is very spick and span, all beds are made up in the same fashion. The MA explains that the patients and staff make the beds and a lot of attention is given to them being made just *so*, sheets spread tight, single white blanket folded at the end, pillows facing in the same direction. The opening to the pillow case is meant to face left, although apparently and provokingly not all of them do. He asks me what I think of the ward, I think he expects some praise, I find it hard to find the right words. Finally I say it is very tidy, and comment that the beds are made up as you might find in an army barracks - maybe not the best thing to say, as he looks at me askance.

The imposition on patients of pointless but exact exercises, such as precision bed-making, reinforced their loss of self-determination, as noted by Erving Goffman (1991). Additionally for the outsider, the absurd *ceremonialisation* of the enclosed universe that is institutional life, reinforces the belief that theirs was an enclosed universe premised on concepts and governed by rules that were utterly removed from and alien to a more normalised existence (Goffman, 1991: 47). The 'military model' imposed at Sentosa once again draws parallels with Britain in the early twentieth century where similar conditions could be found in Severalls Hospital, as this extract indicates.

The chief male nurse ... played more of the role of a military commander than one having any *familial* associations (my italics). Discipline was firm and the regimes strict ... (Gittins, 1998: 99).

Despite the bizarre nature of regimented routines imposed by medical assistants as a main duty in their nursing role, the tempo at the hospital from the staff point of view, was regarded as soothing *and* containable. Better still, it appeared to stand in sharp contrast to the conditions of the rural clinics and was, as one informant says, an easy going life in which there was little to do and consequently little expected of patients. The development of community psychiatry, with all the attendant challenges and demands, would apparently fall heavily upon medical assistants. This however was not a topic that was raised by these respondents as relevant to their understanding and practice of nursing care in a psychiatric hospital. These respondents did not express any resentment about being relegated to *just* 'following' medical orders, like the nurses, but actually found their supervisory role a very welcome relief from the burdensome chore of treatment in the wider community, rather than a form of professional emasculation.

8.3.3 Nurses: professional skills and 'supervision' in the 'asylum'

Of the younger generation of nurses I interviewed several explained that this was a temporary placement and, unlike some of their older colleagues, few had an abiding interest in psychiatric nursing as such, while psychiatric training amongst nursing staff, was a rarity. Less than a bare handful of nurses and medical assistants had completed specialist training; a deficiency that was only partially met by attempts at in-house training and plans to access long-distance courses from the West and the Asia Pacific region.

Once again in common with Severall's Hospital of a much earlier era, few nurses found work at Sentosa as attractive as some of their male counterparts did (Gittins, 1998: 158). While in interview most felt that their preferred position was back in general nursing practice but that often events had conspired to ensure that they served a term at this hospital. Equally little enthusiasm was expressed for the practical considerations of community-based care, as noted by this dubious respondent:

'Relatives put patients into hospital (general hospital). They want them to be safe. I don't think they will like our patients being there. It will be a problem ... maybe chronic patients would be better'.

It was considered understandable amongst nurses that the general public would not wish to rub shoulders with psychiatric patients in general hospital settings. Two particular reasons were offered for this view, one being the notoriety of psychiatric patients as incorrigibly unpredictable and violent, and the second being the stigma associated with mental illness.

If community-based care was not regarded by nurses as offering an invigorating and liberating alternative to the current scenario of institutional care, the hospital itself was also regarded as an equally unattractive prospect for nurses. Some participants declared that the best place to be, professionally speaking, was on the sick ward where nurses were able to carry out basic nursing tasks very similar to those that they had been trained for in general hospital practice; and with no consequent loss of skills in those areas. Nurses in interview frequently expressed the fear of becoming deskilled in comparison with general nursing colleagues elsewhere. Furthermore, in agreement with the views of medical

assistants, the perception from nurses was that there was little else to do but 'supervise the patients' and 'give out medications': patients generally requiring some form of additional professional expertise that could not be met through basic nursing practice.

A further point of interest was that in group interviews, most young nurses did not appear to find the different professional expectations that were attached to their role a doubtful practice. The issues of greater medical responsibility as given to medical assistants, at least in terms of prescribing of medication as opposed to following medical orders, were apparently accepted as unproblematic. Nurse perceptions to these gender differences in the professions appeared to conform to the comfortable notion of *equal* but *different* and the 10% extra 'critical allowance' that they received in their pay packets as a token of their essential status in hospitals acknowledged this difference. In turn these views tended to uphold Karin's assertion that gender roles in Malaysia are 'bilateral' and complementary and do not conform to analyses of gender bias because they are not subject to defined positions of hierarchy, as in the West (Karim, 1995: 36). Yet at the same time, the account given by the CPN points towards the reduced effectiveness of nurses based on these differences and indicates the factual, if not perceived, repercussions of institutional sexism that operates towards nursing staff in the medical establishment as a whole.

At Sentosa, with the presumption that time hanged heavily on their hands, nurses on several female wards could be seen working alongside patients for hours on end, engrossed in the most monotonous of the 'female' occupational therapy tasks, such as the 'thread-sorting' chores. Perhaps overtly this was to provide an industrious example to patients, I however viewed it as providing an interesting example of how the barriers between nurses and female patients could be blurred to a minor but significant degree. In comparison, however bored they might confess to being, medical assistants usually observed the distinctions of rank, maintained their distance with patients, and did not seem to participate in the occupational therapy work and general chores that patients were regularly allotted.

Despite the discontent of many nurses several stated that they had managed to find sufficient compensation in the job to outweigh its shortcomings, at least in the short term. Becoming deskilled however could be seen to be a very real danger for nurses and one that was duly recognised by visiting nursing students from the local university.

'I think things are different from what I expected. Well, we came here to see if the theory we learn in college is like it is at the hospital ... and it's different I think. It doesn't fit. There's not much happening on the ward. Maybe it's the management's fault. There's OT, but if you're not stable? No, I don't want to go into psychiatric nursing when I graduate, I want to work in a (general) hospital and get lots of experience.'

The students' general disenchantment with the reality of nursing at the hospital, compared to expectations derived from classroom tuition, was compounded through the advantage of comparisons with other hospitals on the Peninsular, as one student stated:

‘This place is much more like a mental hospital, like an asylum. There’s no stimulation for patients here, maybe they should have things like behaviour therapy, relaxation therapy and group therapy.’

Evidently therefore, nurses and medical assistants at Sentosa tended to jointly regard the job of psychiatric nursing as being fundamentally concerned with supervision rather than with therapeutic tasks. Because of this ambitious staff amongst the nurses were unlikely to consider psychiatric nursing as anything other than a temporary departure from mainstream and more socially valued work in the health services.

Just as medical assistants resigned themselves to working at the hospital for personal and practical reasons, some of the younger nurses offered explanations of domestic convenience as a reason for temporarily accepting a post at the hospital. To reiterate, close to the hospital lies an army barracks and it was quite common, if somewhat incongruous, to find army personnel eating in the *al fresco* hospital canteen. The association between the army barracks and the hospital was maintained not so much through the quality of the hospital dining facilities one guesses, but more likely due to the fact that several of the younger nurses were married to army officers. These nurses however were birds of passage, moving from one post to another across a wide variety of health resources according to their husband’s army transfers and consequently arrive at Kuching for a brief season only. Nurses like these were prepared to transfer to other postings across the country as required by the army and their husbands, for as one nurse put it: ‘wives follow husbands, not husbands wives’.

There were mixed opinions on how this affected nurses' attitudes to work and careers, some maintaining that it was better to keep moving and get general experience. Others admitted that constant transfers tended to jeopardise their attempts to climb the promotional ladder, although this served their husbands' careers well. In a group discussion with nurses one responded by saying that her soldier husband was proud of her professional nursing skills, 'because I can diagnose illness in our children'. This comment acted as a good reminder to us all that gender norms demand that the role of work for women should be subjugated to that of wives and mothers. This said, nursing was considered 'a good job', far better than secretarial work and most other traditional forms of female employment as well as better paid.

At Sentosa, however, the nurses were seen to be unable to fully utilise their basic nursing skills and seemed in general not to have acquired a compensatory new set specific to their role in psychiatric care. That this was true of the medical assistants as well offered no consolation, and postings such as this one to Sentosa appeared to do little more for most than expand their *curriculum vitae* to some extent, in readiness for better opportunities elsewhere.

8.3.4 Social work and counselling services at Sentosa

Hospital Sentosa, perhaps somewhat incongruously, boasted of the service of a hospital counsellor and a small social work team, consisting of young women that were still in the experimental stage of consolidating career options. In interview the counsellor conveyed that she primarily focused on the families of patients, rather than patients themselves, as these were not seen as being able to benefit particularly from counselling therapy on the

grounds of their disorders and lack of insight. Families by contrast were regarded as requiring a lot of emotional support to continue their onerous involvement of relatives with mental illnesses. Views from Male Ward 1 regarding the counselling service differed, with Teo, for instance, grumbling that neither he nor anyone else on the ward had ever seen the counsellor despite a wish to do so; the general conclusion was that she was too 'afraid' of them to entertain a direct referral.

Equally social work at Hospital Sentosa was also under-utilised by patients and appeared to play a marginal and low status role in the daily activities of the hospital (Dominelli, 1992: 89). Somewhat surprisingly, in view of its profile in community psychiatry elsewhere, no mention was made of the hospital's social work team as key players in future community-based services. In other Asian regions, such as Hong Kong social work is seen as an important component in terms of smoothing the transition from hospital to successful community living (Pang *et al.*, 1997: 213).

Predictably the role of social work at the hospital was seen exclusively in terms of 'bed clearing', a restrictive stereotype that can nonetheless be found in hospital institutions universally and subject to orders by those higher up in the hierarchy (Barrett, 1996: 65; Brian, 1986: 118). The two social work professionals were heavily reliant on the second-hand guidance of the CPN team in outlining their duties as unfortunately neither had qualifications or a background in social work. Referrals therefore tended to concentrate purely on locating families of patients in order to effect discharges and skills. Social work skills therefore were dedicated towards detective work and negotiation to ensure that families took responsibility for the care of patients, as described in this account.

‘Relatives move and the hospital cannot trace addresses. Some relatives run away from the patient, one mother left her son here for one month and said she would take him back when he was well. But when the patient was ready to go home the mother had gone, she had moved to Miri. So we have no choice but to send him back to the longhouse and hope the other residents look after him. I was angry with the mother, but also you can’t blame her, because the patient was violent at home, asking for money and she was the only carer. But also she didn’t control him or help him take his medication, didn’t supervise him at all. Many families don’t want to take relatives home, they don’t see this as a hospital, a hospital where people are discharged – they see this as a place for crazy people to live. And they think the Government should take care of them.’

Unfortunately then the hospital plans for community-based services did not seem to incorporate a feasible alternative vision for patients other than that of continuing to live with relatives. This is a situation, which even in the context of the UK, with its attendant supportive services and financial benefits, is described by one author as ‘precarious, and contingent upon the good will of family members’ (Hatfield *et al.*, 1992-3: 32-3). Given this situation the distinction, to quote Foucault, between ‘care in the community and care by the community’ remains somewhat clouded, with some tragic repercussions befalling patients whose families were clearly opposed to their presence³ (Foucault, 1976: 44).

In addition to their limited training, hospital social workers at Sentosa were expected to act as autonomous hospital agents, independent from social services and were effectively cut off from support from social-work peers. Their ability to challenge their restrictive role and advocate on behalf of their clients had they so wished to do, would have been

³ One social worker described a particular case where a multiply admitted patient that I knew by sight, was discharged back to the care of his family despite the fact that he was being kennelled in a stifling zinc-roofed cell in the garden. After one unsuccessful suicide attempt, which resulted in a readmission to Sentosa, he was once again turned over to his relatives where he finally succeeded in hanging himself. It is a rather telling indictment of social work assessments conducted at the hospital that his living conditions were reviewed but not condemned as unfit prior to his last and fatal discharge.

very limited, as was the time spent on the wards. No direct assessment of needs was carried out with clients, apart from a general home assessment and for the most part there was a perceived reluctance to engage with patients; wards were seen as grim, depressing places, which were generally unnecessary to visit.

8.4 The world of medical officers

Doctors at Sentosa are normally young male house officers and in the business of acquiring a number of specialisms, of which psychiatry was only one and often far from the favourite. Like the majority of the nursing staff, serving doctors tended to regard their posting at Sentosa as a temporary bond that increases their general medical experience and added to their marketable skills. Some however announced that they had little choice in terms of transfer and were here 'against their will'; a situation that one doctor denounced as a demoralising and counterproductive measure that impacted on the care of patients.

'We have internal politics about the level of staff, and OK I am not the best medical officer in the world, but some of the others are worse. It's a symptom of how sick things are here: people are transferred against their will, and unless you're really bad, for the Government's part they don't try to keep *you* happy, you try to keep *them* happy. If I am bad they won't sack me, if I am not happy, I quit. Other places if you don't do the job you lose the tender; here you don't lose the tender until you fall out of political favour.'

Dr Khairul was fairly unusual in feeling that work in psychiatry was reasonably rewarding, an area 'where you can see progress in patients', but unattractive as a career if one stayed in Government-run posts due to the poor salary and career prospects. Consequently, however interesting he found psychiatry, he intended to leave the hospital

and enter private general practice as soon as possible. Regardless of the expertise that in theory existed in the hospital, the dearth of alternative therapies, such as psychotherapeutic interventions, coupled with discouraging conditions and attitudes operating at the hospital, made some doctors long to set up practice for a more stimulating and fee-paying clientele. This unfortunate situation is accordingly reminiscent of Joop de Jong's observation of the hierarchies of treatment that may be expected by categories of patients based on economic strata and purchasing power, which was a notable and lamentable aspect of institutional life at Sentosa.

On a number of occasions I witnessed colleagues in Asia giving large amounts of drugs and electro-convulsive therapy (ECT) for a variety of diagnoses to low income patients, while reserving (psychoanalytic) psychotherapy for a small elite in a private practice. (de Jong, 2001: 139).

Dr Fabian, unusually for a man, 'followed' his wife to Kuching, where she was fortunate in obtaining a more successful post than the one he held at Sentosa. Dr Fabian was clearly unhappy in his work, regarding psychiatry in quite the opposite way to that of Dr Khairul, as being an area where work was demoralising, as progress was almost imperceptible. Along with his more enthusiastic colleague he saw it as a dead-end career and palpably yearned to escape. Additionally and perhaps most importantly, he seemed very bothered by how medical colleagues regarded the work, which added to his general dissatisfaction and frustration.

'There's a lot of stigma in being in a psychiatric hospital in Malaysia. Do you agree with me? And when you tell people, other doctors, you work at Hospital Sentosa, they say, "oh, that place!" It's not easy to be here. Some people, even you know, doctors, seem to think that if you work here long enough you might become insane as well – it's contagious, sort of thing.'

The stigma of working at the hospital did not only impact on doctors but was a concern that nurses and medical assistants also acknowledged, as confided by one individual working on a male chronic ward:

‘I work here for the family’s sake. But there is stigma working here. Other staff ask you where you work and you say “7 mile”, and they smile ... there is stigma working here. One time I didn’t say where I worked, I’d say “3rd mile”⁴. Not many people want to work here’.

Stigma therefore was regarded as the major enemy militating against community acceptance of people with mental illnesses, with the resulting assumptions that wards would continue to exist occupied by patients who were unlikely ever to be discharged. The prevailing perception amongst lower-ranking doctors and nursing staff conformed with Estroff’s (1981) analysis that it was unrealistic to hope that the labelling and social discarding of patients would be prevented through the adoption of community-based services.

Prior to commencing fieldwork, although aware of stigma I had grossly underestimated the extent of this prejudice towards mental illness in this region. Staff accounts refined my rather vague appreciation of the issues at stake and participants such as Dr Abdul Kadir further enlightened me through his opinion that mental illness was regarded as being *more* stigmatising than leprosy, a common disease in the region in the recent past.

⁴ The greater Kuching area is divided into subdivisions relating to the calculation of miles counted from the city centre. Consequently Hospital Sentosa is located roughly seven miles from central Kuching.

If Foucault employed this analogy as largely a symbolic motif, Dr. Abdul Kadir by contrast pragmatically talked in shockingly literal terms (Foucault, 1965). Accordingly findings indicated that working in a psychiatric hospital was viewed by staff generally as not only stigmatising in itself on a professional basis, but as psychologically and perhaps even morally hazardous in its insidious contagion.

8.4.1 Doctors' views of nursing colleagues

Disinterest and disillusion among house officers extended beyond their own particular circumstances and were directed to those further down the hierarchy as well. A dim view was often taken of the quality of nursing care undertaken at the hospital. Some doctors in interview were quite scathing in their evaluation of their colleagues' work, but equally rather nervous of retaliation to open criticism that could be and had been rewarded by petty acts of revenge, both in and outside of the hospital setting. Most of these doctors had enjoyed a traditional training overseas in developed countries, such as Britain. During this time they had been embraced in a medical culture of agreed expectations and values that were apparently shaken upon their return home and particularly so in relation to their work at Sentosa.

'Well after all, I've lowered my expectations, haven't I. I mean I just don't expectI came back from 3 years overseas and Hey, when I start a job it's the nursing staff that teach me things, they look out for me, they know! But you can't expect that here. You just get, "whatever you want doctor". I mean there's nothing! You can't expect it. Developing nation! I don't know what's expected in Malaysia, I only know what's in this hospital. It has low calibre staff. Problem staff get dumped here - transferred here. By the time they end up here there's a problem, although obviously I'm not talking about everyone. The staff here are pretty institutionalised themselves.'

The almost inevitable ‘institutionalisation’ that could be found amongst patients *and* staff alike was a common theme amongst doctors still undergoing adjustment to the hospital environment. This served to reinforce anxieties about their own circumstances and prospects whilst underscoring the need for more support and guidance from nursing colleagues, who under other circumstances would probably be viewed as knowledgeable and trustworthy guides.

‘You find some (patients) in the chronic wards Male 2 and 3, lying under tables and things like that. Some have been here 15 to 20 years, longer! There’s not a lot you can do with them. And the other staff, some nurses and MAs well they feel, that’s what chronic patients are like. It’s taken for granted that there’s not much you can do to help them...Some of the nurses and MAs are quite good, the older ones are very good, but many of the nurses and even MAs have slacked off and compared to the general hospital not so well medically trained, they don’t know what to do. They’ve gone rusty.’

The subsequent effort involved in attempting to bring progress to the wards was raised in interview as an arduous, difficult and indeed futile task in many cases, with the inertia of nursing staff opposing the authority of these ‘new brooms’. The common view amongst new doctors was that too often any change that they initiated flew in the face of an entrenched attitude by nursing staff, as described in this account by a female doctor.

“You not only don’t do what I want, you sabotage my treatment! Why don’t I just give you a bucket of pills and let you do what you want!” Hey who cares? These are *psychiatric* patients. In this country if they die the family think “good”. You’ve [directed to researcher] seen the four chronic wards, they’re abandoned people.’

Finally, while gender differentials could be seen to play an important role in relation to nursing staff, this was not an area that could be adequately explored amongst serving doctors at the hospital. The unfortunate consequence of the scarcity of female doctors inevitably meant that in relation to the topic of work and careers insufficient analysis based on gender could be brought to bear upon the position of women and male doctors. Findings pertaining to female doctors in this chapter therefore remain undifferentiated from those of men. It would be fair to say however that amongst interviewed doctors of both sexes and all ranks, very few regarded their post at Sentosa as being other than a temporary and frustrating sojourn. Even for those with a commitment to mental health work their sights were set on opportunities elsewhere. Psychiatry at Sentosa was in general seen to be an unrewarding business in terms of professional careers and working conditions and for those intending to continue some sort of interest in psychiatry, private practice was seen as by far the best personal option.

Although evidently doctors in particular saw themselves as quite removed from the world of the nursing staff, findings indicated that doctors and nurses shared common concerns regarding how duration at Sentosa would impact on their future careers. Furthermore the stigma of working at a psychiatric institution was one that was invariably raised by all categories of staff participants but particularly by doctors and medical assistants. Finally, findings indicated a preoccupation amongst doctors and female nurses alike with the

effects of demoralisation and the loss of skills and direction. This was encompassed by the use of the derogatory term 'institutionalised' as directed by doctors towards nursing staff and indicated fears of collegial disapprobation and professional marginalisation in the wider arena of professional work.

CHAPTER NINE

STAFF STRATEGIES OF CONTAINMENT ON THE WARD

9.1 Introduction

This chapter, being the final chapter on findings and staff issues, is devoted to the issue of containment of patients at Sentosa through strategies that can be seen to be both physical and attitudinal. Findings based on staff accounts as well as through observation, serve to define and demarcate the perception of the fundamentally impermeable boundaries between madness and sanity. Historical rationales used at Sentosa on the issue of patient control are compared with current ward policies and are seen to inform present staff practices. Finally, the impact of these issues are related to views of staff upon topics such as occupational hazards and personal vulnerability, while these in turn are seen to impact on the fieldwork process and relationships with respondents.

9.2 Moral containment of patients and ethnic typecasting

While the plight of long-stay patients forms an area of concern as well as frustration for staff, more importantly this also served to provide an arena for racial assumptions and stereotypes that surfaced in relation to racial theories. Staff and visitors, such as myself, are liable to note the conspicuously high numbers of Chinese patients of both sexes on virtually every ward at Sentosa. Naturally this is a somewhat sensitive subject, especially for Chinese members of staff, who may find themselves subject to the same racial prejudices as are applied to Chinese patients.

In Malaysia racial and ethnic questions normally revolve around the safer topic of multicultural celebration rather than dissonance: unity rather than fragmentation, overall progress rather than racial discrimination¹ (Ashencaen Crabtree, 1999b). Accordingly, Rostom and Lee conclude their report on psychiatric institutions in Peninsular Malaysia by applauding the way services meet the cultural needs of patients through observing 'cultural, spiritual, religious and dietary' norms (Rostom and Lee, 1996: 26). While to some extent through the celebration of local, ethnic festivities on the wards, this, so far as it goes, can be seen to occur at Sentosa as well.

At Hospital Sentosa the predominance of Chinese patients on both the female and male wards can hardly be ignored, and statistical information from the hospital confirms that Chinese patients form the overall majority of patients. In order to put this into some sort of context however, figures relating to ethnic breakdown were compared with Hospital Bukit Padang in Sabah (a small hospital of 302 beds) and Hospital Bahagia in the State of Perak (an enormous hospital offering approximately 2,600 beds). These were reviewed in relation to the official population census of the States and the results duly compared (Department of Statistics, 1991) (Appendix IV). Based on these variables it could be seen that at Sentosa figures for multiply admitted Chinese patients in 1998 of both sexes stood at 43% of the overall hospital population, and commensurately first-admission

¹ The race riots in 1969 where hundreds of people were slaughtered gave impetus to the government's affirmative action policies towards Malay and indigenous people (*bumiputera*), which are still in existence today despite muted controversy.

patients stood at 34%. These figures however do not reflect a discrepancy in terms of over-representation of Chinese and Malay patients based on the Sarawak population census, but in fact show a remarkable conformity in terms of representational percentage². Yet the fact remains that the hospital population as a whole supports a high concentration of Chinese patients and these are located notably amongst the 'chronic' population.

Given the same variables the figures for the Perak and Sabah hospitals indicate a similar scenario to that of Hospital Sentosa. Here, despite the contrast in population percentages, such that in Perak, the Chinese population is roughly half the number of Malays, whereas in Sabah the opposite situation holds, Chinese still outnumber Malay patients by a high ratio. Furthermore despite a small national and State presence, Indian patients in Perak are also over-represented. The preponderance of long-stay Chinese patients of both sexes in a contemporary Malaysian psychiatric hospital offers some useful insights in relation to similar findings of asylum care and ethnic breakdown in colonial Malaya (Eng-Seong Tan and Wagner, 1971; Jin Inn Teoh, 1971). Although the presence of Chinese patients at the hospital in relation to cultural issues requires a more in-depth and dedicated study in its own right, these findings are indicative in that they resonate strongly with that of

² A point of interest is that at Hospital Sentosa Dayak patients are under-represented based on population percentages. It should additionally be noted that Melanu Dayaks are categorised according to religious rather than ethnic background, as are the Orang Asli of the Peninsula. Specifically, Melanu Dayaks who have converted to Islam are accorded the honorary status of *Malay*, whereas Melanu Christians remain in their original category of Dayak. The significance of this interesting fact carries resonance in terms of camouflaging ethnic representation in government statistics as pertain to government bodies, like Hospital Sentosa, although Melanus are very much a minority ethnic group in any case.

Nazroo (1997) and Rack (1982) in suggesting that migration issues may impact heavily on the mental health of ethnic groups. Whilst in accordance with this, despite acculturation, succeeding generations appear to remain susceptible to the diagnosis of mental illness compounded by the oppression of institutional racism (Barnes and Bowl, 2001; Fernando *et al.*, 1988).

9.2.1 Ethnic stereotyping: the perpetuation of race theories

In answer to my questions regarding the predominance of Chinese patients staff frequently accounted for this through personal interpretation of cultural and racial difference that served to highlight assumptions and indeed prejudices on ethnic grounds. The situation on *Mei Kui* ward provides a useful illustration, in that here the ethnic breakdown was reversed and permanent residents were more likely to be of Iban and Malay origin rather than Chinese or Bidayuh. Explanations for this were again based on the mythology of ethnic difference and related to the ‘impulsive, violent, lacking self-control – no thought for the consequences’ behaviour of Iban patients for example. The Chinese by contrast have a lot of ‘self-control’, but are docile and predisposed to schizophrenia. On one of the chronic wards a Dayak medical assistant had this to say on the subject of Chinese attitudes towards mental illness:

‘They don’t like mental illness in the family, it’s seen as bad luck, so they (patients) are dumped here, but with Malay families even if someone is very very ill they still visit. Chinese people are very superstitious.’

The stereotypic concept of the Chinese family was often portrayed in staff and patient accounts as being highly competitive, exceedingly hardworking, as well as insular, family and clan orientated. In addition they were also depicted as mercenary and potentially ruthless with unproductive members of family, especially if these are stricken with mental illness (Ashencaen Crabtree, 1999b, Chen, 1995: 324). Certain members of staff generally proffered the power of stigma as a reason for the high numbers of patients, especially as this was the one most often put forward by the director of the hospital, himself Chinese.

‘The Chinese believe in a genetic disposition. This tends to damn the whole family, including siblings, who may have a higher difficulty in finding a spouse, *lah*. Another reason is that the patient is not to blame but they may have done something terrible in a past life. And it may not be what they have done but an ancestor. The Chinese believe in cause and effect – karma, bad stock, but (this is) also a question of morality. The Chinese consider them (psychiatric patients) to be a shame and must be hidden, otherwise brothers and sisters affected. Madness is incurable ... education won’t help because they still believe it comes from past wrongs. The only thing we can do is to educate them into distinguishing between milder and more severe illnesses.’

Dr Tiong’s explanation was compatible with that put forward by Rack who points out that where there is no obvious external cause for mental illness it is natural to ascribe a causation to something ‘in the blood’ (Rack, 1982: 173). This also provides a good reason for social rejection of the afflicted and stigmatised and serves to give a plausible account for the high numbers of chronic patients at Sentosa (Yee and Au, 1997: 31), in agreement with Arthur Kleinman:

...stigma associated with categorizing individuals as mad in Chinese culture is more severe than that in the West, since the stigma attaches not just to the family member, but to the family as a whole. (Kleinman, 1988b: 49).

Another Dayak medical assistant also adopted the explanation of stigma but in so doing underlined his own prejudice in associating this with other qualities reputed to be typically Chinese.

‘Stigma! Chinese people don’t want someone ill like this living with them. They don’t want anyone to know, so they send them here. We natives³ show more love for our relatives and keep them with us, but not the Chinese Some do visit the patients here but they are *more* than Chinese – they are Christians and they *must* love others... Most Chinese ... [dismissive hand gesture] they are too busy making money.’

A Dayak nurse on another occasion pointed out a Chinese patient on Female Ward 1 to illustrate a point regarding the propensity of the Chinese to mental illness and to desertion by their families:

‘You see her. You should visit her house [disgusted expression]. They have a big statue in the house, maybe Buddha, and (joss) sticks everywhere, it is eerie, is that how you say it? Probably that is what made her ill, her and her sister - they are both here. The parents seem to want them to stay here, they don’t take them home.’

³ Commonly used colonial expression, which is still used among local people (and the Government) to describe indigenous inhabitants of Borneo.

Here then the issue of religion is used to illustrate the 'otherness' of the Chinese. Wherein the natural avariciousness and ambition seen to be typical of Chinese people by some members of staff, is redeemed through Christian principle, whereas adherence to their own set of values (in this case Buddhism) is both alien, alienating and of dubious morality. Chinese values for these informants are often sharply contrasted with the apparent and much lauded 'tolerance' of Dayak and Malay families, this being a commonly held assumption in the hospital, supported to some extent in other research studies of Chinese, Malay and Indian families (Bentelspacher *et al.*, 1994: 290-1). Although interestingly a similar study conducted by Wintersteen *et al.* did not find any conclusive evidence of this cultural trend (Wintersteen *et al.*, 1997: 201). Nonetheless at Sentosa the belief persists that Chinese families are more neglectful of relatives with mental illnesses than other ethnic groups. This view underscores racist stereotypes, which do little to challenge the accepted view that Chinese patients are often the helpless victims of their own cultural cul-de-sac, thereby avoiding placing the phenomenon in the wider context of social accommodation and assimilation of ethnic diversity (Ashencaen Crabtree, 2001).

As staff accounts confirm, the Chinese as an ethnic group are regarded as being predisposed and susceptible to developing psychiatric problems. By contrast, racist beliefs concerning the overrepresentation of African-Caribbean people in psychiatric care is reversed in this context (Fernando, 1995; Kleinman, 1988b). Chinese susceptibility towards mental illness is frequently seen by Chinese staff as well as by patients as being caused by an excess of mental sophistication as well as frustrated ambition, such as is

exemplified by the person of Jacob in Chapter Five (Chi-Ying Chung *et al.*, 1997; Falbo, *et al.*, 1997). In these accounts the view appears to be that for Chinese migrant communities the struggle to attain material and educational privilege, and the successful outcome of these endeavours in Malaysia, has not acted as a protective factor against mental illness, but indeed in some ways the reverse holds true (Chew, 1999; Ramon, 1996).

The outcome of these gross ethnic stereotypes strongly indicates that a significant degree of racism was commonplace in the hospital setting and was duly noted by patients. Maria, a Chinese patient on the private wards, disliked the Malay nurses who cared for her. She described them as speaking 'harshly' to her and attributed this to racism.

'I don't know why they speak to me like that. Perhaps they think the government belong more to them than to the Chinese. There aren't very many Chinese in power you know. The Dayaks (nurses) are all right but the Chinese nurses are very nice to me, they are motherly and kind.'

Racism at Sentosa therefore served as a means of moral containment of female and male patients through classification based on cultural values, with Chinese patients being seen to be victimised by their own ethnic group. Accordingly therefore they were the objects of a certain level of pity at the hospital, as well as derision. Chinese patients were viewed by staff as being indisputably social outcasts in a way that Malay and Dayak patients rarely were, and therefore in practical as well as social terms, were consequently easily dismissed as utterly forsaken and therefore inconsequential.

9.3 Physical containment of the debased

In discussing issues of control and containment on the wards, probably the most tangible evidence of this can be seen in relation to treatment programmes such as ECT as well as through strategies like the use of locked sections on wards, as discussed in Chapter Seven. The physical restraining of patients is imposed largely according to the socio-economic status of patients of both sexes, while gender norms, as has been seen, dictate the processes and the means of containment (Cogliati *et al.*, 1988: 99). From all accounts the rigid demarcations of patient liberty on the grounds of wealth have been in place at Hospital Sentosa since its inception with congested, confined public wards standing in opposition to low numbers on relatively free private wards. These historical distinctions however were overturned during one particular period of radical change in the 1980s, in effect a small-scale social revolution, where the walls of the asylum were literally brought down, or at least for many.

The change from the locked to open-ward system was the major sweeping reform of Dr Abdul Kadir who, inspired by changes taking place in psychiatric institutions in the West, as for example occurred notably under Basaglia in Italy, consequently sought to create a more liberal environment (Scheper-Hughes and Lovell, 1986). Although the open-ward system came into being only a few years ago, in the hospital it has acquired a rather legendary reputation amongst staff, who recall it as being probably the most profound change in the management of patients in their careers.

‘Now what has changed is the management, when I was here last time (the undefined past) things were different, patients were very difficult: abusive, assaulting staff. The patients were like animals. I remember one crawling on the ground blind and other people hitting themselves - and they didn’t get better. We were afraid of the patients and they were dangerous, unpredictable. But if I were locked up like that I would go mad too.’

In reminiscence Dr Kadir states that, in common with similar policies taking place at Fulbourn Hospital in England, few members of staff were enthusiastic at the changes taking place (Clark, 1996). These changes were seen to bring down many of the tangible and perhaps non-tangible barriers that divided patients from their caretakers and were both feared and deplored, as indicated by this account from a medical assistant.

‘We, the staff were on this side [indicating the small square of the nurses’ station] in a cage here. The patients were over there. Our attitudes? Maybe we were afraid. You go in and all the patients are around you. We didn’t know the patients. We thought they were the same, all aggressive. But it was much like now in some ways but very depressing... The floor was concrete and covered in shit, so we had to clean up every day with people just sleeping on the floor.’

In interview Dr Kadir expressed disappointment that in his opinion the open-ward system at Hospital Sentosa was gradually being dismantled over time and fulminates over the current state of affairs.

‘Can I say that once the ward was opened up there were less incidents of conflict. Now it is becoming closed (again) since (the new director) took over a few years ago. But the staff wasn’t happy then. There was a lot of resistance. But I saw that in terms of violence and benefit to the patients, it was better when it was an open ward. Patients could wander around and mingle with the public. And *female* patients were given open-ward access *as* much as the men.’

Findings in this study however support Dr Kadir's views, as evidently most women patients no longer enjoy this level of freedom in comparison with men on wards. An additional trend was noted however in the latter months of fieldwork, which indicated that male patients in turn were beginning to be subject to confinement in much the same way as women. Whereas previously on Male Ward 1 the grill gate to the hospital corridors was normally left unlocked permitting free access of male patients and visitors on the open ward, more and more frequently I found that the gate was padlocked. When questioned on these changes, medical assistants and particularly junior individuals gave the fear of 'absconding' patients as the primary reason. Thus it would seem that over the course of time the opportunities of male patients to leave the ward was becoming gradually eroded, as the trend swung back towards a more restrictive model of care.

9.3.1 Fear of the oppressed: staff accounts of the locked wards

Staff descriptions of conditions on the ward recalling the days of the locked wards, are illuminating and harrowing. Long-serving nurses and medical assistants whose careers at Hospital Sentosa may stem back over thirty years easily recall the time when patients were herded behind bars eating, sleeping and defecating on a concrete floor. The conditions under which patients lived were appallingly degrading and inhumane, which many members of staff now freely acknowledge. The horrors of working in such a menagerie of the desperate, so similar to historical descriptions of maltreatment, is one that is powerfully recalled by members of staff (Alexander and Selesnick, 1967; Scull, 1979; Shorter, 1997). At Sentosa under similar circumstances patients were unable to satisfy even basic instincts for self-care and were therefore seen as closer to beasts than

people (Foucault, 1965: 74). Conditions for staff were also poor, albeit to a far lesser extent, in which patient faeces, for instance, had to be cleaned up by medical staff without even the benefit of additional cleaning labour or even protective gloves. Aggressive incidents towards other patients were common occurrences as were the occasional attacks on staff with fear of patients running high.

‘We used to be afraid of the patients and they looked at us with a lot of fear. Now it is much better, we are used to working with patients like these... Before the conditions were bad, with patients just lay around on the floor. They had hair lice and skin problems - ringworm very common. Patients were washed with OMO which made their hair stick up like this ...[demonstrates]. Even the diet had been much poorer - it is much better now.’

These descriptions conform to traditional concepts of the insane as basically brutish and in need of kennelling tactics and other associated forms control (Kraepelin, 1962). There was however a practical reason behind mass incarceration of patients and this related to the extreme unattractiveness of the nursing task given these appalling conditions.

‘There was only one medical assistant and an assistant, sometimes not even an assistant. So how can 1 man see to 40 plus patients? Impossible! So they stayed in the locked ward ... they were very aggressive. Now, there are four medical assistants on the ward, so a patient sees that and doesn’t make trouble. If he is aggressive, four of us go in and restrain him. Then, you would be too frightened to go in alone ... the patients are clever they see more staff and they behave better’.

The deplorable state under which patients were kept inevitably created mutual suspicion and fear between staff and patients and can be read as projected fear of the oppressed through the guilt of the oppressor. The dehumanisation and indeed *demonisation* of psychiatric patients under this kind of regime evidently created severe anxieties amongst staff that were compounded by the threat of the removal of the physical barriers which kept these wretched inmates at bay (Clark, 1996).

9.4 Staff perceptions of risk

Today the gradual and immediate improvements in care generated by the switch to an open ward are recognised by staff but this is often conceded somewhat grudgingly. In reluctant agreement with Dr Kadir, however, long-serving staff comment that the more liberal regime of the open-ward did tend to reduce incidents of patient violence. In confirmation, Mary Acton focuses on the comparative rarity of violent attacks by psychiatric patients in the UK, concluding that those most likely to be at risk of such behaviour are normally psychotic with a history of compulsory admissions (Acton, 1990).

A familiar and much publicised concern in the UK surrounds the question of aggression by psychiatric patients, particularly in relation to community care and the apparent lack of professional supervision. An emphasis on violence on the ward is proportionately reduced in the public eye, while in the UK a Department of Health report on psychiatric nursing barely mentions the subject. Equally service-user literature has justifiably concentrated on the violence experienced at the hands of staff rather than the risk of

violence to staff (Bell, 1996; HMSO, 1994; Laing, 1996; Rogers *et al.*, 1993). However just as Elvis on Male Ward 1 expressed a fear of the uncontrollable madman in Chapter Five, the staff at Hospital Sentosa expressed a significant level of anxiety and suspicion of the insane, in which category ironically the timid Elvis through being a patient would also be included. While violence from women patients was not regarded as a particularly onerous hazard, albeit one that certainly did exist, male patients were singled out as offering the worst level of risk for male and female members of staff (Orme, 1994; Radford, 1996; Ussher, 1991). In common with for example social services personnel in the UK, patient abuse at Sentosa was viewed in terms of actual bodily harm and sexual violence rather than inclusive of psychological and verbal abuse, which may be regarded as simply part of every-day life (Hester, 1994: 57).

9.4.1 Empathy and complicity: interviews with staff

As noted in Chapter Four, engaging medical assistants in discussion raised few problems in comparison with nurses. These barriers to better understanding of nurses were eventually and unexpectedly overcome and an almost wholehearted embrace replaced the arm's lengthy approach of nursing sorority towards me. This was a transient but very valuable change in fieldwork relations that culminated, much to my advantage, in some companionable and deeply illuminating discussions on the perceived hazards of the job.

The sequence of events was elucidating in that for the first time on this ward I was invited into the sanctum of the nurses' private coffee room and allowed to partake in their elevenses while talk flowed freely. The conversation was very revealing and at last I felt invited to be part of their inner group and complemented myself on my achievement until later upon reflection I realised the true nature behind my apparent breakthrough. Prior to this, I had felt I reached something of an impasse with the nursing staff on this particular ward. My friendly relationships with many of the women patients there tended to militate against being able to form a good working relationship with the staff, who clearly regarded themselves as polarised from patients and were therefore quite suspicious of my motives. Therefore I felt far from a sense of belonging, so far as my relationship with the nursing staff went, but all this was to change on the morning that I witnessed an assault on a patient. To summarise the incident, a nurse was in the process of arresting a patient's movement by grabbing her arm through the bars of the locked ward, a struggle then ensued, while the nurse shouted for assistance. Another patient approached her with or without hostile intent and, with her hands occupied, the nurse reacted by pushing her away with what I would describe as a kick to the stomach. I did not see the cause of the scuffle, but I did see the outcome and I was aware that the nurse involved and her colleagues saw me watching. Shortly afterwards I found myself invited to coffee where the topic of the discussion was risk of violence to staff by patients, a subject discussed at length with nurses as being one close to their daily concerns.

My later guess was that the nurses having realised that I had seen an incident that could be fairly described as compromising to the nurse involved, reacted by closing ranks, and in so doing attempted to enclose me as an adopted initiate as well. Over coffee and snacks my understanding was sought in relation to the risks of the job and several examples were given to me of attacks perpetrated on vulnerable members of staff. I would say that while my understanding and sympathy was probed, a more valuable commodity at that time may have been my complicity and silence on the incident I had just witnessed.

Having stated this, the insights I developed from this incident and the inclusion I generally experienced on occasions from then on enormously enriched my understanding of what it was like for nurses, and later still for female doctors in the enclosed community of the institution. These accounts differed from those of male staff respondents in which to generalise along somewhat stereotypic grounds, men on the whole tended to be reluctant to voice their innermost fears to me, although assailed me with lurid second-hand stories of violent patients. Their own experiences remained concealed behind a manly air of fortitude combined with a touch of gallows humour. Typically, experienced medical assistants especially those on *Mei Kui ward*, were more likely to exude this type of humour than were junior doctors. Although *Mei Kui*, the forensic ward, was not generally seen as a popular place to work by staff, its reputation offered compensations. For this ward was seen as being a tough place for tough men and this notoriety rubbed off as a form of exaggerated machismo in the staff, who regarded themselves as 'stronger' than other male personnel in being able to contain their feral charges; male madness in

this respect being by far the most threatening in its manifestations than that demonstrated by women.

Is it that men's madness is more dangerous, that is somehow needs to be contained, as a wild lion would need to be put behind bars? Is it that because women are expected to be mad, their diagnosis is not a surprise and offers no threat whereas men's does? (Ussher, 1991: 171-2).

Additionally, Mei Kui was also seen as 'more important than other wards - because the medical report is based on our observations'. In other words the professional observations of the medical assistants could help to make the difference between incarceration in a prison or a hospital or indeed between life and a State-mandated death sentence. Accordingly this kind of professional responsibility generated interest in the inmates and did no harm to the self-esteem and general reputation of their keepers. Staff on *Mei Kui* therefore demonstrated on the whole fewer effects of demoralisation in comparison with staff on other wards. Equally however they showed a reluctance to reveal any perceived weakness of character in the interview situation, with a consequent lack of detailed information on violence towards staff on the forensic ward.

9.4.2 Cunning and deceit: the *essentialised* patient

Doctors, especially junior doctors, working in the out-patient clinic were more likely to emphasise the potential dangers of dealing with psychotic patients than the nursing staff. One drew my attention to the lack of an alarm in the clinic, the awkward and potentially dangerous access arrangements of consulting cubicles, and the generally casual attitude the hospital apparently had towards ensuring staff safety, issues he was clearly unhappy

about following a recent assault on another doctor. Because doctors primarily deal with a large number of psychotic patients who require assessment before admission to the ward, the risk of violence from this group is higher than from patients in the public-ward situation. By contrast however, nursing staff of both sexes were more likely to express the greatest anxiety over non-psychotic psychiatric patients. These differences reflect the roles of medical staff, whereby nursing staff daily deal with a variety of patients, of whom the psychotic patients form a minority normally. Nursing staff were therefore much more preoccupied with issues of daily supervision and the risks associated with that role.

Nursing accounts from both male and female nurses were remarkably similar in describing the assumed essential nature of psychiatric patients. This was often depicted in stereotypic and dualist terms, of being both irrational yet calculating, devoid of commonsense yet devious. Consequently ward staff frequently conveyed the risk involved in taking patients to task over misdemeanours as offering an opportunity for retaliation on unsuspecting staff. It was made clear to me that it was important therefore, for staff not to be lulled into a false sense of security or to place themselves at a disadvantage in terms of maintaining discipline, as this account from a nurse on the acute female ward indicates.

‘If the patients see you understaffed then they try to challenge youYes, they remember when you have to restrain them, but they may not remember the details but they remember who they don’t like.’

Similar accounts from nursing staff on the male and female wards all focused on the treachery of patients, who, when the time seemed opportune might suddenly attack for injuries real or imagined. This was exemplified through the experiences of Sister Weng who was punched in the stomach by a male patient in a fit of rage 'because his wife had left him' and Sister Angela who was hit in the mouth with a cup of water she had handed to a patient.

Patients, I was given to understand, are 'clever', they approach 'behind your back', when staff are alone or with their attention on other tasks. This kind of discourse concentrated on the deceit and treachery of the subordinated and reflected the uneasiness staff felt over the prevailing discrepancies of power. The *status quo* ensures that patients feel regularly helpless: a patient can be surrounded and overpowered by several members of staff and subjected to various indignities and physical trials without recourse to negotiation or effective protest. The portrayal of psychiatric patients as essentially amoral, opportunist, fundamentally dangerous and anti-social justified therefore the measures of control regularly meted out by staff. These perceptions therefore lent themselves to an evident tendency towards the custodial, as noted by (Standing Nursing and Midwifery Advisory Committee (SNMAC), 1999) in the UK. The swings in ward policy towards the conservative and disciplinary, unequally balanced by moves towards more liberal regimes, did little to allay staff fear of patients, resulting in 'crack-downs' and a continuous and vicious circle of the associated dread of the oppressed.

9.4.3 The accounts from women professionals: abuse as a gender issue

It would however be unfair to dismiss staff fears as exaggerated or misplaced given the evident seriousness of some of the attacks, particularly those inflicted on female staff by male patients (Hester, 1994: 153). Personal experiences of violence were offered by female staff respondents among doctors and nurses; for example this account from one of the most experienced and approachable of the long-serving nurses:

‘Last time I was attacked was in 1996, I was directing a patient to the admission room but he looked lost so I said, “never mind, I’ll take you there”. On the way he suddenly hit me violently in the head and I was knocked unconscious, and then he beat me in the belly and in the head with his fists. I heard about all this from the people in OT (occupational therapy ward) who saw my legs kicking around, even around even though I was still unconscious. I was given 2 days sick leave by the doctor and told to go home. I had headaches for a year and a half and I think it all had a bad effect on my memory, it’s not so good anymore.’

The violence perpetrated on women members of staff can be viewed as an occupational hazard of dealing with male psychiatric patients who victimise women professionals in their embodiment of a wider system of control whilst being personally vulnerable to attack (Hester, 1994). Abuse is compounded through institutional responses and collegial attitudes as this account from a still traumatised female doctor indicates.

‘I had a very bad experience in January where I was beaten up, perhaps you heard? He (the patient) was just sitting across from me like this. Usually everything is OK, you get a bit anxious once in a while, but he just went! He grabbed my hair and pounded my head into the glass on my desk. I screamed, luckily and one of the MAs came in and pulled him off me. It was pretty nasty; actually I mean no bones broken but the trauma, the fear. Dr Tiong came down and said “take a few days off”, but I had enough people saying by Monday, this happened on a Wednesday, [imitates sighing impatience] “You fall off a horse

you get back on”, and I’m saying, “I don’t *need* this!” But when I take time off, it’s just a loan, so I came back to work too soon. X (male colleague) has apologised for this, his social skills aren’t so good anyway, but his idea of supporting me is he sat beside me, the day I returned and critiques how I am dealing with patients at that time. I mean talk of interpersonal skills! I am traumatised! Shut down! My interpersonal skills were not the best that day, I mean after that I leave the hospital in tears.’

Findings based on staff accounts indicated that at Sentosa little awareness of staff anxieties was demonstrated at a managerial level. Consequently issues like rapid response and standard alarm systems seemed to be at a rudimentary level of implementation and poorly applied. If male doctors and medical assistants found the current system inadequate, women members of staff were evidently even more at risk of attack, and in addition to the risk of beatings were also subject to sexual violence by male patients.

‘I was going to the toilet, but not the staff toilet but the one for the public because it was nearer. There was a man from the out-patients (clinic), a patient, and I didn’t see him but he came in after me, pushed in after I got into the toilet and knocked me onto the floor, he tore my *baju* (shirt/jacket) well of course I kicked him but he was on top of me. I saw his “thing” ready to enter ...it was horrible! I didn’t tell anyone for three days, I was too afraid he would find out and come back.’

9.4.4 The impact of staff accounts on fieldwork relationship with respondents

The detection and increasing awareness of a sense of pervading vulnerability in staff began to erode my own trust of patient participants to some degree. Previously in undertaking my fieldwork I experienced many different emotions but none of these could be described as fear, as such. A sense of my own personal safety had been formed through a naïve belief that I was obviously a well-meaning individual, whilst relying

heavily on my outsider status as being removed from the 'vectors of power' played out in the hospital system (Narayan, 1997; Pettman, 1992).

Following interviews with staff on occupational risk at Sentosa I found that I began to feel vulnerable in the presence of some patients, not all men by any means, and in parts of the hospital where previously I had felt perfectly safe although not necessarily always comfortable. The caution that nurses now began to urge on me in my interactions with patients altered my perception of inviolability and went some way to creating distance between patient participants and myself. The somewhat disconcerting habit, for instance, of seemingly harmless, grandmotherly Luwee in her tendency to approach me from behind and catch in an enveloping embrace now began to assume more sinister overtones. On another occasion I was quite shaken to find a patient standing directly behind me during an interview when a nurse began suddenly to indicate this by warning gestures. To my shame, I discovered it was none other than Soo Mei from Female Ward 1 who wanted to bid me an emotional, final farewell as she was about to be discharged and realised she would not be seeing me again. A similar and equally innocuous incident took place with a male patient on *Mei Kui* ward that despite its reputation seemed to me at least, to be an unthreatening and indeed almost welcoming ward, due to its busy and friendly air, generated in no small part by the patients themselves.

9.4.5 The repercussion of distrust on staff relationships with patients

The watchful nervousness that I began to develop at one point, almost entirely through being influenced by staff accounts of violence, was illuminating. The anxiety that staff conveyed prevented them forming friendly and trusting relationships with patients, while instead the theme of the duplicity and veiled hostility of patients ran as a common warning amongst them and was duly imparted to new members of staff (Higgins *et al*, 1999: 101-2). The official response to violence towards staff in its inadequate and indeed almost callous indifference permitted staff anxieties to grow and fester. This in turn led to hardening of attitudes in staff, towards their own vulnerabilities and those of colleagues with resulting repercussions on their emotional resilience towards managing patients and the job in general. Women professionals at Sentosa were seen to be particularly vulnerable to the institutionalised response to abuse, as summed up a weary although angry response from this woman doctor.

‘Being a woman here? It has its plus and has its minuses. It has its pluses because the male staff (MAs) look out for me. Dr Jerry said, “You’ve got to take charge!” But he’s a man, I mean I’m sorry but its fine for a 6ft something guy, I mean I didn’t bother to tell him that, but if you can’t see that there’s a difference because I am a woman and smaller. I mean sometimes the patients go for me, and the MAs say “Dr P go away!” It has its pluses as I say, but it has its minuses, they (MAs) may not take me as seriously as male colleagues. So being a woman, protects me – it makes me less effective, but it protects me.’

Female doctors at Sentosa attempted to claim a rightful position of authority that was nonetheless seen to be an anomaly on the grounds of gender, the majority of women occupying a significantly lower position in the medical hierarchy. Consequently while being expected to demonstrate the behaviour and standards of control over staff and patients that senior male colleagues demanded, they were awarded less professional credibility *as* women. A consequence of this was that medical assistants might react protectively towards women doctors at a personal level, while hospital policies and systems did not appear to offer particularly effective protection towards female and male members of staff alike. Instead a hard-boiled collegial attitude of ‘if you can’t stand the heat get out of the kitchen’ was imposed by senior, male doctors on junior doctors of both sexes and findings indicated that this impacted heavily on the morale of these members of staff.

Although anxiety and trauma appeared to be better handled by women nurses in the exclusively female company of other nurses, nonetheless the masculinised values prevalent in the hospital hierarchy prevented these from being validated in the wider context of work. Feelings of vulnerability therefore seemed to remain unendorsed and poorly supported with resulting symptoms of ‘burn-out’ evident in many members of staff, and conveyed in interviews, particularly amongst women and male junior doctors (Higgins *et al.*, 1999: 76-7). Open disillusion with the work varied amongst staff, and this appeared to be rife amongst junior doctors of both sexes whose notions regarding the care and treatment of people with mental illnesses had undergone the greatest change in expectation since beginning work at Sentosa. Nurses and medical assistants did not voice

this level of disillusion but conveyed that their more pessimistic views had been borne out by their experiences and that consequently less of a professional and attitudinal adjustment had been made towards their charges over time. A uniting factor amongst doctors and nursing staff was a notably cynical and weary attitude towards the remedial care of recalcitrant psychiatric patients. For the majority of staff the perception was that little could be offered but accommodation and containment, with an associated emphasis on the need for staff to cover their backs and retain control at all times.

CHAPTER TEN

CONCLUSIONS AND IMPLICATIONS

10.1 Introduction

In this, the final chapter of the thesis, the dominant themes of the study are brought together in a concluding discussion, where the aims of the study and methodological considerations are considered in relation to the chosen methodology. Accordingly the challenges encountered in the undertaking of a feminist methodology are subject to further reflection with regard to its perceived utility as well as limitations and dilemmas. Following from this an overall summary of findings is offered, supported by literature, as discussed in preceding chapters. Implications for policy and practice from a feminist perspective are subsequently considered in relation to specific findings from the study, concluding the chapter with suggestions for areas of further research.

10.2 A review of the methodology

The broad aim of this study has been to offer a feminist account of Hospital Sentosa in relation to the gendered terrain of the culture of the hospital as it impacts upon the lives of women psychiatric patients. While the perspectives of women patients are privileged in this study commensurate with the commitment to focus on gender as a primary category of analysis, this was not seen as precluding the perspectives of male participants (Harding, 1986; Pettman, 1992; Scott, 1986, Stanley and Wise, 1993). The incorporation of the accounts of male patients was commensurately found to provide a crucial basis for comparisons to be drawn that were subject to gender analysis. In addition the views of

staff of both sexes were also sought as offering a useful account of attitudes towards patient care and the conditions of work; these served to support the development of further insights into the culture of the hospital.

As noted in Chapter Three, this study has allied itself to a large extent with a standpoint feminist view that has remained permeable to some postmodernist considerations. To summarise this position therefore, partisan stances, as manifested through a feminist perspective, do not negate the goal of producing valid knowledge of the condition of oppression (Ramazanoglu and Holland, 2002). It is not however asserted that this forms an 'objective' and 'detached' truth of the world of respondents as a variation of positivism and that therefore all that can be offered is an attempt to offer some *truths* rather than *the* factual truth of the condition of women respondents (Hammersley, 2000; Maynard and Purvis, 1994).

My intention accordingly has been to adhere to three main conditions as outlined by Webb (2000), in that firstly I have sought to overturn a traditional distancing of the researcher from the subject of research in favour of more egalitarian and reciprocal relations with participants. This, I believe, did occur on many occasions in the research process, particularly in relation to women patients and at a later point with female nursing staff, resulting in much enriched data. Secondly, Webb (2000) states that feminist standpoint research should be undertaken by women, for the benefit of women and in accordance with the precept of Stanley and Wise (1993) through the filter of a feminist subjective consciousness. Consequently I have attempted to adhere to these prescriptions

and thirdly, in so doing, have conformed to the last condition, which relates to the adoption of a self-reflexive stance, in keeping with feminist ethnographic aims (Abu-Lughod, 1990; Hammersley and Atkinson, 1983; Harding, 1986; Hirsch and Olson, 1995; Moore, 1992; Ramazanoglu and Holland, 2001).

In this study therefore self-reflexivity has been employed as a critical tool indicating the means by which findings have been reached as a form of research accountability, as well as providing a vital means of achieving greater rigour of analysis (Burman, 1999). The simultaneous exercise of ethnographic data gathering in relation to a self-reflexive exercise has shaped an account which is informed by my assumptions and beliefs and underpinned by a political, ethnic and cultural positioning (Alcott, 1991; Auger, 1995; Berg, 1989; Denzin and Lincoln, 1995; Goodall, 2000; Hammersley, 1990b; Lyons, 1999; Mauthner and Doucet, 1998; Tindall, 1999).

The standpoint position has been critiqued by feminists in relation to postmodernist considerations as frequently failing to account for differences between women and instead assuming an equally oppressed condition of 'sisterhood' prevailing among women of different backgrounds (Oakley, 1984; Mies, 1994; Patai, 1991; Pettman, 1992). In this study therefore I have additionally sought to analyse the issue of power differentials in relation to the obvious arena of comparisons between the sexes, such as can be found in the differences between female and male patients, and between those of the nursing staff, as discussed in Chapter Nine. Of equal relevance however, has been the deliberate move away from generalised and *essentialising* notions of equal oppression

amongst women (Felski, 1989; Ornter, 1995). This has resulted in insights into the oppression experienced by women patients by female nursing staff, and indeed within their own ranks, where female patients can be seen to oppress their peers, which will be discussed further.

Finally, at this late stage in concluding the study, some paradoxes and dilemmas that were referred to in Chapter Three remain to some extent unresolved and open to further reflection. These issues lie primarily, in the consideration of research accountability, which in reference to Judith Stacey (1991) revisits the issue of feminist research as inherently exploitative of female participants through the presumptions of rapport. Such connections with women, and many of them very vulnerable individuals, were experienced during the course of fieldwork. I have consequently experienced a sense of apprehension as well that of heavy responsibility relating to the betrayal of confidences obtained through rapport and subsequently utilised and atomised in the process of writing and eventually dissemination (Mauthner and Doucet, 1998).

While participants were aware of the purposes of fieldwork, questions remain how far they were aware that whispered confidences, gestures of disgust, 'slips' of the tongue, and the like were equally grist to the ethnographic mill and duly recorded, to be re-presented eventually in text. In consequence I have found a continuing dilemma with regard to how far I can justify research that is totally reliant on the goodwill of others with the ensuing plundering of personal lives. This has been of especial concern where I felt that information gathered and potentially seen as compromising or contentious might lead to

repercussions for respondents, who in turn may have been unaware of running any form of risk, personal or professional.

A further source of anxiety has lain in the severing of fieldwork relationships that developed into quite intense bonds of friendship among, admittedly, only a few participants and those particularly with women patients. Departure from the field on a permanent basis was in the event an abrupt ending, although I had planned and attempted to phase it out over weeks. I am aware that my sudden absence from the site could nonetheless have be regarded as a further betrayal of participants. In the end I did not manage to bid a personal farewell to all of my closest contacts, many of whom remained behind at the hospital with few hopes that they too would one day leave permanently. I recognise with sadness that they may have been given the choice to speak of their lives at the hospital, but not to leave, as I had always been free to do.

Although these issues continue to resurrect themselves as uncomfortable and personally problematic, the politics of feminist research towards a goal of transformation has provided a balance that in the end has shifted towards a justification of the study. In agreement with Kelly *et al.* (1988) I acknowledge that any form of measurable emancipation for patient participants under the circumstances is unlikely in the near future and is accordingly a somewhat grandiose and unrealistic ambition.

Consequently I fully accept that the lives of participants are very unlikely to be subject to any significant level of change in the short term or possibly at all, but rather that long-term changes in the hospital system may be assisted by the dissemination of the findings of this study. Any changes therefore are likely to represent small gains at local policy level only, rather than in the broader arena of national service delivery. In this study however it is argued that the position of women psychiatric patients is disenfranchised at many levels and to a significant degree of severity. The impact of institutional life on women labelled as mentally ill is a subject of deep obscurity and consequently any light that can be cast on this area as may be considered a progressive and therefore important step forward however modest.

10.3 A summary of findings

This section covers a number of themes relating to the broad, general outline of psychiatric care in Malaysia and distilled to the details of the lives of patients at Hospital Sentosa. Accordingly findings refer initially to the backdrop of colonial influences upon psychiatric models as I understand them to be practised at the hospital. These in turn relate in the following sections to the generic condition of male and female patients that are subject to gender analysis illustrated by comparisons of gender disparities. Finally, a summary of findings related to staff perspectives and attitudes is offered from the viewpoint of staff towards work conditions and their roles, as well as that of patient care and attitudinal stances towards their charges.

10.3.1 Hospital Sentosa and the inheritance of psychiatry and colonialism

As discussed in Chapter Two, philosophies of psychiatric care in Malaysia can be viewed as having been both literally and metaphorically transported there from Britain (Bhugra, 2001; McCulloch, 2001; Littlewood, 2001). It is argued that these continue to cast an influence on attitudes, practices and policies that at Hospital Sentosa are re-enacted on the wards. While community-based psychiatry as discussed in Chapter Eight, Section 8.2.1 offers one model of Western ideology attractive to the higher echelon, at the level of the individual wards staff accounts indicate that such paradigms are effectively an irrelevance. It is furthermore argued in the thesis that the polarities of visions of care can be viewed as swinging from the liberal to the custodial but that each are correspondingly premised upon colonial paradigms rather than indigenised psychiatric models. These models are translated into views and actions that act correspondingly as incongruent claims, anachronistic and mutually incompatible with patients at the receiving end of seemingly inconsistent policies and capricious but damaging practices.

Hospital Sentosa in its spatial geography and social as well as sexually segregated areas, can be viewed as being based upon notions of the self-contained asylum of the eighteenth and nineteenth centuries that sought to impose social and gender normative values in terms of physical geography and isolation from society (Goffman, 1968, Goffman, 1991; Prior, 1993; Ramon, 1988; Saris, 1996: 543; Turner, 1992). Consequently, as noted in Chapters Five, Section 5.2 and Chapter Seven, Section 7.4, men and women occupy separate facilities at Hospital Sentosa and enjoy no social interaction that is not heavily subject to custodial measures by staff, in keeping with traditional asylum practices in

Europe (Clark, 1996; Foucault, 1976a; Gittins, 1998). Furthermore, class differentials are demarcated through the differences in conditions, diet and freedom of patient access between the congested 3rd class 'public' wards and the more liberal, infinitely more pleasant, sparsely populated 'private', fee-paying 1st and 2nd class wards (Chapter Five, Section 5.2). The differences therefore between the conditions of men and women patients on the wards, as will be discussed, are characterised by both gender and class distinctions.

10.3.2 Admissions and discharges

As noted in Chapter Five, Section 5.4, the admission of individuals to Hospital Sentosa was apparently a relatively unproblematic procedure for the Authorities and families alike, in which patient rights were not safeguarded by specific mechanisms. Compulsory certification was carried out under time-worn, colonial legislation that did not offer a comprehensive definition of mental disorder (Ashencaen Crabtree and Chong, 2001). Consequently the hospital in common with asylum care in nineteenth-century England accommodated a heterogeneous population of patients of diverse disability whose problems could be seen as life problems and forms of social transgression and social rejection (Shorter, 1997).

Social transgressions on the grounds of gender normative behaviour can be seen to play a crucial part in the labelling of individuals as mentally ill. In accordance with traditional preoccupations in the West with the issue of women's sexuality and moral conformity, women admitted to the Hospital Sentosa were frequently defined as deviant on the

grounds of moral degeneracy, with all the stigma and loss of credibility associated with that state (Barnes and Bowl, 2001; Cogliati *et al.*, 1988; Goffman, 1993; Gomm, 1996; Fernando, 1995; Rosenham, 1993; Scheff, 1996; Szasz, 1974; Ussher, 1991). As respondent accounts testified, this was seen to carry a devastating impact on women who were mothers of children, who were therefore liable to forcible separation as a result of their status as moral polluters. Men on the other hand, although also burdened with the stigmatised role of social deviant, were viewed in terms of criminal or social recidivism and general incompetence. Although this resulted in social rejection that held some similarities to that experienced by women, the denigration to personal self-esteem and extended damage to family relationships appeared to be not quite so utterly injurious and discrediting under the circumstances.

Furthermore the discharge of patients was seen to be an area of competing inequity to that of admissions. As indicated in Chapter Five, Section 5.4, due to the lack of a review system or appeal tribunal procedure, patients of both sexes could find themselves languishing on the wards for indefinite periods of time (Butler and Pritchard, 1983; Hudson, 1982; Pringle and Thompson, 1986). The co-operation of relatives was required for discharge procedures to be effected and this could result in long delays for patients who were seen to be dependent on their families for continued support, particularly so in the case of women.

These gendered differences however were seen as negated to some extent by the very large numbers of 'chronic' patients that formed the main body of the patient population at the hospital and contributed to its significant overcrowding problem (Estroff, 1985; Gomm, 1996, Kleinman, 1988a). The definitions of 'chronicity' as opposed to that of 'acute' states at Hospital Sentosa were regarded to be less associated with medical prognosis than acting as social indicators and tokens of professional expectation. As noted in Chapter Five, Section 5.3, 'chronic' status denoted an individual for whom there was no real hope of discharge due to family rejection and lack of alternative community resources, thus necessitating permanent admission.

Finally, the issue of admission raised interesting questions regarding both gender and ethnicity, in which it was noted in Chapter Two that historically, due to the shortage of women per capita in colonial nineteenth-century Malaya, admission rates of women to psychiatric asylums were favourably low. Yet the position of migrant Chinese and Indian groups indicated a very high relative presence in colonial asylums of the time. As indicated in Chapter Five, Section 5.4, findings suggest that it is likely that women were not necessarily subject to a higher level of admission to the hospital than male counterparts, despite perceived differences in rationale relating to admission (Busfield, 1996; Chesler, 1996; Miles, 1988; Russell, 1995; Wetzel, 2000). Although once admitted, women did appear to represent an equal number to men in terms of the long-stay and predominantly Chinese population of chronic patients, which formed the largest classification of patients at Hospital Sentosa.

Accordingly in comparison with the situation in colonial Malaya, hospital statistics indicate a predominance of Chinese patients in contrast to the proportional representation of other ethnic groups in the multi-ethnic State of Sarawak. The reasons for this over-representation remain far from clear but, as Chapter Nine, Section 9.2.1 indicates, this appears to stand in association with the perception of extended stigma in the wider family. This situation in turn shows parallels with contemporary Western critiques regarding issues of migration, trauma and subsequent institutional racism in the newly adopted country, which are seen to impact on the successive generations through diagnoses of mental illness (Barnes and Bowl, 2001; Fernando *et al.*, 1988; Nazroo, 1997; Rack, 1982).

10.3.3 Socialisation strategies for patients on the ward

One of the most striking features of the public wards was the bare, depersonalised although congested environments that these represented. On both the female and male acute wards, as well as on the chronic wards, staff conveyed a preoccupation with maintaining a 'tidy' ward created through discouragement of token attempts by patients to define their space through ornamentation or practical storage of possessions, as noted in Chapter Eight, Section 8.3.2. On the contrary, on the female acute wards for example, patient respondents stated that they could not even claim possession to their beds, which could be occupied and even befouled by other patients (Chapter Five, Section 5.5). This served to perpetuate the message that admission to hospital both symbolically and pragmatically meant the absolute dispossession of individuals in their enforced relegation to the status of 'patient'. Dispossession and to use Goffman's useful term, 'mortification'

(1991) of patients were further underlined through such features as poor food served with little ceremony and few niceties. Or the donning of androgynous, ill-fitting and drab hospital uniform, shrewdly perceived by patients as creating visible tokens of stigma and social segregation, and in the case of women serving also to accentuate an enforced identity of sexlessness (Showalter, 1981).

The lack of choice in terms of recreational facilities combined with depersonalised areas made wards, as respondents noted, a boring, depressing and monotonous place, where food and sleep measured the tedious tempo of life. In turn the hospital was viewed by some professional respondents as conforming with that of a traditional asylum model in the warehousing of an undifferentiated, neglected mass of socially forgotten inmates (Barham, 1992, Deva, 1992; Sutton, 1997). Male patients received some respite from the ward environment in being able to partake of outdoor recreational activities, such as football. Women patients however led an almost totally confined life indoors and were expected to occupy themselves on the wards through such inactive, gender stereotypic activities, typified by the make-up sessions and leafing through women's magazines that formed a curious contrast to their enforced androgynous identities (Chapter Seven, Section 7.4.2).

Findings indicative of lesbian alliances amongst patients on the ward reflected a strategy of subversion against the sexual segregation of women from men and the de-sexualisation of women patients. Staff attitudes to lesbian activities were notably negative and prejudicial, and consequently represented an area of some tension, in which cosmetics

could be seen as aids in support of a heterocentric identity that did not however logically include the consummation of heterosexual alliances with men.

10.3.4 Peer relationships on the ward

Findings indicated that the social world of patients on the ward could be dissected into three main types of relationship applicable to both sexes in which power struggles were enacted and alliances cemented. The first of these relationship types was defined as 'reciprocal' in which female and male patients compensated for loss of friendship ties in the community of origin through the development of companionship on the ward. Cordiality and mutual benefit were the two main advantages of reciprocal relationships, in which trade amongst patients eased social interactions, and could bring the benefit of a rise to power of the 'trader' who became a figure of some influence and authority.

Considering this rise to power led to deeper analysis and a further identification of a social role: that of the patient *prominent* (Chapter Six, 6.3 and 6.3.1). The ward *prominent* was a recognisable feature of most wards studied and could in turn be embodied by a malign or fairly innocuous individual regardless of sex. These were correspondingly similar however in holding a higher status than the general mass of patients and they had shown no mean degree of cunning and tenacity in obtaining and maintaining their privileges (Felski, 1989; Ortner, 1995; Pettman, 1992). The role of the ward *prominent* was largely supervisory but occasionally appeared to be more menial in nature, yet their tasks were seen to pay valuable dividends in terms of overall responsibility, power and corresponding personal comfort and satisfaction.

Finally, familial types of relationship were considered in which these were seen to have a particular cultural resonance as a legitimate social means of developing connections with other unrelated individuals for mutual benefit (Karim, 1995). A phenomenon peculiar to the female wards was the tendency towards adopting familial relationships that are prevalent in Malaysian society; these types of relationship in the ward situation were openly exploited by staff who used them to develop a practical tie between patients. These notably were initially pragmatic alliances premised upon labour, in which the more able-bodied amongst patients were expected to care for those with fewer abilities. These relationships therefore could be dubbed as 'pseudo-family' ties of, for example, adopted 'mother' and 'daughter' obligations that could become intimate bonds, which helped significantly to materially supplement nursing labour.

10.3.5 Patient labour and gender

While the tedium and depersonalisation of wards was an issue that applied to both female and male patients, so too was the expectation that the labour of patients could be rightfully exploited with a view to increasing the strained hospital revenues. Exploitation of the labour of patients has traditionally been used to support the self-contained, enclosed world of the asylum (Barham, 1992; Black, 1988; Gittins, 1998; Prior, 1993). Findings noted in Chapter Six, Sections 6.4 and 6.4.1 respectively, indicated that this was an area that was heavily subject to gender stereotypes in relation to appropriate work for the sexes. The imposition, for example, of futile *ceremonialised* tasks, such as precision army-style bed-making as described in Chapter Eight, Section 8.3.2 was regarded as an

important skill for male patients to grasp on one ward, indicative of a staff attitude towards the regimentation and discipline of patients (Goffman, 1991).

A more responsible task directed particularly towards female patients was that of the care of other less able patients through familial ties, as discussed in the previous section. This phenomenon was noted to occur commonly on the female chronic wards, which were most likely to be associated with infirmity and disability. Accordingly, as indicated in Chapter Six, Section 6.4, caring tasks were viewed as being particularly appropriate for women in their reinforcement of notions of gender-appropriate labour (Gittins, 1998; Showalter, 1981).

These types of labour were unpaid in terms of tangible remuneration but the issue of paid patient labour could if possible be regarded as even more subject to gender disparities than that of unpaid labour. Male patients considered able to work were allocated occupational therapy work in reasonably skilled areas such as carpentry, basketry and livestock farming on a sliding scale of pay. As described in Chapter Six, Section 6.4.1 however, women patients by contrast were given the least skilled and most monotonous of tasks, subject to gender norms. These in turn commanded the lowest of the exploitative wages allocated to patients under the current system and, as noted by Wetzel (2000), therefore served to replicate to an acute degree the social and economic inequities of the patriarchal and capitalist system in the wider social arena.

10.3.6 Control and containment on the wards

The issue of containment of male and female patients at Sentosa cuts across several different areas and themes, not all sexist, although all were seen to be forms of oppression imposed on patients. Medical treatment and in particular ECT were seen by staff to be a useful method for controlling unruly individuals on overcrowded wards (Chapter Seven, Section 7.3). In consequence it was routinely applied to both sexes without a particular bias being noted towards female inmates in contrast with Ussher's observation regarding women in the UK (Ussher, 1991). That this was a feared form of treatment for all patients interviewed on the subject was revealed through respondent accounts and is discussed further in Section 10.4 in relation to practice implications.

Treatment programmes notwithstanding, the containment of patients could also be viewed in terms of attitudinal stances by members of staff. These were demonstrated through a number of perceptions suggesting the recalcitrant and unsalvageable nature of psychiatric patients, and could be seen to be particularly interesting in relation to ethnic issues. As discussed in Chapter Nine, Section 9.2.1 therefore racist views were offered by staff in reference to the predominance of Chinese patients, and theorised on with regard to imputed Chinese characteristics and values.

Physical containment was another noteworthy aspect of hospital life, where men and women patients could experience a very different set of practices governing freedom of movement and general access. While each ward held a 'locked section' used for psychotic and challenging patients of various descriptions, for women the locked

philosophy extended to the entire ward, which was sealed against free access onto hospital wards. In discussion of this phenomenon in Chapter Seven, Section 7.4 this was seen to impact on women at a variety of levels including that of health through the prevention of access to better nutrition at hospital food-outlets as well as with regard to smoking habits (Chapter Five, Section 5.5.2). Men by contrast, once out of the locked section, were at greater liberty to go out of the ward and from there surreptitiously out of the hospital grounds altogether (Chapter Six, Section 6.2.3). The imposed passivity of women patients was accordingly subject to feminist analysis that employed binary oppositions in noting the subsuming of concepts of femininity, sexuality and fertility in relation to class distinctions that served to impose the heaviest set of restrictions on premenopausal women occupying a low socio-economic stratum (Chapter Seven, Section 7.4).

Finally, as previously discussed, at Sentosa the whole concept of freedom of access is viewed as being uneasily positioned in competing ideological moves towards liberalism and conservatism. These polarised positions are typified by the open-ward system, in opposition to the custodial and indeed punitive atmosphere of the locked-ward system that continues to occupy staff memories and mentalities (Chapter Nine, Section 9.3). The swing towards physical constraints and containment is demonstrated at the hospital through an increasing move towards the closure of the open-ward system for men, that has long since been abandoned in the case of women (Higgins *et al.*, 1999; Standing Nursing and Midwifery Advisory Committee (SNMAC), 1999).

10.3.7 Staff attitudes towards work

Staff respondents among the general nursing staff tended to confirm my impressions, as well as those accounts given by patient participants, in articulating that their duties occupied narrow parameters, characterised by 'supervision' of patients and regimentation of *ceremonialised* tasks (Chapter Eight, Sections 8.3.3). Most of the nursing staff had not undergone any formal training in psychiatric nursing and the different roles occupied by female nurses and male medical assistants under the generic term 'nursing staff' could be seen to dictate attitudes towards work at Sentosa. Medical assistants interpreted their duties at Sentosa as being in general preferable to the more arduous duties of running general clinics in rural areas of Sarawak. That medical assistants in this latter role were given the responsibility of diagnosing and prescribing medication was not seen as particularly more attractive than the lesser tasks of following the orders of doctors at Sentosa, given the advantages of an apparently undemanding atmosphere on the wards.

Nurses by contrast found the hospital a deskilling environment to which there little professional kudos was attached. Nurses were therefore more likely to express discontentment and frustration with their perceived role at the hospital, and the sick ward was regarded as a better environment than the general wards due to the chance of practising *real* nursing skills. A point of similarity between doctors and nursing staff was that a large number of the nursing staff were temporary transfers to the hospital, supplementing a dwindling cohort of long-serving staff now reaching retirement age. This new generation of nursing staff were for the most part uncommitted to psychiatric work and, in the case of nurses in particular, were anxious to return to general practice.

Due to the shortage of female doctors at the hospital it was not possible to offer an analysis of career expectations in comparison with those of male doctors of similar rank, their views being undistinguished by obvious gender disparities. Junior doctors of both sexes appeared to be suffering from the impact of disillusion and professional frustration. Views given in doctors' narratives indicated a general sense of despondency with their transfer to the hospital and, with few exceptions, little enthusiasm for psychiatric medicine on the whole and especially in the public sector. These doctors conveyed discomfort with the culture of the hospital as representing a place of professional marginalisation as well as being one where little hope was offered of patient recovery.

Professional marginalisation could be seen to impact upon doctors, and other members of staff, who regarded themselves as being personally subject to stigma through association with work in psychiatry. An additional theme related to this, revolved around the professional risks of working in an environment characterised by the 'institutionalised', in which nursing staff were implicated as conforming to a stereotypic image of lax standards and professional indifference. This was seen by doctors to reflect upon the welfare of patients who were regarded as neglected and 'abandoned' by practitioners and society alike.

10.3.8 Staff perceptions of risk

Finally, a developing rapport with nurses as discussed in Chapter Nine, Section 9.4.1 enabled me to develop a deeper understanding governing low staff morale in which the issue of emotional 'burn-out' was evidenced in the form of fear of patient violence (Section 9.4.3). Traumatized women nurses and doctors gave accounts of physical assault and even attempted rape with an added critique on how colleagues and management had reacted to these events. Men by contrast were reluctant to offer specific accounts of attack and any associated trauma, although they confirmed the views of nursing staff that patients could be dangerous. Accounts of the viciousness of patients had in turn become mythologised by staff into *essentialised* accounts of patients as treacherous and opportunistic and as such these views played an important role in staff tendencies towards custodial and punitive practices, such as the restraint of women patients (Chapter Seven, Section 7.4.1). Punitive measures typified by past recollections by staff of the 'locked ward' system appeared to create a reaction of dread of the oppressed patient that fed back into a vicious loop of oppressive practices played out over time.

10.4 Implications for policy and practice: a feminist interpretation

The findings of this study indicate that many examples of staff practices on wards at Hospital Sentosa could reasonably be regarded as oppressive, but are considered a normal part of the hospital culture and therefore enacted to some degree or other on every ward scrutinised during the course of fieldwork. As has been argued such practices impact the most heavily on women, yet patients *per se* are subject to a variety of restrictions, repressions and inequities that demand reform.

An agenda of maintaining class distinctions in the form of allocated space is associated with the significant overcrowding of the public wards. This in turn gives rise to squalid conditions with the perceived unrest and disorder amongst patients quelled through the use of locked sections, restraints and the misuse of ECT, which is at best regarded as a regrettable but necessary fact of life. The congestion of these wards in turn is correlated with a totally depersonalised environment of communal facilities at the most intimate and basic levels, which, as has been seen, patients regard as degrading and even disgusting. The imposition of these conditions, in relation to a generalised demand that patients ought to adopt a dubious hospital uniform and conform to a series of petty restrictions and bizarre modes of conduct, all serve to emphasise an inexorable process of socialisation into the ignominious role of *patient-hood*.

Complaint and rebellion against this process is duly regarded as staff as an indication of pathology rather than a legitimate protest at the disenfranchisement of the individual, which in turn serves to justify even more punitive and disempowering measures (Baron, 1987; Goffman, 1991). Practices such as these speak audibly of an ideology that is far removed from contemporary Western notions of service user and stakeholder rights in relation to the regulation of so-called measures of care and control in the hospital system (Campbell, 1996; Rostom and Lee, 1996). At the same time however, from the point of view of patient care, moves by the management of Hospital Sentosa towards a community-based psychiatric programme jar with the current situation of a strictly professional, hierarchical and undemocratic power base. This will remain an anomalous

situation unless it is to be eventually understood that these moves stake a claim to form be a new and indigenised psychiatric system for the community that shares no common assumptions and ideologies to the similar moves taking place in industrialised nations elsewhere.

In terms of admission and discharge the current legislation does not safeguard the rights of patients, and is generally recognised as being quite outdated and in need of rapid revision (Ashencaen Crabtree and Chong, 2001). Furthermore, as has been seen, this legislation enables patients with a variety of disabilities to be placed at the hospital where their special and individual needs cannot be catered for. This is simply a further consequence of a lack of adequate resources in the community that cannot cater sufficiently for even former in-patients with a genuine psychiatric history. Long-stay patients, as indicated in Chapter Eight, are destined for a permanent residency at the hospital that is immaterial to the realisation of plans for community-based psychiatry for 'acute' patients in Kuching.

To reiterate, findings indicated that the conditions for women patients in general at Sentosa were particularly poor, following the assumptions by staff that a cloistered and restricted life governed by gender normative stereotypes was an acceptable regime. The inability of most women to enjoy free access from their wards on the spurious grounds of moral interests was a disturbing feature of patriarchal oppression in which women members of staff were clearly implicated (Felski, 1989; Ortner, 1995). The use of women's labour on the wards in the care of other patients was compounded as an exercise

in exploitation, through the expectation and indeed insistence by staff, that women apply themselves at the least skilled and least rewarded manual labour under the guise of therapeutic work (Gittins, 1998; Wetzel, 2000). If occupational therapy is to have any credibility whatsoever at Sentosa this must be reflected, as one respondent pointed out, in the individual tailoring of skills to work, irrespective of traditional Western and stereotypic models of gender-appropriate employment (Gittins, 1998; Karim, 1995; Showalter, 1981).

While accounts from patient participants were very illuminating, staff respondents equally provided some interesting and indeed often disturbing accounts of staff responses to a generally inhospitable working environment with ensuing professional dissatisfaction. In clarification: although an open-ward system is nominally in place at Hospital Sentosa, each ward operates largely autonomously and policies are implemented by staff into daily practices that may differ, sometimes widely, across the hospital. Unresolved staff anxieties revolving around the stereotypes of the unpredictable and ferocious nature of psychiatric patients for example, or in the case of women, their moral laxity, strongly influence how liberal practices are in any given ward regardless of stated policy. These staff attitudes are in turn duly imparted to new members of staff who are usually inexperienced in psychiatric care and are therefore not likely to question the received wisdom and practices of older, more established colleagues.

Policy statements therefore are not likely to be strictly followed, but appear to be viewed by staff as operating in a permissive environment of staff interpretation in which practice

often runs independently of policy rather than influencing the latter as a praxis paradigm. These attitudes therefore translate into prejudice towards psychiatric patients in general as well as fostering racist views and the disfavours of certain patients on ethnic grounds, leading to a tendency towards custodial and coercive measures (Standing Nursing and Midwifery Advisory Committee (SNMAC), 1999).

Such a situation results in and is exacerbated by the shortfall of personnel at the hospital and was seen to be indicative of the stigma associated with working at a psychiatric hospital. This in turn led to the use of non-voluntary and often temporary transfers of staff, many of whom are inexperienced in psychiatric care and often reluctant to be posted to a psychiatric institutional setting in the first place. Furthermore the lack of specific training could be seen to be a key factor in the attitudes of nursing staff, both temporary and permanent, in the comprehension of how patients should be cared for, supervision and regimentation being seen as a paramount professional duty given the vacuum of more progressive and appropriate forms of care.

The outcome of such attitudes and practices resulted inexorably in high levels of demoralisation amongst staff and apathy that led to a high turn-over of staff, affected the quality of their work, influenced the implementation of policies at the hospital, and gave rise to prejudice towards and fear of their charges. Such an environment of anxiety and defensiveness created difficult and unpleasant working conditions for staff that were not easily subject to positive change. For those who chose to remain at Sentosa, particularly medical assistants, the conditions at the hospital although far from ideal, were seen to be

somewhat less onerous but not necessarily more stimulating or worthwhile than work elsewhere. These views in turn were reinforced by the dearth of innovation or indeed dedicated interest amongst most members of staff at all levels of rank, with a general view amongst female nurses and doctors that psychiatric work held no real future for them. These attitudes were further compounded by a seemingly lax managerial response to basic safety precautions, as discussed in Chapter Nine, jeopardising staff safety and furthering an already heightened sense of prejudice towards psychiatric patients.

10.5 The contribution of this study to knowledge

The unique contribution of this study to a wider body of knowledge lies at both a conceptual and methodological level. In the first instance, conceptually the study seeks to hear and amplify the voices of women patients in this region. Their accounts dramatically break out of the silence to which they have been habitually relegated in speaking of lives lived within the institution as well as beyond its walls. The implications of this strategy are of enormous importance in putting flesh on the otherwise rather bare feminist theoretical skeleton of what it is like to be a woman under those material and specific social conditions. The strong resonance between narratives and theory lends a muscular and vigorous credibility to critiques that demand that women's experiences of psychiatric services deserve a closer and dedicated scrutiny tied to policy change that too often reinforce sexist oppression within the closed walls of the institution.

At a methodological level, the study offers an original contribution in that, as discussed in Chapter One, qualitative work in Malaysia, as well as many other developing nations, has yet to achieve general acceptance within the academic and scientific community. In this study service user accounts are used to good effect in exploring the culture of the study site, yet this remains a singular and indeed virtually unknown use of methodology within the parameters of research in this region.

In relation to this point I argue that the study offers a genuine challenge to feminist critiques, such as that espoused by Daphne Patai (1991) who maintains that it is not possible for white, feminist researchers to carry out research amongst women from developing regions without replicating the exploitation of social, class, and economic disparities between First and Third World nations. As discussed in this study I maintain that despite the many differences that were apparent between myself and my respondents, I do not accept that this resulted in overtly hierarchical relationships grounded in exploitation. Rather that relationships were to a large extent reciprocal, in that through favouring me with their accounts, patient respondents found a validation of their experiences in a respectful and accepting alliance, however temporary, between researcher and respondent.

10.6 Implications for further research

To reiterate, qualitative studies have yet to establish their academic credentials in Malaysia. Studies of psychiatric services tend to focus on the efficacy of treatment and career considerations, leaving a void with regard to service-user perspectives (Campbell, 1996; O'Hagan, 1996). This reflects not only the heavily dominant position of the medicalised and scientific approach popular in this region, but also an attitude that ascribes deeper political and ideological issues towards the rights and status of psychiatric patients (Ashencaen Crabtree and Chong, 2000). As can be seen from staff accounts, as for example in Chapter 8, Section 8.3.3 and Chapter 9, Section 9.2.1 of this study, views towards patients were often negative and antipathetic.

Qualitative studies from this region that seek to balance the hegemony of dominant medical perspectives are scarce in research literature (Ashencaen Crabtree, 2001; Barrett, 1993; Fidler, 1993). This is not to imply however that quantitative studies offer no potential in closing a void with regard to such topics as gender and admission rates in Malaysian psychiatric institutions. As this study has suggested in Chapter Five, Section 5.4, this issue may hold some interesting comparisons with evidence from the West (Busfield, 1996; Chesler, 1996; Miles, 1988; Russell, 1995; Wetzel, 2000).

Furthermore, an area of particular import with regards to this study is that of the position of Malaysian women psychiatric service-users, whose accounts have previously remained for the most part unsolicited and whose needs are habitually classified and subsumed under generic nosologies of psychiatric pathology (Arif and Maniam, 1995; Lau and

Hardin, 1996; Lim *et al.*, 1994; Osman and Ainsah, 1994; Ramli, 1989; Razali *et al.*, 1996; Rhi *et al.*, 1995; Varma and Sharma, 1995). An evident lack of dedicated and specific studies of women's narratives in relation to the issue of mental illness and psychiatric services represents a large vacuum open to further and extensive research.

In addition to the enormous gaps in relation to the issue of gender and psychiatric services in Malaysia, a further deficit lies in that of ethnicity, admission and discharge rates, which seek to go further than offering an inquiry into pathology. That this is a sensitive subject in Malaysia has already been noted in Chapter Nine Section 9.2. The evidence from the study at Sentosa offers some clues however regarding the predominance of Chinese patients and suggests an area of enormous potential for future research, ideally modelled on indigenous needs and interpretations.

Finally, as indicated in Chapter Six, Section 6.3.1, a fruitful area for further study lies in the issue of traditional healing in this region, which is considered, a highly important and attractive resource for local people (Rhi, B-Y *et al.*, 1995). The variety of healers operating within specific cultural contexts and cross-culturally as well has been subject to anthropological consideration for some time (Barrett, 1993; Bentelspacher *et al.*, 1994; Bernstein, 1993; Fidler 1993, Kleinman 1980; Kleinman, 1982; Razali, 1995; Razali, 1996 *et al.*; Razali, 1997; Wintersteen *et al.*, 1997). Yet despite these studies, there

remains insufficient information on traditional healing strategies that take into account and contextualise contemporary mental health services, service-user concerns and cultural responses to mental illness in terms of parallel or competing paradigms of healing in this region (Ashencaen Crabtree and Chong, 1999).

APPENDIX I

LETTER OF CONSENT

Faculty of Social Sciences
Universiti Malaysia Sarawak
94300 Kota Samarahan
Sarawak
Malaysia

Tel: 82 671000 x 298

Fax: 82 673205

Date

Dear

I would like to introduce myself. I am a lecturer at the Universiti Malaysia Sarawak currently doing research into the perceptions and experiences of the users of mental health services at Hospital Sentosa. I am seeking interviews with people currently on the ward who would be willing to discuss their experiences. I understand from ward staff that you may be willing to consent to being interviewed by myself on a strictly voluntary and confidential basis in a private place free from interruptions.

If you do not speak English well and require translation skills these can be provided in the following languages: Bahasa Malayu; Mandarin; Hokkien, Haka, Bidayuh, Iban. Translators are subject to the same conditions of confidentiality as the principal investigator.

You are under no obligation to agree to be interviewed and your refusal will not affect current services now or in the future. No one involved in the research project is connected with Hospital Sentosa in any way and information given by interviewees is for academic purposes only and will not be divulged to hospital staff or anyone not associated with the research project. All interviewees are guaranteed absolutely anonymity at all times.

All information will be treated in the strictest confidence and stored securely away from the hospital and will not be accessed by anyone unconnected with the research project. Data stored on cassette tapes and computer discs will be destroyed by June 2000 following the writing up of findings. Some information regarding medication, admission dates and referrals to other mental health services, for instance the Community Psychiatric Nurses, may be requested from the Medical Officer in charge of your case. Access to medical records will not be requested.

Research findings will be written up in the form of a doctoral thesis with additional academic papers. If you wish to you may see copies of the write-ups prior to

publication and your comments and observations are welcomed as very valuable and helpful. At no time will your identity be revealed in any way.

Should you agree to be interviewed please inform your medical officer or myself and an interview time and place can be arranged. You will be asked to read and sign a consent form prior to the interview.

Finally, I would like to emphasise that you have the right not to interviewed or not to have your interview recorded; you may also refuse to answer any questions which you would prefer not to reply to for whatever reason. You may decide to terminate the interview at any time and if so, you do not have to give reasons for your decision and no repercussions will follow such a decision in any way.

I do hope that you will be feel able to assist in the research project and if so, I look forward to meeting you in due course. Please feel free to contact me at the hospital or at the above address should you have any further queries, I would be very pleased to hear from you.

Thank you for taking time to read this letter.

Yours sincerely

S. Ashencaen Crabtree
Principal Investigator

APPENDIX II

EXAMPLE OF SEMI-STRUCTURED INTERVIEW SCHEDULE: MULTIPLE/FIRST ADMISSION PATIENTS

Section 1. General Data

- 1.1 Ward
- 1.2 Male/Female
- 1.3 Age
- 1.4 Race (Religion)
- 1.5 Multiple/First admission
- 1.6 Diagnosis (if relevant)
- 1.7 Current admission date
- 1.8 Home (location)
- 1.9 N.O.K (if relevant)

Section 2. Life On The Ward

- 2.1 Describe a typical day on the ward
 - 2.2 Describe routines in more detail [*Prompts: recreation/work/medication sleep/meals/visitors etc.*]
-
-

Patient Labour:-

- 2.2a Describe work routines on the ward
 - 2.2b Describe work in the OT Dept/Elsewhere in the hospital
-
-

==

- 2.3a (Multiple admission) How are things different on this ward on this admission?
- 2.3b (First admission) How does the hospital compare with your expectations?
- 2.3 Describe the kind of people (patients) you know on this ward
- 2.4 How would patients refer to themselves here?
- 2.5 How do staff refer to patients here?
- 2.6 Describe who are your friends on the ward [*Prompt: what makes someone a friend? What would not make someone a friend? Can staff be friends? Describe*]

- 2.7 Describe the kinds of staff you meet on the ward [*Prompt: rank/types*]
- 2.8 What do you like/dislike most about being in hospital?
- 2.9 Tell me about the locked section [*Prompt: why is it used? Who goes in? What is it like? How long is someone kept inside? What is there to do inside?*]

Section 3. Perceptions of State of Mind

- 3.1 How were you admitted to hospital [*Prompt: circumstances*]
- 3.2 (Multiple admission) How does this admission compare with last time?
- 3.3 How would you describe why you are here?
- 3.4 What was life like for you around the time you were admitted? [*Prompt: personal problems? Are the staff aware of this history/account?*]
- 3.5 What sort of words would you use to describe how you are feeling at this time [*Prompt: in relation to admission/state of mind/etc*]
- 3.6 Do you feel the staff understand the way you feel?
- 3.7 How do you feel about the way the staff are taking care of you?
- 3.8 What improvements would you suggest?

Section 4 Medication

- 4.1 Describe the kind of medication/treatment you are receiving at the moment
- 4.2 What other sorts of treatment have you had on this/past admissions. Describe
- 4.3 What does the medication feel like?
- 4.4 How have the staff explained the reasons/use of medication/treatment to you?
- 4.5 Describe how helpful the medication/treatment is in your case? [*Prompt: How far do you feel you need the medication/treatment*]
- 4.6 How helpful was the explanation to you (family)?
- 4.7 Are you expected to take medication when you are discharged? [*Prompt: How do you feel about that?*]
- 4.8 Does anyone help you take the medication/treatment when at home?
- 4.9 For what kinds of reasons might you decide not to take it?
- 4.10 How far do you feel the staff understand reasons why someone would choose not to take medication/treatment?
- 4.11 Can you think of other ways you could be treated which would be better for you? [*Prompt: what do you think would be the opinion of the staff/family towards your idea?*]

- 4.12 Discuss how useful traditional/alternative treatment could be for you (people here) ? [*Prompt: Personal experience (details) ? Instigated by who (family)? When? Etc]*

Section 5. Social Circumstances: Family and Friends

- 5.1 Describe your home and family [*Prompt: What constitutes family? Urban/rural? Employment? Who lives at home/away? Etc.*]
- 5.2 How would you describe your relationships with your family? [*Prompt: who do you feel closest to? Why?*]
- 5.3 How far do you feel they (family) understand/accept your admission(s) to the hospital?
- 5.4 Describe your friends at home? [*Prompt: How long have you known them? Are you still in contact? How often do you see them weekly/monthly? What do you enjoy doing with them? What do you enjoy doing alone?*]
- 5.5 How far do you feel they (friends) understand/accept you admission(s) to the hospital?

No stable cohabitation:-

- 5.6a Divorce/separation [*Prompt: When? Circumstances? Custody of children?*]
- 5.6b Plans for long-term cohabiting relationship one day? Describe
-
-

Section 6. Social Circumstances: Mobility and Employment

- 6.1 Upon discharge where are you planning to live? [*Prompt: same place as before?*
If elsewhere, where and why?]
- 6.2 Ideally where would you like to live?
- 6.3 Current employment? [*Prompt: what do you do for a living? Same/different to past employment?*]
- 6.4 What kinds of plans have you made about supporting yourself upon discharge?
- 6.5 Describe some of your proudest achievements
- 6.6 Describe how you see the future for yourself

APPENDIX III

PARTICIPANT SAMPLE SIZE

A precise sample size of respondents interviewed in this study is difficult to quantify, as although an interview schedule was used at the beginning of fieldwork, as discussed in Chapter Four, this gave way to an interview method of ‘opportunistic sampling’, in which less control in the selection of candidates was used (Burgess, 1995). This created a more flexible interview style where participants chose to discuss issues with me singly or in natural groupings in a fluid manner. Nonetheless a calculation of sample size can be indicated from the following interview types.

1. Semi-structured interviews with patients.

Approximately 28 interviews were carried out with patients using an interview schedule (see Appendix II).

2. Focus group discussions with psychiatric service-users in the hospital and community.

Half-way homes: 8 individuals.

Day Centre: 7.

Hospital Sentosa. Female patients: 8.

Hospital Sentosa. Male patients: 8.

3. Opportunistic sampling of patient participants.

Approximately another 40 individuals.

4. Semi-structured interviews with staff and other allied professionals.

22 formal interviews were carried out using an individually tailored interview schedule.

5. Opportunistic sampling of staff participants

Approximately about 20-25 members of staff participated in these types of interview.

APPENDIX IV

Table 5.
Census Population by Ethnic group, Sarawak 1991
(General Report of the Population Census of Malaysia, 1991)

Total	Malays Bumiputera, including Melanu Muslims, Orang Asli Muslims	Dayaks Bumiputera* Including: Ibans, Bidayuh, Melanu Christians, Orang Asli Christians	Total Bumiputera	Chinese	Indians	Total Malaysian Citizens
1718380	360415	744312	1209118	475752	4608	1700019

Table 6.
Census Population by Ethnic Group, Sabah Including the Island of Labuan 1991

Total	Malays Bumiputera	Dayaks Bumiputera* including: Dusuns Kadazans, Bajaus, Muruts	Total Bumiputera	Chinese	Indonesians	Indians	Total Malaysian Citizens
1863659	123810	609257	1003540	218233	142272	9310	1398873

Table 7.
Census Population by Ethnic Group, Perak (Peninsular Malaysia) 1991

Total	Malays Bumiputera	Other Bumiputera	Total Bumiputera	Chinese	Indians	Total Malaysian Citizens
7460363	8306234	127592	8433826	4250969	1380048	14475387

APPENDIX V

GENERIC POLICIES, GENDERED PRACTICES: PSYCHIATRIC CARE IN KUCHING, SARAWAK, MALAYSIA

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ABSTRACT

This presentation focuses on findings from ethnographic research undertaken at the local psychiatric hospital, Hospital Sentosa, Sarawak. Hospital policies are explored in relation to in-patient procedures and how these are interpreted in staff practices towards male and female patients. Findings indicate that gender norms and stereotypes are often replicated and reinforced in relation to concepts and assumptions surrounding mental illness and its effects.

INTRODUCTION

This paper considers some findings from an ethnographic study of daily routines and interactions at a psychiatric hospital in the Kuching area of Sarawak, in Malaysian Borneo. The paper offers insights into the way certain hospital policies are translated by staff into discrete ward conventions, frequently but not always based on perceived and culturally informed gender norms and expectations. Due to the constraints of space the paper seeks to offer merely a condensed interpretation of findings on the part of the author. Although the ethnography covers the entire hospital and attempts to study the experiences of both patients and staff, this paper omits the experiences of the latter. Furthermore only four wards are focused upon, these being two 'acute' wards, Male Ward 1 and Female Ward 1, and two 'chronic' wards, Male Ward 2 and Female Ward 2, with some supporting examples drawn from other wards.

The ethnographic study takes a self-reflexive feminism position as its particular political and epistemological stance and the experiences of patients (and staff) are therefore considered from this perspective. This is not to suggest however that the experiences of male and female 'patients' are interpreted in gender exclusive or oppositional ways but instead I readily acknowledge that many incidents are identifiable as the common lot of psychiatric inpatients in this particular setting. Research methods included lengthy periods of observation as well as interviews with informants both informal and formalised, individual and group interviews.

THE STUDY SITE

Hospital Sentosa is one of four psychiatric hospitals in Malaysia supplemented by numerous psychiatric units spread unevenly around the country with the Borneo States (Sarawak and Sabah) enduring the most scarce resources. The ethnographic study took place at a small psychiatric hospital built in the 1950s during the colonial era and was designed to relieve the overcrowded and inadequate conditions of current psychiatric facilities at the time. The general layout of the hospital is even decades later not unattractive, being of a low open-plan design set around a central grassy compound with the 'public' wards situated separately from the 'private' wards and the forensic block for the criminally insane. Yet the open-plan appearance of the hospital stands in contrast to the locked and once again overcrowded conditions of individual wards. The hospital, in accordance with Malaysian health policies, operates a tiered system of 1st, 2nd and 3rd class patients with accommodation, freedom of access, dietary and other facets of daily life demarcated according to rank and fees.

The hospital population is unequally divided into 'chronic' and 'acute' patients with the majority of patients being long-stay 'chronic' patients, many of whom have resided at the hospital for many years, some since the days of the colonial authorities. Many of these patients are described as 'mentally stable' but are regarded by the staff as unable to survive outside of the hospital due to social stigma, scant Government financial benefits and a dearth of suitable accommodation. In the context of Malaysia, the emphasis for continuing care of people with psychiatric problems is placed firmly on the shoulders of

the extended family unit. If this support is not available then there is little choice but to attempt a completely independent existence or remain at the hospital on a semi-permanent basis.

'Chronic' patients are accommodated in several wards and are also present in the two acute wards allocated to male and female patients respectively. There is a heavy ethnic over-representation of Chinese patients of both sexes amongst the chronic population but an investigation of this phenomenon lies outside the brief of this study although it is to be hoped that future research will concentrate on this conspicuous and ominous situation. It is of interest to note that at Hospital Sentosa at least, the numbers of male and female patients in the population overall are fairly evenly balanced: in 1997 males represented 57% of multiple admissions and by 1998 the number had risen slightly to 58% of all admissions. In 1997, men still outnumbered women in terms of first admissions by a ratio of 68% but by 1998, this had dropped to 62%. An earlier study of care-giving families of Sentosa psychiatric patients suggested that gender played an important role in how families responded and related to mental illness. This study suggested that there was no concrete bias as regards a greater tolerance towards female service-users, in fact somewhat the reverse (Ashencaen Crabtree, 1999). Looking however at the 1997/1998 admission figures, it would appear that men during these two years were slightly more likely to enter the hospital as patients than were women. This stands in some contrast to the assumption that since globally women are more likely to suffer from mental distress than are men then they would have a higher presence in psychiatric institutions. Although as Wetzel points out, schizophrenia is equally distributed between the sexes (Wetzel,

2000: 206) and this is the dominant diagnosis at the psychiatric hospital under study although affective disorders as well as learning and physical disabilities are represented to differing degrees.

SERVICE DELIVERY

The hospital is operating during a time of transition from an asylum model to one of decentralisation and community psychiatry. The future of the hospital lies in the continued care of its large, long-stay population with plans to eventually care for acute patients in the psychiatric wing of the General Hospital. Yet the move towards care in the community is not destined to be a straightforward transition and has been dogged by differing interpretations of the mental health needs of the community at large. Typically there is a tension between national policies and actual local service delivery in the implementation of these policies. At Hospital Sentosa, the community psychiatric nurse programme, which commenced in the early 1990s, has doubled in size since 1997, yet the small team of CPNs has remained the same and shows no real signs of expansion to match its increased duties, in accordance with moves towards care in the community (Ashencaen Crabtree and Chong, 1999). Furthermore it is worth noting that decentralisation is not a political move of individual and group emancipation but is tied purely to logistical and fiscal policies and the rise of service-user perspectives has yet to emerge as a presence (Rostron and Lee, 1996: 25). With the move towards decentralisation in the background, the privatisation of health care has been foregrounded in the last couple of years and this has been seriously discussed at Government

level and is seen by many to be virtually inevitable. Although privatised care will not directly affect Government-run psychiatric institutions there are fears amongst mental-health professionals that this will have repercussions which will further demote an already marginalised profession and public service.

Against the backdrop of large-scale national changes the hospital continues to implement its own policies regarding patient care and these local-level policies can be interpreted as having providing small-scale revolutions in paradigms of care and treatment, to borrow Thomas Kuhn's useful expression (Kuhn, 1962). These revolutions seek to displace some well-established assumptions concerning psychiatric patients, and based on experience are likely to continue to involve controversy and dissent. Probably the most dramatic change in hospital policy has been the move from closed wards to an open ward system, brought in by the previous hospital director over a decade ago. It is not altogether clear how strictly observed this policy was meant to be at the time of implementation but my findings suggest that this policy is open to interpretation by individual wards, which conduct themselves on largely autonomous lines, of which more will be said later in the paper. A much more recent change has been one of 'rehabilitation' of acute patients through improved and increased occupational therapy combined with attempts to increase the discharge rate. Furthermore, there is a concern to review the medical treatment of patients and polypharmacology practices. Commensurate with this there appears to have been a recent drop in the number of people given ECT treatment, although this impression has yet to be subjected to a proper hospital audit.

ADMISSION TO HOSPITAL

The acute wards and the chronic wards are designed as counterparts to each other yet are in many ways conducted on very different lines. With the exception of one chronic ward, the wards resemble each other closely in layout. Normally the public (3rd class) wards consist of a large open dormitory-style ward with communal bathing and lavatory facilities leading off the ward. This is divided at one end by a locked barred section that houses a further number of beds, all of which are usually occupied with separate toilet facilities. The locked section looks out into the main ward and out onto an open verandah where patients eat and work and which in turn leads to the hospital corridor, access being via a grilled gate. Patients newly admitted to the acute wards need to adjust quickly to the ward environment since there is no privacy but shared accommodation with many others, most of whom are veterans of multiple admissions or long-stay patients. A cooling-off period upon admission of psychotic or resistant patients of both sexes is usually administered in the locked section of the general ward for a few days assisted by the use of tranquillisers.

Non-voluntary admissions are subject to the orders of a magistrate who is empowered to order the apprehension of 'any person reported to be of an unsound mind or to be behaving in such a manner as to suggest that he is of unsound mind' for a period not 'exceeding one calendar month' under the Mental Health Ordinance Sarawak 1961. At which time a medical report must be prepared and following this period an inquiry held;

however the detainee has no right to be present at an inquiry if the magistrate 'is satisfied that, by reason of his lack of understanding, no good purpose would be served by his attendance'. However since no specific professional is empowered to oversee the duration of detention and uphold patients' rights it is not uncommon for patients to languish in institutional care for periods far exceeding the maximum period.

Voluntary admissions are usually brought about through the intervention of family members who normally bring their relatives to the outpatient clinic. Based on my findings it would seem that the testimony family members give concerning the patient's state of mind exercises a considerable amount of influence in ascertaining whether someone should be admitted or not. A 'voluntary' admission therefore is in reality heavily mediated by the wishes of the family, as is discharge. Apparent relapse, antisocial, unconventional or aggressive episodes are seen as valid reasons to persuade or coerce patients to accept voluntary admission but so too, are behaviours such as 'wandering' out of the house and social and sexual relations with the opposite sex, the latter being a particularly strong motivator for families in the case of single women.

The heavy paternalism of the current system, which additionally fails to secure a review of custodial care and treatment, effectively relegates patients to an uncertain period away from their normal life with no access to appeal except to the immediate authority of staff. Admission, detention and discharge therefore seemingly lie outside the control of voluntary and non-voluntary patients and outward compliance with routines and care treatment may appear to be the only way to secure a release. Conforming to the system is

therefore shown by such behaviour as a willingness to take medication without complaint and wear the androgynous and dowdy hospital uniform of baggy shorts and tunic devoid of any underwear for either sex. Compliance with daily routines includes eating the starch-rich, unpalatable hospital diet uncomplainingly and undertaking chores willingly, such as precision bed-making techniques with hospital corners and pillows facing the correct direction. Observation of personal hygiene at given times is required, as are the serving-out of food and washing-up duties, for instance. Compliance in short with all aspects conforming to those which could be said to meet Goffman's definition of the 'total institution' (Goffman, 1961).

Patients are socialised to accept that personal space has been reduced to a minimum whereby not even your own allocated hospital bed is yours alone but may be shared by other people at times. The conventions of the ward being such that certain rituals must be closely observed whilst others concerning personalised space and personal needs are drastically eroded.

Recreational activities are highly structured affairs, with group exercise undertaken with other wards but with minimum interaction between men and women. The lack of social contact between the sexes is a conspicuous, albeit to some extent a culturally normative, part of institutional life, and one which is carefully upheld by ward staff on the grounds of morality and order. The wards are characterised by their bareness and for the most part, antiseptic cleanliness. There are scant recreational outlets, the wards themselves being virtually devoid of stimulation short of a communal television set and radio that are

normally controlled by the staff. To reiterate, wards function in an autonomous fashion and Male Ward 1 now boasts a small badminton court for patient use, whilst on Female Ward 2 a make-up session one morning a week is proving to be a popular activity amongst certain patients who normally function poorly in other daily activities. The therapeutic effects of the make-up sessions remain unclear amongst staff; my observations are however that the devastatingly depersonalising and desexualising institutional process seems to be dramatically reversed in these sessions. Although they conform closely to traditional gender normative behaviour they also represent an almost unparalleled opportunity for self-expression, creativity and self-affirmation.

A sense of identity is of course closely allied to the roles allocated to patients and each ward appears to hold certain individuals, of necessity long-stay, whose function it is to assist staff and oversee the activities of other patients including assisting with administering of medication. These individuals are both a source of help to the staff as well as representing a certain threat to the status quo, whereby when a ward 'kapo', for want of a better expression, becomes too removed from the subservient role of patient and identifies themselves too closely with members of staff they must be reminded in no uncertain terms of their status. This often involves a 'scolding' or a spell in the locked section or even at times a reduction to the ranks. Whilst this special role can be found in most wards I have observed, the way it is carried out is peculiar to the individuals concerned. On Female Ward 2 (a chronic ward) the 'kapo' is a fearsome individual who maintains her authority through obedience to the staff and gratuitous brutality to the patients. On Male Ward 1 this position is occupied by a non-aggressive but solitary and

introverted individual who stands aloof from other patients, wears his own presentable clothing and maintains a brooding distance from all others, patients and staff alike.

PATIENT LABOUR

Labour at Hospital Sentosa is divided into several different areas of work, some of which serve to maintain the day-to-day running of the hospital machinery and others which are seen to benefit the patients rather than primarily the hospital. Occupational work has been established at the hospital for many years but it is only now viewed in terms of therapeutic benefits as opposed to just keeping patients occupied. In keeping with this view occupational work has largely been the province of long-stay patients, whilst there has not been a perception that this could be of value to recently admitted acute cases. Occupational work encompasses various types of labour, from projects to generate income to activities whose main aims are to occupy minds and hands in the passing of time, to cleaning and care duties. Asylums have as a general rule utilised the labour of patients to maintain the institution to the extent of attempting to generate a financial return on institutional care, which despite cost-cutting measures is an expensive enterprise. In this respect Hospital Sentosa is no different from past institutions which hoped to supplement the costs of care through inmate contributions of their largely unwaged or poorly paid labour (Black, 1988: 2; Barham, 1992: 8).

At Hospital Sentosa occupational therapy is divided into work considered suitable for men and women respectively, with the former being able to participate in carpentry,

basket weaving and farming activities, which take place on a small scale in the hospital grounds. Women are occupied solely with handicraft work, which consists basically of repetitive work using fabric. Women are given handicraft tasks to do dependent on their skills and levels of concentration. The majority is given the least skilled task, which involves extracting threads from scraps of material. The 'thread sorting' activity is tedious work which usually takes place at long trestle tables on the ward, the piles of individual threads are then used as stuffing material for a small range of household goods manufactured by staff and other patients in the occupational therapy department. Curiously the ward nurses are also heavily involved in this monotonous thread sorting work, with perhaps a view to providing an industrious example, working alongside patients for hours on end. Staff mostly undertakes the sowing of patchwork quilts with few patients being seen as skilled enough to participate in this activity, the final product going on sale to the general public.

By contrast with the predominant activity for women, male patients are given the opportunity to apply their skills in carpentry, producing sturdy and creditable pieces for sale. The basketry department produces an array of smaller items and larger pieces of furniture, and these items are usually sold to kindergartens in town, which hold a contract with the hospital. Finally, male patients are also involved in small-scale gardening activities with the chronic wards producing leafy vegetables, which are mostly sold to staff. The forensic ward for the criminally insane keeps livestock, such as quails and goats and livestock farming appears to provide a small but steady income to be ploughed back into the hospital revenues under the 'Patients' Fund' from which patient salaries are

deducted. Occupational work undertaken by men and women differs not only in the levels of skill required, with women relegated to largely unskilled and highly monotonous activities but this is also reflected in the token earnings that patients achieve based on sales. The most lucrative line of work lies in livestock farming, with basketry and carpentry and other forms of farming and handicrafts taking their place in a falling scale of earnings, with women under the present regime earning the least.

Unpaid labour is confined to ward activities whereby patient assistance is sought in the myriad of small chores not covered by the hospital's contract cleaning agency. Tidiness and cleanliness are strongly emphasised on most wards, with staff priding themselves on a spick-and-span appearance and which is in general easily achieved through the almost complete lack of personal possessions held by patients. Of more utility on the chronic wards is the care given to patients by their peers with the encouragement of staff, whose duties are somewhat relieved by this daily assistance. The relationships between patients are normally interpreted by staff as parental or filial, whereby on Female Ward 2, the care of some of the elderly and/or disabled individuals is very largely undertaken by their more able companions. Here, for example, a very disabled young woman with cerebral palsy and learning disabilities is cared for by an elderly patient, who bathes, toilets, dresses and feeds her as a matter of course each day. On Male Ward 3 (another chronic ward) a fit elderly patient in his mid-eighties cares for a much younger man suffering from significant physical and mental problems. The staff largely regard these pairings as of mutual benefit to patients who through these means may develop a long-term intimate

relationship imitative of normal family interactions in a largely static patient population, whilst the practical advantages to the running of the ward are self-evident.

FREEDOM OF MOVEMENT

This section reviews the open-ward system that has been a familiar concept at Hospital Sentosa for several years, yet one that is open to interpretation and variation by members of staff. It also considers the notion of freedom of movement both beyond and within the ward environment in relation to assumptions of gender, which in turn relate to cultural norms. First of all, the notion of freedom of movement relates not only to gender issues but to class considerations, whereby the private wards contain no 'locked section' and patient freedom of access is assumed unless there are good reasons for curtailing it. On the general (3rd class) wards however, the free access to the hospital grounds and beyond is by no means assumed with a series of obstacles placed in front of patients to prevent unrestricted access.

At the beginning of fieldwork a year ago I noted then that the grilled gate on Male Ward 1 was normally left open and patients were at liberty in the 'open section' to wander in and out at will. The majority however did not enjoy this freedom but only a select few and some that remained on the open ward did not venture out unless directed to the occupational therapy department. A larger proportion of patients however were not given access to the open section and verandah area and were instead incarcerated in the locked section, sometimes for days on end, until their mental state was thought to be sufficiently

trustworthy to be allowed out. Some male patients at liberty to roam are known to walk into the small township nearby which has since sprung up over the years following the construction of the psychiatric hospital; which, in common with many other similar institutions of the time, previously stood in isolation in the countryside (Prior, 1993: 26). These patients are highly conspicuous due mostly to their hospital uniforms and trips to town are usually a combination of recreation and business, for some patients habitually carry out minor shopping of snacks and cigarettes for other patients, for profit reasons or favours. Veteran patients are often quite well known in town and have become by all accounts skilled at acquiring minor goods free from shop vendors, which has occasionally led to complaints and some ill will towards the presence of the hospital. Having observed the liberty of certain patients over the course of time I was interested to note that in the latter months of fieldwork this liberty was severely curtailed through the locking of the ward grill gate. The justification for this new strategy by staff revolves around the perceived and verbalised need of the staff to prevent escapes by disaffected patients, although patient abscondments have always been a minor feature of ward life. This curtailment appears to herald a reduced level of tolerance towards access of male patients to the world beyond the ward and these changes can also be connected to the recruitment of new members of staff fresh from placements outside of psychiatry.

Whilst the free movement of men on the open section of the acute ward has recently been curtailed, their erstwhile liberty has not been shared by their female counterparts on Female Ward 1. Here the open/locked geography of the ward is subject to a different interpretation and flow of movement. Women on the acute ward are all confined to the

ward except during periods of work undertaken in occupational therapy, exercise sessions or other escorted forms of recreation. The demarcation between open and locked is less clearly drawn and those relegated to the locked ward for periods of the night and day will also be allowed to join companions on the open section at selected times. The movement on the ward between these two distinct zones is fluid in the case of women patients, whilst the boundaries between the ward and access to the hospital are carefully guarded by staff. Reasons given for this curtailment of freedom are locked in contradiction and dual conceptions of female sexuality. Women patients on Female Ward 1 are in the majority of child-bearing age and their sexuality is seen to be a commodity that needs to be controlled by staff. On the one hand women with mental illnesses are seen as childlike and potentially vulnerable victims of unscrupulous men. This can be read as an identification of women patients as the mad woman in her innocent Ophelia mode (Kromm, 1994). On the other hand women patients can be simultaneously seen as predatory and promiscuous, inclined to solicit sexual intercourse without discrimination (the Bertha Rochester image from *Jane Eyre*).

In keeping with both these timeworn images of madness and female sexuality, women patients are capable of responding to the sight of a young male doctor visiting the ward, with a lusty lack of inhibition. A quiet woman patient with learning disabilities readmitted onto the ward due to pregnancy for the second time by a neighbour was categorised by staff as a 'rape victim' or at least as a victim of seduction by a wily opportunist, which was seen as much the same situation. The woman herself referred to

her impregnator as 'her boyfriend', this being passed off as a sign of her naiveté and inability to care for herself.

The open ward system has been criticised by some members of the staff on the grounds that male patients might impregnate women patients as *happened in the past!* In actual fact I can find no evidence that this event took place and suggest that it is likely that it has become part of the staff mythology of resistance constructed and maintained against the free movement of patients. A further argument which has been used to good effect at Hospital Sentosa lies in the issue of staff accountability for patients permitted free access, an argument that was also used in the UK during the transition from a locked-ward tradition to an open-ward system (Clark, 1996: 106-7). Women patients are strongly identified within their biological roles whereby the liberty of young fertile female patients has habitually been circumscribed, whilst by contrast elderly women on the chronic wards are allowed to wander around the hospital but rarely go out beyond its boundaries.

The discourse used by staff in relation to male and female patients and their freedom of movement is highly revealing, whereby men are seen to be more independent, more aggressive and more opportunistic and recidivists. This therefore results in the majority of men being confined in locked wards and a minority on the open ward confined and controlled to prevent 'escape', the whole language of control relating to incarceration and resistance. On the female wards however, notions relating the passivity and vulnerability are constantly reinforced, whereby 'aggressive' women are not solely confined to the locked ward but are free at times to mingle with others on the open section, which is of

course not open but also confined. Commensurate with this interpretation is my observation that while restraints are still widely used at Hospital Sentosa these are much more likely to be used on women and particularly elderly women, than any other group. The use of restraints on women for reasons such as 'behavioural' problems, fights or wandering, powerfully reinforces the whole notion that physical passivity is normal for women and that confinement is an appropriate management technique compatible with gender difference. Men by contrast are much more likely to find themselves placed back in the locked section for antisocial behaviour, possibly commensurate with Jane Ussher's view that male madness is deemed to be more dangerous than women's and requires confining behind bars (Ussher, 1991: 171).

CONCLUSION

The management strategies of Hospital Sentosa involve devolving many daily decisions to individual wards which often carry a customer service 'mission and vision' statement on public display, whilst hospital policies appear to be somewhat nebulous. This may in part be due to the shortage of trained psychiatric staff at the hospital, as most new recruits come from the general hospital service and rural polyclinics. Staff care is mostly confined to supervisory roles but these again rarely include therapeutic activities or specifically orientated care of people with special needs.

To summarise, based on findings to-date it would appear that gender issues play an important role in how patients are perceived and treated by staff. In general it would appear that psychiatric patients in this region are conventionally considered incompetent, vulnerable and in need of supervision and protection through family and institutional care. While this is true of both sexes, women notably occupy the perceived position of the most vulnerable and the least responsible or capable of independent self-maintenance. Whilst admission and management practices consistently reflect this view of women as essentially in need of paternalistic care. In the hospital setting women are the most confined, the least stimulated in terms of occupational work and also the least rewarded. The consequences of these deeply disempowering notions seem to relegate women psychiatric patients to the most controlled and concealed members of an already heavily marginalised minority in contemporary Malaysian society.

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**Standing at the crossroads: Mental health in Malaysia since
Independence**

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STANDING AT THE CROSSROADS: MENTAL HEALTH IN MALAYSIA SINCE INDEPENDENCE

INTRODUCTION

As the title of this chapter conveys, mental health services in Malaysia have evolved rapidly over the last few decades in terms of services and associated ideologies, whereby traditional asylum care is now giving way to other models. The changes however which have altered the face of service delivery over the last few decades have also brought services to a critical point whereby hard decisions about the direction in which to proceed for the new millennium need to be made.

In order to focus on some of the issues involved in this decision it is necessary to reflect on what has been achieved so far, therefore the first part of this chapter briefly considers the evolution of mental health services in Malaysia prior to Independence. With this orientation, legislation and services post Independence are reviewed and trends towards privatised health care are considered. From this vantage point, the dilemma facing policy planners, psychiatric professionals and consumers is explored in terms of the morphology and ideology of future services in their effect on these different parties, whose interests have all too often been subsumed under one dominant perspective.

SERVICES PRIOR TO INDEPENDENCE

Prior to the late nineteenth century mental health services in Malaysia were very rudimentary and limited. Penang was the location for the earliest recorded asylum care under the auspices of the colonial authorities in Penang, a Crown possession for fifty years since 1786 (Baba, 1992). Although prior to 1829 internees were predominantly syphilitic European service-men the inmate population apparently altered then, for by this date there were a mere 25 inmates in this asylum of which now only one was a European. A further institution was opened in Penang in 1860 but this did not remain for long with the Sepoy Lines asylum at Singapore being subsequently obliged to absorb their internees following closure (Murphy, 1971). The next institution on Peninsula Malaya was not established until 1909 when the Central Mental Hospital was built in Tanjong Rambutan a few miles from the tin-mining town of Ipoh in Perak (Eng-Seong Tan and Wagner, 1971). This name was later changed to Hospital Bahagia in 1971.

In 1887 an English psychiatrist by the name of Gilmore Ellis was appointed to take charge of the new Singapore asylum, which had replaced the original one built in 1862. Despite the ravages of beri-beri and cholera which raged amongst the internee population, Ellis attempted to improve conditions for the mentally ill, bringing with him the new attitudes towards hospitalisation as therapeutic care and not merely incarceration. In the first year he implemented the forerunner of occupational therapy: rope making or weaving. Furthermore he abolished straitjackets, provided

recreational activities, instituted a new improved method of record-keeping and prosecuted an attendant for ill treatment of a patient. A high discharge rate and rudimentary aftercare of discharged patients were the additional hall-marks of the remarkably progressive service offered at this time. Referrals came from the nearby States of Johore, Malacca and Selangor to as far afield as Bangkok and Australia, deemed to have much inferior services at that time (Murphy, 1971). The quality of early psychiatric care in Malaya therefore could be seen to be equivalent in care and beds per capita to that of Britain and demonstrably ahead to that of America.

Unfortunately this flowering of therapeutic care in the asylum in Malaya deteriorated from the beginnings of the twentieth century in common with many other countries at that time due in part to an enormous rise in admissions. Additionally whereas admissions had previously been acute in nature, thereby allowing a high discharge rate, the socio-economic circumstances of the period altered, with chronic cases now representing the majority of internees. For instance, at the Sepoy Lines asylum 20% of all admissions were suffering from the dreaded neurosyphilis. This was thought to be due to an over-representation of males to females, mostly as a result of peripatetic immigrant labour of single males. Furthermore by 1906 alcoholic psychosis was beginning to replace illnesses caused by opium consumption (Jin Inn Teoh, 1971).

Prior to World War II three further psychiatric institutions were built following the example of the Central Mental Hospital in Perak. In 1933 the State of Johore established a lunatic asylum and in 1935 a psychiatric hospital to absorb the overspill of admission. In Sabah and Sarawak two further hospitals were built in the 1920s (Eng-Seong Tan and Wagner, 1971). The advances made prior to the war were

catastrophically reversed with the invasion of the country by Japan, the retreat of the allied forces, the consequent privations, looting and anarchy. Such a complete breakdown of order did not bode well for the care of asylum internees and indeed it was been estimated that 3,800 patients alone died at Tanjong Rambutan, Ipoh caused by abandonment, starvation and gross neglect (Tai-Kwang Woon, 1971).

Following the war the asylums were once more inundated with patients overwhelming the disproportionately small staff numbers. In contrast with the dedicated improvement which had taken place in the past, conditions in, for instance, the Central Mental Hospital, Perak were rife with incompetence and malpractice. These abuses lead to a Royal Commission of Inquiry in 1957 which revealed various forms of malpractice taking place in the rigid hierarchy of asylum care. The culmination of these inquiries led to further investigations and recommendations for improvements by the World Health Organisation in 1960 (Deva, 1992).

MODERN PSYCHIATRIC SERVICES

Since Independence in 1957, apart from the four government-run hospitals, Hospital Bahagia (Perak), Hospital Permai Tampoi (Johore), Bukit Padang (Sabah) and Hospital Sentosa (Kuching) there has been in the latter years a move away from large, centralised asylum care towards community-based care. Currently government funding of health services accounts for on average 5.5% of the overall budget with approximately only 3.9% of the Ministry of Health's budget allocated for the running of psychiatric hospitals. A further 1.5% is put aside for the running of psychiatric services in general and district hospitals (WHO, 1991; Tan and Lipton, 1988).

Decentralisation has resulted in the development of small psychiatric units in general hospitals with the first opening in Penang in 1985 and which now number in the region of 17. In addition there are now over 80 community-based psychiatric clinics spread unevenly over the country. The progress of decentralisation can be demonstrated in the decline of beds for psychiatric patients: in 1983 there were 3.85 beds per 10,000 population in Malaysia and by 1990, 2.26 per 10,000. Additionally there has been a decline in the number of days that hospital beds are occupied with a far more rapid turnover achieved in the last few years. Bed occupation has fallen from a stay of 16 months per individual patient in the late 1970s to a current average of between 7-30 days. This said, many long-stay patients are obliged to take up hospital beds in the event of there being no other form of suitable accommodation to meet their needs in the community for whatever reason. A WHO report in 1988 stated then that 60% of beds were occupied by patients for more than 1 year, although length of stay of recently admitted patients had started to fall to an average stay of 3 months. The following table provides further details of the number of outpatients seen in the recent past at the four psychiatric hospitals.

Hospital	1995	1996	1997	1998
Hospital Bahagia	21168	20182	19536	16682
Hosp. Permai	4580	4982	5271	5687
Sabah	11225	11092	11640	10933
Sarawak	20651	21212	19802	22287
Total	57624	57468	56249	55589

There continues to be a serious shortage of psychiatrists in Malaysia, whereby although the World Health Organisation (WHO) states that there should be a ratio of 1:100,000. The exact number of psychiatrists is in dispute with figures ranging from about 43 (Rostrom and Lee, 1996) to 103, according to the Malaysian Psychiatric Association. What is known however, is that in Sarawak for instance, the ratio is

closer to 1:270,000 with less than half of these psychiatrists in government-run practice. Furthermore on the Peninsula psychiatrists are very unevenly spread and are largely concentrated in the Kuala Lumpur Klang Valley area. The Malaysian Psychiatric Association regards increased recruitment of psychiatrists to be problematic due to the perception that there is little future in the specialism beyond Government postings. The Government has attempted to increase the number of psychiatrists in the government sector however this has not been very successful. In 1990 there were only 15 superscale posts for psychiatrists, of which only 4 were filled. In 1996 there was an increase of 31 superscales posts made available, of which only 28 were filled. Unfortunately the move towards corporatisation of health services does not include psychiatric institutions which will remain government-run bodies with the associated concerns that the psychiatric services may be stigmatised within the medical professions and will in turn affect the recruitment of personnel in addition to fears of deteriorating services and quality of care. Additionally the number of supporting health professionals is correspondingly low, whereby although there are over 800 nurses working in psychiatric facilities, only 150 are trained psychiatric nurses. Here again, the non-corporatised status of many psychiatric resources threatens to create static conditions in terms of the mobility of staff to transfer to other posts as well as reduce incentive to gain further qualifications in their specialism in relation to career advancement and remuneration. In addition such a scenario will militate against increasing the numbers of allied professionals such as suitably trained occupational therapists and social workers, of which there are already seriously inadequate numbers.

Finally, there has been a significant increase in the number of day-care centres for psychosocial rehabilitation, of which half are run by non-government organisations (NGOs). Yet although this has been an important addition to existing services, most organisations are badly affected by under-funding and this has jeopardised the planning of services as well as the necessary stability for the improvement and maintenance of existing programmes compounded by the perennial problem of staff recruitment. Many valuable opportunities therefore have failed to be implemented or have not been able to reach fruition to the detriment of service users. The move towards decentralisation may be seen to be a good one, yet the care provided for people with mental health problems continues to be poor, constrained by financial concerns, recruitment problems and hampered by orthodox views of psychiatric patients and their needs, as will be discussed later in the chapter.

LEGISLATION AND CONSUMER SAFEGUARDS

Legislation relating to mental health in Malaysia is an area urgently in need of updating and amendment. Currently the three applicable items of legislation are as follows: The Mental Health Disorder Ordinance (1956), the Mental Health Ordinance Sarawak (1961) and the Lunatic Ordinance of Sabah (1953). Supplementing these antiquated laws is the Care Centres Act (1993), which attempts to address the issue of the setting-up, registration and supervision of 'care centres', a wide and loosely defined term covering non-government facilities offering day or residential care. This piece of legislation has only just been enforced in Sarawak and the Care Centres Act (1993) therefore provides an important stepping-stone towards regulating standards in

residential care, which previously were not safeguarded under any legislative framework at all.

The three mental health Acts referred to above will, it is hoped, soon be combined under the new Mental Health Act, which has been eagerly awaited for several years but has yet to be passed by Parliament. Although at the time of writing it remains unclear what this new Act will cover, we are led to understand that it will be based in part on similar legislation internationally. Whilst it seems most unlikely that the new Act will offer a radical reformulation of existing laws, there is hope that consumer rights will be more adequately addressed. Unfortunately the lack of consultation with interested parties has been of great concern. What consultation has taken place with the psychiatric profession has been very limited in nature and does not bode well for far-reaching consideration and participation by the general public. The conclusion to be drawn is that mental health issues continue to be regarded as specifically a medical problem and not one relating to the broader area of psychosocial triggers within society. This is somewhat contradictory since counselling, both formal and informal, has grown enormously in popularity in this region and yet somehow appears to remain divorced from the fundamental issues of mental health needs and consumer rights (Ashencaen Crabtree and Chong, 1999).

Although at the moment merely a subject of speculation, it is to be hoped that the new Mental Health Act will attend to some of the outstanding issues which the current legislation has failed to address. First of all, it should be of concern to professionals and the public alike that procedures leading to compulsory admission to hospital are unstandardised throughout the country. Such a situation is liable to lead to the

transgression of service-users' rights due to legislative discrepancies existing in certain States. In Sarawak it is not unknown for families to have successfully argued for and obtained certification of individuals as a temporary admission against the will of the patient *and* the medical opinion of the doctor in charge. Furthermore this infringement of rights may be further compounded by the lack of adequate monitoring by staff of the maximum time-frame allowed for temporary admissions. These problems form a compelling argument for the recruitment of more psychiatric social workers in Malaysia who could be invested with the power to assist psychiatric personnel in the gate-keeping of access to services in order to avoid inappropriate use of resources as takes place overseas. Unfortunately the invaluable role social workers play in relation to tackling family dynamics leading to irregular admissions, as well as assisting staff to observe patients' rights is severely under-utilised.

DISCRIMINATION

It is so much of a truism that people with mental illnesses suffer from discrimination that the implications and consequences of such prejudice are rarely calculated in terms of social costs. Discrimination as a term makes an important step in highlighting policies and practices which are prejudicial in content as a result of the stigma associated with mental illness. So ingrained are these attitudes that as the Mental Health Commission in Wellington, New Zealand (1997) argues, the insane can be seen as 'legitimate outcasts' such as criminals may often, but less frequently be thought. The rights of people with mental illnesses are thus regarded as of less consequence than those of 'normal' people and may be transgressed with greater impunity.

For many psychiatric service users in Malaysia, the opportunities to be reintegrated into society are highly problematic. There exists no legislation to prevent discrimination in terms of housing, education, health care and employment rights for these individuals. Supported lodging and employment schemes have attempted to redress this situation in a few cases, but nonetheless the presumption is that these schemes are only for those whose families are unwilling or unable to support them. Additionally, the financial rewards for supported employment are minimal and the status of the work very low. In some unfortunate sense this then becomes a circular argument whereby individuals may therefore prove their inability to return to the status of legitimate citizenship by being locked in a system of supported schemes which are themselves stigmatising (Estroff, 1985).

In terms of health care and welfare provision the current situation is bleak, whereby there are no legislated guarantees to ensure that psychiatric service users may be able to access these resources when in need. Welfare provision is notoriously scant and with unclear criteria which can be interpreted arbitrarily by State welfare departments across the country. To compound this problem, the term 'disability' currently only covers those suffering from physical handicap, blindness, deafness and learning difficulties, and therefore does not adequately address those disabled through severe psychiatric conditions.

Malaysia's move towards increasing privatisation of health services should be viewed with apprehension for those concerned with mental health issues. Psychiatric service users are some of the most impoverished groups within society, with few individuals

able to contribute their labour to the workforce due to prejudice or disability. It is apparent therefore that they will be highly disadvantaged in the financial negotiation for private medical service. Furthermore, mental illness is not covered by medical insurance and this therefore should be seen as an example of overt discrimination on the part of insurance companies towards psychiatric service users and their families.

THE CROSSROADS

A review of the developments that have taken place in mental health services in Malaysia brings us to some important divergences in the vision of what constitutes effective services. It would be naïve to think that there can be a unilateral opinion on an issue which affects so many people. Instead it would be fair to say that historically a dominant perspective has shaped mental health services, relegating other perspectives to, at best, marginal discourses. To reiterate, despite the efforts made, one such area, lies in the uneven distribution of services and psychiatric personnel across the country. It is to be hoped that this is but one facet of overall development, which increasing progress will address. This said, it is to be feared that the move towards privatised care may seriously compromise quality of care in the comparatively low-status psychiatric services within the competitive market economy. Should this scenario occur the right to treatment will eclipse the further and equal right, being that of refusal of treatment. The right to refusal can emphasise the benefits of alternative forms of treatment, such as, psychotherapy, alternative medicine, social work crisis intervention strategies, all of which may be seen to be more appropriate and less intrusive for certain individuals than conventional admission and medication. Too often, orthodox medicine takes a polarised stance in relation to other effective methods of management, yet this creates an unnecessary, divisive dichotomy, which is

frequently not in the best interests of psychiatric service users. A 'seamless', multidisciplinary approach between psychiatric professionals, public health staff, health visitors and welfare services, would enable more rapid intervention at an earlier stage in the lives of individuals and their families. This would of course require new approaches in services which conventionally operate in a nuclear, independent fashion, yet the advantages in more cooperative, broader, inter-agency work could be enormously beneficial.

Despite many of the advances made in mental health services, paternalism continues to be the dominant ideology which has both shaped and controls contemporary services. Deinstitutionalisation has been a pragmatic move, which has little to do with the social emancipation inherent in, for instance, the democratic psychiatry movement in Italy in the 1960s spearheaded by the subversive psychiatrist Franco Basaglia (Scheper-Hughes and Lovell, 1986). Deinstitutionalisation in Malaysia has not put forward the concept of service-user empowerment but is solely limited to practical movements towards the relocation of services (Rostrom and Lee, 1966). This then represents the fork in the road for service delivery in the new millennium: whether to accommodate the consumer perspective or whether to continue with care which has so far been predominantly custodial and controlling.

Within government-run services, such as the hospital setting, the transformation from passive patient to that of the active service user, will require a willingness to share power which has been held exclusively by psychiatric professionals. Enormous political and professional commitment will be needed in order to address hospital regimes which are regimental and dehumanising in daily practices and routines. This

will also call for a sufficient budget to enable problems to be tackled such as the gross lack of privacy to be found in many psychiatric hospitals, poor food and the imposition of uniforms which clearly demarcate the difference between patients, staff and visitors.

Although it is not difficult to find many examples of demeaning and exclusionary practices within hospital settings, even NGOs have lamentably failed to utilise opportunities to involve service users in the planning of programmes. Control has remained firmly within the paternalistic hands of those who predominantly have no personal experience of psychiatric services themselves and frequently inadequate comprehension of power disparities, social exclusion and discrimination meted out to service users in their daily lives. Until service users are actively invited to share control on committees formed to benefit them and until their voices are actively listened to by programme planners and policy makers, the custodial and the charitable models will remain firmly intact. Unless these critical issues of ideology are openly debated the discourse of self-help and autonomy, strongly promoted in all other areas of marginalised social strata, will continue to be devoid of content or relevance for psychiatric service users.

CONCLUSION

In conclusion, the development of psychiatric services viewed in purely quantitative terms shows that significant strides have been made towards increasing resources in line with achieving fully developed status. It has yet to be seen how corporatisation and privatisation will contribute to realising uniform quality mental health services throughout the country. The indications are that this development may provide an

enormous challenge to overcome for mental health professionals concerned not only to maintain but to improve their services. The shape of service delivery however cannot be viewed only in these terms and here a philosophy of social inclusion for service users represents a critical turning point in how services should be integrated into society. The citizen rights of service users have been severely deprioritised up to the present time, marginalised in society their rights have not been as rigorously observed as they should be and additionally they have been excluded from active participation in the planning of psychiatric services. Yet the vital changes taking place in these services in relation to the needs of the population, demands a critical and urgent reappraisal to include all interested parties including the general public in the debate concerning the changing face of services for the new millennium.

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