

THE CHEMICAL GENERATION: A CRITICAL ANALYSIS OF MEDICAL ‘EXPERT’ DISCOURSE AND THE CONSTRUCTION OF MENTAL ILLNESS

By Katie Ware¹

This dissertation is a critical analysis of medical ‘expert’ discourses about mental illness. I make reference to key texts from the medical establishment as well as critical criminology texts. I take as my criminological starting point, critical criminologist Joe Sim’s argument that medication is used in prisons as a form of control rather than a form of therapy (1990). At the root of this practice is the underlying assumption of medical experts that deviancy can be detected like an illness and treated as such, which would in turn regulate crime. My interest in Sim is due to my argument that the happenings within the Prison Medical System (PMS) are not that different from the happenings in the outside world’s medical establishments. With reference to drugs being used as a form of control within prisons, I explore whether these kinds of findings are pertinent in the surgeries of general practitioners, and whether a similar theory of control applies to the use of medication in individuals, especially children and teenagers, who are perceived to act outwith the social norm.

The first chapter, the methodology section, mainly utilises the theories of French philosopher Michel Foucault, American feminists Hilary Allen, Linda Alcoff and Laura Gray. I use Foucault (1980) to explore the link between truth, power and knowledge in relation to medical expert diagnosis of depression. I acknowledge the ‘Order of Discourse’ to explore the construction of medical discourse through mechanisms of power (in Shapiro, 1984:108). The construction of discourse follows a hegemonic pattern that subjugates counter-hegemonic discourses (subjugated knowledges). In this case, it is essential to conclude whether ‘expert’ discourse remains unquestioned, hegemonic, and the patient’s discourse marginalized. Hilary Allen’s argument about discursive manoeuvres being a strategy deployed by ‘experts’ to challenge and discredit subjugated accounts of an event will be utilised for my analysis of medical expert discourse surrounding mental illness (in Carlen and Worrall, 1987). The methodology section outlines the strategies I deploy to analyse diagnosis and prescription guidelines, and how I examine these medical discourses for their hidden agendas. Alcoff & Gray (1993) are used to examine survivor discourse and strategies deployed by those in

¹ Dissertation submitted in partial fulfilment of the Degree of BA Honours in Criminology and Criminal Justice, Department of Education and Social Science, University of Central Lancashire

powerful positions that silence survivor discourse, or use it as a technique for recuperating hegemonic discourse.

The second chapter consists of a brief history of medical discourse and an examination of the doctor/patient relationship. I examine the argument of Sim (1990) - that prisons use medication as a form of control rather than therapy- and look into the historical context of the Prison Medical System (PMS). This is important for an understanding of how prisons came to use drugs in this manner and the effects this practice has on the general population. Foucault's *Birth of the Clinic* is used to examine the development of the medical clinic and the doctor/patient relationship (1973). I apply the work of Foucault's *Madness and Civilization* to explore how the idea of 'madness' has developed throughout history and is still considered a threat to the social 'norm' today (1989). Relating to this, I draw upon Foucault's theory of normalization and bio-power, along with Rose's theory of governmentality and (state) control.

In the third chapter I explore Sim's (1990) argument that drugs are used as a technology of control in the PMS, and compare this with that made within general practitioner's surgeries. The point of this examination is to determine whether a similar theory of control can be applied to the use of medication in individuals (especially children and teenagers) who are labelled as troubled/troublesome. Within this chapter I question the lack of resistance against 'expert' knowledge, and the use of silencing strategies that render subjugated speech as mad (Foucault, 1980). Furthermore, I provide a discourse analysis of practitioners' guidelines and the diagnosis of depression. Here, I examine various medical texts for this purpose. My aim is to examine dominant discourses surrounding the diagnosis of mental illness and argue that these discourses remain unquestioned and unchallenged. Survivor discourse is also examined, as I explore whether these subjugated discourses reveal useful and important knowledge about the individual experience of taking medication. I also investigate how experience is subjugated through hegemonic 'expert' discourse. For this purpose accounts of individuals who have been prescribed medication and their accounts of this experience are included. I also focus on the use of Ritalin to control the behaviour of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and liken this to Sim's argument that drugs are used in the prison system to control disruptive and difficult to handle inmates (1990).

Method behind the ‘Madness’

This methodology section begins by setting out a view that clearly distinguishes this dissertation from a positivistic concern with evaluating different therapeutic regimes imposed on those individuals labelled troubled/troublesome. My aim is to explore the discursive construction of mental illness, especially depression and ADHD, within a medical diagnosis. Discourse analysis is my tool for this critical examination as the construction of mental illness in medical discourse is the primary concern. Within this analysis, discursive manoeuvres that delete the agency and delegate the responsibility of an event are highlighted. In this case diagnosis guidelines and antidepressant-induced suicide are the focus of concern.

I begin with the master of discourse analysis, French philosopher Michel Foucault, who argues that in every society discourse is regulated and controlled by those in positions of power (in Shapiro, 1984). There is a struggle waged through and between discourses. Discourse, Foucault argues, is ‘the power to be seized’, as those whose discourse is acknowledged are able to gain power through this practice (in Shapiro, 1984:110). The production of discourse is, in every society, controlled through processes of selection, organization and distribution. This entails three ‘procedures of exclusion’. The most familiar exclusion is prohibition, or the forbidden speech. Foucault argues that whether the speaker is heard or not depends on the subject spoken about, the circumstances and the “privileged or exclusive right” of the speaker (Foucault in Shapiro 1984: 110). A pertinent example is the doctor, or psychiatrist having a privileged speaking position and the patient’s speech being marginalized. An attempt to voice disagreement with a medical ‘expert’s’ diagnosis results in further marginalization.

Foucault argues that the second element of exclusion is the division and rejection of speech considered mad as opposed to what is considered ‘reasonable’ (in Shapiro, 1984:110). Non-expert discourse is considered to be less prevalent than that of ‘expert’, and is also considered to hold less currency, value and truth. It is subjugated. Although some attention is given to subjugated knowledges (i.e. the patient), this discourse is controlled by a ‘framework of knowledge’ through which speech is rendered sensible (Foucault, in Shapiro, 1984:111). We can clearly see this division of reason versus madness in the network of institutions that allow a doctor, or psychiatrist, to control the discourse of the patient.

The final exclusion that Foucault identifies is the conflict between true and false. ‘Truth’ is upheld by an arrangement of institutions that conduct the ‘will to know’ and is governed by a system of exclusion, ‘a historical, modifiable, and institutionally constraining system’ (Foucault in Shapiro, 1984: 112). Scientific thought is considered to be the ‘true’ discourse and remains largely unchallenged and unquestioned. The claim to science is reliant upon institutional support, and is reinforced and maintained through a system of practices such as those within the medical field. This will to truth dominates the production of discourse and although it is understood to be the greatest restriction on other discourses, it is the strongest and most powerful form of exclusion

as well as the most accepted. This is the power of scientific hegemony (Foucault in Shapiro 1984).

'Expert' knowledges have been challenged by what Foucault refers to as a 'local character of criticism' (not reliant on the consent of hegemonic ideology), advanced by 'an insurrection of subjugated knowledges' (Foucault, 1980:81). By subjugated knowledges, Foucault is referring to organic knowledges that have been buried or blocked, as well as knowledges that have been disqualified or considered inadequate - this is extremely relevant as it is the discourse of the patient that is subjugated. The combination of these subjugated knowledges is characterised as genealogy, which is an anti science that acknowledges a 'historical knowledge of struggles' for knowledge to be made useful in a tactical manner in the present (Foucault, 1980: 83). Genealogies are considered to be a struggle against the effects of power produced by scientific discourse. Genealogies are counter-hegemonic, as is this dissertation, and allow subjugated knowledges to take precedence over hegemonic discourses. This provides valuable insight and knowledge of an event or object governed by science (in this case, patient discourse is privileged over medical discourse).

For Foucault (1979) there is a link between discourse, power and knowledge. Knowledge and 'truth' are produced by and in discourse. Although Foucault is referring to discourse on sexuality, it applies equally to any discourse. Those in positions of power dominate and maintain the production of discourse, which in turn produces 'truth' and knowledge. It is essential to note that 'truth' is portrayed in such a manner that it benefits the hegemonic group. It is important, therefore, to assess who does the speaking about a particular subject, what their speaking position and viewpoint is, and more importantly, how the subject is put into discourse. These many forms of power through which discourse is filtered are referred to as 'polymorphous techniques of power', and it is through these techniques that individual behaviour is controlled and penetrated (Foucault, 1979:11). In regards to mental health, it is the doctor/psychiatrist that controls discourse; those that experience the occurrence are subjugated. The knowledge and 'truth' produced with the discourse about the illness are not by those that experience it, but by those that seek to control it.

Foucault's theory has been enormously influential and adapted in a wide range of fields, notably those of particular concern for feminism. Feminist psychologist, Nicola Gavey (1989) argues that counter-hegemonic discourses are subordinated, as are those of feminism, but that resistance can be found in poststructuralism as it challenges the idea that there is an absolute 'truth', as opposed to a scientific claim of ultimate 'truth'. Each individual has a choice to locate themselves in alliance with different discourses and although the claims of science maybe considered to have a privileged place, it is not 'the best or only approach (Gavey, 1989: 462). Poststructuralism is an essential element of my methodology as it is precisely the scientific claim to an ultimate 'truth' about depression and diagnosis that I am challenging and resisting. As with Gavey (1989), it is a fundamental feature of this dissertation to acknowledge that there are many different 'truths' and experiences. Neither can ever be fixed or universal.

As Gavey states, discourse analysis is 'one tool for critical analysis' and as there are many different interpretations of a text it is also a very valuable tool (1989:466). Close attention must be paid to the social context and language of a text, and also its relationship to power structures, the production of subjectivity, the reproduction or challenging of existing power relations. An aim of discourse analysis is to reveal 'discursive patterns of meaning' as well as to highlight contradictions and inconsistencies (Gavey, 1989:467). There are no fixed rules within this method of analysis but attention to detail in language and the wider social picture are essential elements. As I am discursively analysing various scientific and medical texts, Gavey's approach to discourse analysis provides the framework within which I will work.

Feminist Hilary Allen's concern is with how women who have committed serious crimes are transformed into harmless women with the aid of discursive manoeuvres (in Carlen and Worrall, 1987). Her analysis of psychiatric reports reveals that discourse analysis is concerned with more than just the reading of texts. There are hidden agendas that delete both the agency and moral responsibility and shift the focus away from the offender. This strategy is crucial for my discourse analysis of medical and psychology texts regarding the diagnosis of depression and the prescribing of medication. The giving of a medical explanation for child or teenager's behaviour and then prescribing medication implies not only a universal truth but also a universal experience. Furthermore, the implication that the conduct of the child/teenager is abnormal legitimises the actions of the doctor/psychiatrist. An incorrect diagnosis remains unquestioned due to the 'expert' advice. It is of great importance to notice these manoeuvres in the construction of medical discourse and the diagnosis of mental illness.

Finally, I examine the survivor discourse of two individuals who have an adverse reaction to medication and who have experienced homicidal/suicidal thoughts and behaviour. For this analysis of survivor discourse, and the problematic situation of the child's outlet for discourse being to confide in the practitioner, I use theories offered by Alcoff & Gray (1993). This analysis highlights the difficulty for survivor's discourse to be acknowledged and believed due to strategies that marginalize and subjugate the individual's account of events. Furthermore, this section also investigates how those in positions of power recuperate hegemonic discourse by deploying particular strategies. I also take into account Spivak's argument about the danger of a powerful group or individual representing a marginalized and subjugated group or individual (1990). Within this analysis, 'earning the right to criticise' is explored within the problematic context of the medical practitioner claiming knowledge about the experience of taking medication (Spivak, 1990: 62).

Throughout this dissertation I discursively analyse texts concerning medical discourse. The next chapter outlines the development of the doctor-patient relationship and considers the implications that medical power has on those who are subjected to it. I take into account theories regarding governmentality and the impact that processes of normalization have on individual conduct. As Rosenberg argues, the construction of

mental illness has changed overtime (in Busfield, 2001). However, the individual's speech is still subjugated and dominated by those considered 'experts'. I explore the development of the medical clinic, and how medical power developed in prisons first as a form of therapy and then became entangled into a form of control over inmates. Here, work of a Foucauldian nature is paramount, and I use these theories to argue that the foremost concern of any institution, including the medical profession, is discipline and control.

Don't Get Mad, Be Reasonable - A Brief History of Medical Discourse and the Doctor-Patient Relationship

The place of medicine in Western culture is one of dominance (Sim, 1990). The 'experts' who administer medicine literally have our physical and mental health in their hands. There is a tendency to rely on their 'expert' knowledge to guide the individual to a route of 'normality' and well-being. Therefore, it is the 'experts' of positivism that dominate individual perceptions of a 'normal' state, and how 'normal' conduct should be. How the dominance of positivistic insight arose and gained a fundamental hold over Western culture is explored in this chapter. I take a Foucauldian stance when I incorporate the changing construction of 'madness' within this analysis. The underlying aim of institutions to discipline and control the individual is highlighted as being the fabrication of positivism's structure. The use of drugs to normalize the individual taking a position of control rather than a therapeutic purpose is a main focus of concern, as is the role of the doctor subjugating the discourse of the patient.

Considering recent medical discourse, sociologist Joan Busfield (2001) draws on Foucault's work about 'reason' and 'madness' when considering that mental illness can be perceived as a social construct. Although ambiguous, this terminology can mean that a mental disorder is simply a social category or, because mental illness is only a category, it has no objective reality. Indeed, Busfield (2001) cites Rosenberg to argue that the very definition of a mental illness is problematic, as the way we think about and understand mental illness varies over time. However, giving a physical explanation to mental illness is attractive to the medical field as it means that a simple answer can be provided, such as a chemical imbalance in the brain, and can then be treated with medicine's drugs. This implies that the use of drugs is an easy, quick fix solution. Due to the advancement of positivism over the years, sociological factors are increasingly marginalized when understanding mental illness (Busfield, 2001). Focus is purely on the physical body, and treatment of the body, which is often obtained with the use of drugs.

Critical criminologist, Joe Sim (1990), argues that medicine holds a significant place in our culture. It bears a position that is cardinal and represents the victory of science over superstition. As Foucault argues, 'It was in the name of medicine both that people came to inspect the layout of houses, and, equally, that they classified individuals as insane, criminal, or sick' (1980:62). Where psychological and physical healings were once subject to methods of guesswork, scientific treatment now contains aspects of accuracy

and certainty. Sim's analysis concerning the development of the prison medical service (PMS) over the past two hundred years challenges the notion of medical care as a 'journey from barbarism to enlightenment' and reveals the attempt of science to create a well adjusted individual from the criminal (1990:x). Within this creation, 'the will to discipline' has had an extensive impact on the amount of medical care inmates have been subjected to from the end of the 18th Century (Sim, 1990:x).

It is clear that Sim's argument is based on the use of medical power in prisons as a form of control rather than therapy (1990). He draws heavily on Foucault when analysing the processes of discipline, surveillance, individualization and normalization within the prison system. Medical discourse, being part of a disciplinary strategy, constructs members of the medical profession as 'experts' whose task it is to readjust criminals back to 'normality'. As it is the appointed physician who is allowed to prepare and administer medication for the inmates, it is this individual only that has total control over the medical treatment (Foucault, 1977). The central objective of the prison medical personnel is the normalization of the individual criminal, which entails categorization through observation (Sim, 1990). This method has not only contributed to doctors gaining a higher professional status, but has also maintained individualized conceptions of criminality as well as cementing the belief that crime itself is a characteristic associated with the working and lower classes (Sim, 1990). However, medical personnel are no closer to discovering the roots of criminality than they were in the 18th Century, which questions the efficacy of medical power when confronting social and penal problems.

Foucault's distinctive perspective on medical discourse inspires much critical work on the subject. Cousins and Hussain (1984) elaborate on Foucault's argument that internment has always entailed a ritual of purification and is also associated with fear. The 17th Century houses of confinement were important for two reasons: they established a distinguishable regime of internment and also saw internment becoming a strategy of power used to deal with destitution and social disorder. McDonnell states that Foucault's work regarding 'madness' implies that 'institutional practices have a primacy over forms of knowledge' (1986:90). The combining of 'madness' and internment in the 17th Century are fundamental to the genealogy of the asylums of today, as the internment that took place in the Classical Age established the structure of the asylum (Cousins & Hussain, 1984). This then developed the specific institutional environment that made the emergence of psychiatry possible.

Before the emergence of the 'Classical Age', there was no distinction between 'reason' and 'unreason' or 'madness' itself. For Foucault, the Enlightenment represents a historical watershed where differences between 'madness', 'reason' and 'unreason' were distinguished. The notion of 'reason' began to dominate human experience (Smart, 2002). 'Madness' was considered a variety of 'unreason', which had to be eliminated before 'reason' could be accomplished (Cousins & Hussain, 1984). Anyone considered 'waylaid by some form of unreason' would be confined (McDonnell, 1986:85). During this period, the 'Age of Reason', there was also a distinction between human and non-human. The individual following the path of 'reason' was considered

human, where as an individual taking an alternative, 'unreasonable' path, was not fully human (Cousins & Hussain, 1984:123).

The 17th Century signifies a moment when 'madness' was perceived as a problem of the city. The problem of not being able to work and not being part of a group were seen to be a cause and reason of poverty. Factors that determined 'madness' were linked to labour, which also had a great impact on the course of 'madness' itself. Where the Renaissance period saw those considered mad to be allowed their freedom, less than half a century later 'madness' had been segregated, 'bound to Reason, to the rules of morality and to their monotonous nights' (Foucault, 1989:64). However, although there was much analysis of 'madness' in the 17th and 18th centuries, medical therapy held a subsidiary position in relation to internment (Cousins & Hussain, 1984). Until the end of the 18th Century, the Age of Reason confined the debauched, blasphemers and anyone considered corrupt. Foucault (1989) argues that medical history holds a significant importance in incarcerating the sick, the criminal, and the insane away from the rest of a society.

In the 18th Century, the dangerous madmen were subject to a system that aimed to reduce 'raging frenzies' by restraining the confined chained to walls or keeping them on leashes (Foucault, 1989:71). The mad were not considered to be sick as they did not fit the image of 'whatever might be fragile, precarious, or sickly in man' (Foucault, 1989:74). They were looked upon as strange, crazed animals and violent outbursts were considered a threat to society that needed to be controlled. Because of madness' characterization as demonic, or pure 'animal ferocity', it could only be dealt with brutality and discipline (Foucault, 1989: 75). During this period, the insane were also used for entertainment purposes where they would be displayed behind barred caged windows trained to perform acrobatics and dancing. In the early 19th Century madmen would often play the roles of actors and would be the focus of attention to the public (Foucault, 1989).

With the emergence of psychiatry in the 19th Century there developed the idea that madness was 'a disease of the mind' which differed from previous perceptions of the 17th and 18th Centuries where there was no separation between the mind and the body. (Cousins & Hussain, 1984: 125). From the 19th Century through to the 20th Century reform through intervention, discipline and regulation were the main concerns within the prison medical system (Sim, 1990). The fear of the medical profession in the 20th Century was that unless crime was controlled, social order itself was in danger (Sim, 1990). Therapeutic intervention was considered the solution and was based on medical and psychiatric explanations of human conduct. After the Second World War psychiatry was further encouraged and scientific methods for predicting and measuring behaviour increased. Doctors and other medical professionals were increasingly gaining responsibility and respect. Positivist views within criminology were gradually being reinforced.

By the late 1950's the medical profession had access to various psychotropic drugs to 'improve' behaviour in inmates. Doctors believed crime to be a result of underdevelopment, inability to adapt to society and personality defects. Difficult to

handle inmates were dealt with by the use of drugs and by the early 1960's the use of drugs in prisons had dramatically increased (Sim, 1990). The boundaries between treatment and control became increasingly obscured, and the role of the doctor gained even more dominance. Sim (1990) cites Steven Box when arguing that rather than being concerned with the control of serious crime, sentencing policies were/are adapted to instilling discipline into people who do not respond to the softer discipline of work. For Sim (1990) prisons are understood in the context of individualization, discipline and normalization. Control, security and order have triumphed over rehabilitation and reform approaches.

According to Foucault, the main aim of any institution, whether prisons, hospitals or schools, is discipline and control. Discipline is maintained with rules and regulations that function to train people in such a manner that they become useful, docile individuals (Foucault, 1977). Discipline is considered to be a fundamental aspect to a society as, 'discipline 'makes' individuals; it is the specific technique of a power that regards individuals both as objects and instruments of its exercise' (Foucault, 1977:170). The failure of these disciplinary strategies results in control coming into force. A brilliant example of control can be seen in Sim's argument that drugs are little more than a control mechanism used to manage difficult to handle inmates (1990). The success of disciplinary power in a society is reliant on the use of 'hierarchical observations' and 'normalizing judgement' (Foucault, 1977:170&177). The combination of these two strategies is referred to as the 'the examination' (Foucault, 1977:184).

'Hierarchical observations' are combined with technologies, such as the telescope, lens and light beam (medical photography), and produce 'a new knowledge of man' (Foucault, 1977:171). Architecture and the 'organization of space' are a focus of this analysis (O Farrell, 2005: 103). The 'observatories' ideal model is likened to the military camp where the layout allows power to function through observation (Foucault, 1977). Similarly, the layout of beds within the hospital allows the most control possible over the patient. The doctor is able to observe and treat the patient as efficiently as possible. Porter and Jones (1994) draw on Jewson's work when analysing the doctor-patient relationship within the hospital. They argue that the examined patient is in the position to give symptoms, therefore dictating their illness. This resulted in symptom-based medicine. The doctor's dominant role meant that 'pathological lesions' were only understandable to the patient through medical interpretation (Jones & Porter 1994:19). Because of this, the next two centuries saw an increase in the relationship where the doctor dominated the patient. Thus, for Jones and Porter the birth of pathological medicine was a 'creation' rather than a 'discovery' (1994:19).

The relationship between the doctor and patient is significant in Foucault's work on medical discourse. His argument is that observation of the patient leads to experience and knowledge (Foucault, 1973). A 'double silence' is referred to where the doctor observes the patient with a silencing of theories and a silencing of any other obstacle that interrupts his observation, such as discourse/experience (Foucault, 1973:132). Only after this silencing can the doctor be equipped with the 'pure gaze' that allows him to gain knowledge. This gaze refrains from intervention and experimental decision. This

method of observation produces power, which in turn produces knowledge and truth. For Foucault, within this observation the discourse of the patient is salient when acquiring knowledge and truth.

Foucault's belief that subjugated knowledges are important is well presented in his argument that knowledge (about the experience of being ill) lies with the patient rather than the obstacle of clinical theory (Foucault, 1973). It is the patient's discourse that holds importance in assessment; the doctor must be silenced (it is not possible for the doctor/student to be too familiar with observation as repetition produces an increase in knowledge and truth). Intervention is not considered by Foucault to be insignificant but the most significant aspect of the doctor's role is observation – the 'gaze'. As the clinic is considered a construction of the 'gaze' and mutual questions, Foucault (1973) argues that medicine can only advance if the necessity of these methods are realised and deployed.

In relation to observation, 'normalizing judgement' is also highly significant in medical discourse and disciplinary power. Within any institution, whether it is a school, hospital or workplace, the individual is subject to a disciplinary system that functions as 'a small penal mechanism' (Foucault, 1977: 177). Punishment is deployed on those who depart from what is perceived as 'correct' behaviour. By not conforming, the individual can expect to be punished by a programme fixed by regulation. This implies that the fundamental aspect of disciplinary punishment is correction. The disciplines preserve the power of the 'norm' that is established in the organization of education, the medical system and the prison system.

Normalization is considered to be one of the great instruments of power (Foucault, 1977). Judges prescribing normalization take the form of psychiatrists, educators, social workers and psychologists (Smart in Garland & Young, 1992). These authoritative figures of the human sciences perceive the social world as 'a potentially rational order' that can be made whole through 'instrumental-rational conceptions of knowledge and social engineering techniques of intervention' (Smart in Garland, 1992:74). Here, we can clearly see how Foucault's theory about 'reason' and 'unreason' can be applied to the construction of the perceived 'norm' within a positivistic understanding.

Within the disciplinary system, the 'examination' makes each individual a case, where they are judged, measured, and compared with others (Foucault, 1977). They can also be subjected to training, correction, classification and exclusion. Individualizing the excluded has been common practice since the 19th Century leper, the 'symbolic inhabitant' of exclusion (Foucault, 1977:199). Exercising authorities exclude individuals according to a 'binary division and branding - mad/sane; dangerous/harmless; normal/abnormal' (Foucault, 1977:199). The division is one of the techniques used in institutional environments (such as schools, prisons and hospitals) that measure, supervise and correct the 'abnormal' individual. This analysis of exclusion ties in with theories of governmentality, which I will now turn to with reference to techniques of 'action at a distance' and 'circuits of exclusion' (Rose, 2000:323&330).

Rose (2000) argues that Foucault's analysis of governmentality has provided beneficial problematizations. His analysis focuses on the rise of programmes that monitor the conduct of people, and their self-government that directs their conduct to a particular means. This analysis problematizes the power of those authorities that address social problems. It also questions the dependence on professionals such as social workers, doctors, lawyers and other 'experts' to explain and theorise problems of conduct (Rose, 2000). In the 19th Century it was commonplace for expertise in the conduct of conduct to provide solutions to social problems (Rose in Barry, Osborne and Rose, 1993). However, in the late 19th Century and early 20th Century, this approach to governing was perceived to have failed. Instead a new formula, the 'State of welfare' was founded which saw the power of the expert extended throughout society (Rose in Barry et al, 1993: 283). Rather than being governed by social experts, individuals were now governed through society.

In the last 50 years, a new change has developed, referred to as 'advanced liberalism', which governs through the rational choices of the individual rather than through society (Rose in Barry et al, 1993: 283). Here, social experts do not directly govern individuals but are enmeshed in an apparatus of health services that have the welfare of the individual and the whole of the social body as a main area of concern. It is essential that government respects individual autonomy, but at the same time still produces 'desirable objectives' (Rose in Barry et al, 1993: 288). This form of government is dependent upon the relation between social experts and the individual subject. The demands of the expert must be consistent with the individual's own goals for self-government and life enhancement. This relation between autonomy and government is a built in and central part of what we know to be freedom. Because of this it is significant to understand the practice of governmentality and how the invisible goals of government shape our daily lives (Rose in Barry et al, 1993).

The practice of governmentality takes many forms: schools, hospitals, prisons and even the street. Governing through these institutions is referred to as 'action at a distance' and implies that the state is not the sole governing force (Rose, 2000:323). This contemporary form of governing aims to shape individual conduct in such a manner that civility and good health are produced. Relating to Rose's 'action at a distance' theory, Barabara Cruikshank argues that we underestimate how much we govern ourselves (in Barry, Osborne & Rose, 1996). Rather than governance being something that is enforced upon us by those in positions of power, we actually act upon our own subjectivity. Within self-governance, the concept of self-esteem plays a significant role (Cruikshank in Barry et al, 1996). Self-esteem is considered to be something that is owed to a society, due its ability to overcome social problems, rather than being a goal for the individual. By governing the self with the concept of self-esteem the individual lives responsibly, they protect themselves from the social ills of violence and crime. A particular kind of the self is produced with this 'practical and productive technology' that entails knowledge of conduct through calculations, measurements, evaluations and discipline (Cruikshank in Barry et al, 1996: 233).

An individual with self-esteem has very little need for the intervention of doctors and police. Instead the individual builds a relationship between themselves and the 'experts'

of power. By doing this, Cruikshank argues that the individual will 'exercise power upon themselves' (in Barry et al, 1996: 234). Rose (2000) argues that these individuals are included in society. Those who have no self-esteem are considered as flawed. They characterise anti-social behaviour, are outcast from the rest of society, and give cause for intervention in the name of public protection. Rose (2000) argues that although these particular individuals are excluded, there are some strategies deployed that aim to re-include the excluded through training and programmes that re-familiarize the individual to the desired life style. However, these strategies do not eliminate public fear of and stigma of the excluded.

The mentally ill, the pauper, the criminal and the unemployed are perceived as a threat to society and constitute a great social problem (Rose, 2000). Here, the expertise of social scientists is called upon. Social workers, health care professionals and other experts whose objective is the overall welfare of the public have a 'tutelary power' placed in their hands (Cruikshank in Barry et al, 1996: 234). With the aim of producing 'citizens to act as their own masters', society's professionals work to construct the ideal 'happy, active and participatory democratic' individual (Cruikshank in Barry et al, 1996: 247). With this construction of the ideal, responsible and productive citizen in mind strategies of risk management have come into force.

Risk management in penology is concerned with classifying, identifying, and managing 'dangerous' groups (Rose, 2000). The aim is to regulate deviance. Those who cannot be managed are sent to prison. The risk management thesis is defined with the shift toward areas such as psychiatry and has become central in managing the excluded with strategies of control. Professionals who are a part of this strategy include the police, social workers, doctors, educators and psychiatrists (the aforementioned judges of the 'norm'). All these professionals work with risk management in mind – they classify the individual in relation to how dangerous they are (Rose, 2000). To elaborate on this point I now turn to the work of Criminologists, Feeley & Simon (in Nelken, 1994).

Feeley & Simon note a 'paradigm shift' within the criminal justice process (in Nelken, 1994: 173). Where the old penology expressed a concern for the individual with attention to holding the guilty accountable through the concept of responsibility, the new penology is more concerned with the 'identification and classification of groups assorted by levels of dangerousness' (Feeley & Simon in Nelken, 1994: 173). This new penology is considered 'actuarial justice', and aims to regulate groups in order to manage danger. Here, there is no intervention in the lives of the individual, but rather a monitoring of dangerous groups is considered necessary. Actuarial justice is considered to be part of the movement towards 'the exercise of state power as governmentality' (Feeley & Simon in Nelken, 1994: 177). Individuals are perceived to belong to sub-populations that are divided with the use of a categorical basis. Focus is on the *likelihood* of offending with risk management in mind and entails an aspect of preventing future offences. This prevention can be found in the three main elements of actuarial justice: incapacitation, preventative detention and drug courier profiles. It is the latter element that I am most interested in.

In 1974, the Federal Drug Enforcement Agency (FDEA) developed a list of behavioural traits, that when combined are believed to distinguish a drug carrier from other air travellers (Feeley & Simon in Nelken, 1994). This positivistic assessment is clearly discriminatory and is based on stereotyping. The fact that these profiles are used to justify further surveillance on an individual, as well as detentions and interrogations, implies an infringement on human rights. Although drug courier profiles are accepted in court proceedings in a manner of actuarial prediction, data and methods that support their use are limited. Drug use, type of drug and frequency of use are all factors that are used to assess risk and determine a level of dangerousness. Although Feeley and Simon do not identify the type of drugs they are referring to, I imagine an offender who has a history of taking any drugs, including prescription medication, would be perceived as an unstable individual whose discourse would be considered unreliable, resulting in further discriminatory marginalization and subjugation.

An obvious method utilised for classifying and identifying particular groups is statistics. With reference to Bio-politics, Smart argues that statistics reveal the 'norm' of the population (in Garland & Young, 1992). Management of the population in dimensions such as birth/death rates, age and health categories, run parallel with the development and maintenance of the social body. As Donzelot (1979) argues, statistics play a major role in contemporary governmentality as they shape the behaviour of the individual to fit in with the 'norm' through re-grouping, classifying and categorizing. It is only when a civil disobedience or contradiction against the state takes place that the practice of monitoring comes into view and the examination of records takes place. The individual must comply with the demands of the 'expert' for his freedom and autonomy to be maintained (Donzelot, 1979).

An interesting development that comes out of the literature on governmentality and actuarial justice is the idea that discipline has given way to control, in which expert knowledges are used less to diagnose but more to calculate. Furthermore, sites of confinement have given way to flexible and immanent practices of behavioural management. Deleuze (1995) draws on Foucault to argue that disciplinary societies operate within sites of confinement. The individual moves from one site of confinement to another. An example of this is the movement from the family to school, then from school to the factory, and maybe even prison. Each and every one of these sites has an organized time structure and everything has a place. However, there has been a 'rapid advance' since the Second World War, where we are experiencing a shift away from disciplinary societies, towards control societies (Deleuze, 1995: 178). Sites of confinement are breaking down, and although there have been many reforms, this has been to no avail – institutions such as the school, hospital and prison continue to decline. This disciplinary society sees the individual move from one institution to another, where as in a control society such movement is never completed. It is constantly changing. There are control mechanisms 'that can fix the position of any element at any given time' (Deleuze, 1995: 181). These mechanisms are already taking place and are not anything new; they are flexible and immanent. The prison system use electronic tagging, school entails continuous assessment and most relevant to this dissertation, the hospital system entails,

‘the new medicine ‘without doctors or patients’ that identifies potential cases and subjects at risk and is nothing to do with any progress toward individualizing treatment...but is the substitution for individual or numbered bodies of coded ‘dividual’ matter to be controlled.’

(Deleuze, 1995: 182)

To me, this quote perfectly sums up my argument of drugs being used as a control mechanism, not only in the prison system, but also in society in general.

Throughout this chapter, I have argued that the main concern functioning throughout any institution is discipline, failing this, control. Strategies are deployed that aim to produce productive and docile bodies. Those who do not comply with the designated ‘norms’ of a society are subject to training and correction. This correction often includes the administration of drugs so that the individual’s conduct can be moulded to fit in with a desired life style. Deleuze (1995) makes an informative point that rather than control happening intrusively and within an institution, it happens regardless of where the individual is; it is built in. This theory can be applied to medical drug use, as no matter where the individual is their behaviour and conduct is, to some extent, being controlled. As Sim (1990) demonstrates, where drugs were once administered with the pretence of therapy, the notion of control now holds more pertinence. The dominant role of the doctor ensures that the patient’s discourse is subjugated and controlled, ‘expert’ knowledge is considered salient. The next chapter applies these theories to texts from the medical field with the use of discourse analysis.

Trust Me, I’m A Doctor! – A Critique of Medical ‘Expert’ Diagnosis and Prescription Guidelines

Since antidepressant drugs were introduced in the late 1980’s the usage in children has risen dramatically, although no antidepressant is licensed to be administered to children under the age of sixteen (Murray, Vries & Wong, 2004). The ‘black box warning’ issued by the Food and Drug Administration in 2004 expresses a concern about the dangers of taking anti-depressants, especially for children (FDA, 2004). Furthermore, the Committee on Safety of Medicines issued recommendations to withdraw the use of Venlafaxine and all SSRI’s (except for Fluoxetine) in 2003 (Murray et al, 2004). Due to these factors, one could expect the prescribing of antidepressants to decrease, especially in paediatric patients. However, Britain alone sees an average of 13 million antidepressant prescriptions being written out every year (Revill and Doward, 2004). There is also an increase in the prescribing of Ritalin, a drug used to treat ADHD (Atkins, 2000). Within this chapter I analyse an example of the guidelines recommended for the prescribing of antidepressants as well the suggested approach to the patient. The use of these drugs being a quick fix solution is explored and likened to Sim’s (1990) argument that drugs are used in prisons as a form of control rather than for therapeutic purposes.

The main text that I am interested in is Dolan (2003) who is an Associate Clinical Professor of Psychiatry and also teaches pharmacology. He claims that his 'unique book' contains 'principles and guidelines that will result in successful, rational and evidence-based prescribing' (Dolan, 2003:xvii). He is immediately giving the impression that his book stands out above any competition due to its uniqueness (implying that it is incomparable) and is also one of the most reliable due to its rationality. Here, it is easy to refer to Barry Smart's aforementioned argument (highlighted on page 20), that those prescribing normalization see the world as a place that is potentially rational and that the 'norm' is a combination of rationality and reason (in Garland & Young, 1992). Dolan then strengthens his argument with the assertion that the prescribing techniques he uses are evidence-based, and therefore implying that they are the most reliable. This immediately gives him an authoritative 'expert' view that should be trusted without contestation.

With regard to prescribing mental health medication, Dolan states that, 'Although the patient may wish they did not need the medication in the first place, prescribing is a relatively simple and straightforward process' (2003:3). Upon reading this sentence, the first thought that came in to my mind was that if prescribing these drugs is such an effortless task, then why the need for a 442 page book in order to do it? However, the next sentence explains it all when the concern is raised that the patient's reluctance to take medication can 'complicate the prescription' (Dolan, 2003:3). Obviously, the main objective of this book is how to turn the patient round to the doctor's way of thinking. This reluctance of the patient can, apparently, include fears that taking medication will change personality, mind and/or behaviour. It must be plainly obvious that taking any kind of mind-altering medication is going to have some effect on the individual's behaviour, mind or personality. The reason why they are being prescribed this medication in the first place is because the individual's behaviour is perceived as not fitting in with the rational 'norm'. Dolan (2003) argues that prescribing medications require certain knowledge and techniques in order to ensure efficiency. Here, there is no mention of the patient's experience or voice, which of course is subjugated but might be highly informative. Instead, there is an emphasis on 'special knowledge' to which one can only assume is a referral to 'expert' knowledge.

Throughout Dolan's guidelines, he helpfully includes 'talking to patients' sections in order to counter the resistance. In one particular section, Dolan suggests approaching the patient by saying:

'I think I know how difficult it must have been to make the decision to see me about medication today...after trying many methods that didn't work, you may have begun to believe that you were lazy or unmotivated...you have been using a lot of energy to get through the day and accomplish tasks that should be routine...'
(Dolan 2003:13)

Apart from the final sentence coming across more as a hypnotherapy technique, the whole one-sided conversation feels patronizing. It also makes me wonder how the

clinician can possibly know exactly how each patient is feeling. Asserting that every patient may feel 'lazy or unmotivated' implies a universal truth, or a fixed experience. However, as Gavey (1989) argues, there are no universal truths or fixed experiences. This point of speaking for the Patient now brings me draw upon American feminist, Linda Alcoff (1991) who regards the problem of speaking for others.

Alcoff (1991) argues that there is an increasing criticism surrounding the practice of speaking for others. This acknowledgement derives from two sources. The first is that one person's 'truth' or experience is not the same as another's. The individual's social location or identity is significant as to whether their speech will hold authority. It is therefore important to acknowledge the speaker's location and those spoken for. In this case, the practitioner is speaking for the patient whose social location and identity are somewhat different. The practitioner is the 'expert' and the patient is subordinated or marginalized. This theory can be related to Foucault's argument about subjugated speech being prohibited in the production of discourse (in Shapiro, 1984). Although the speech of the patient is not prohibited, it is certainly marginalized.

The second source recognizes that the privileged speaking position of the individual can add to the oppressed state of the less privileged group spoken for (Alcoff, 1991). Referring back to the practitioner's discourse, the assertion that those feeling unmotivated or finding daily tasks that should be 'routine' a chore are in need of medication constructs every individual with these traits as mentally ill. Furthermore, by claiming that the practitioner knows how difficult the patient found it to seek medical help implies that he/she has experienced what the patient is experiencing. In reality it is impossible for anyone to know what another person is feeling and to claim such knowledge is inappropriate.

I cannot refer to the problem of speaking on behalf of others without drawing on the work of feminist Professor Gayatri Spivak, whose aim is to dissolve the power of controlled and selected discourse in order to give room for marginalized discourse to be heard and acknowledged. (Art and Culture, 2000). Here, Spivak (1990) highlights the importance of the speaker's position as to whether their speech will be listened to. For Spivak, 'who will listen' is more salient than 'who should speak' (1990: 59). Spivak (1990) argues that the real problem derives from the hegemonic group taking what they wish from an individual's speech and then using the information in any desired manner, generally to portray their knowledge about the subject. With this analysis I argue that having a privileged position means having a position that lacks knowledge. By this I mean that by not having the experience of an unfortunate event locates the individual in a position that is privileged. Within the medical arena, the practitioner has a position that is privileged, but because he is privileged in the sense that he may not take medication (and therefore is not subject to adverse reactions/ side effects) he has no experience of the patient's position. He lacks knowledge in the patient's experience and therefore, is unable to relate to the patient in any way.

Spivak argues that in order to 'earn the right to criticise', the individual must first thoroughly research the area of concern, but it is essential that they critique their own

historical position as the investigator (1990: 62). However, even with this critique, although the investigator may have earned the right to criticise they have not earned the right to represent another individual or group. The danger of representing marginalized or subjugated groups is misrepresenting or homogenizing them (Spivak, 1990). Dolan's approach to the patient and his idea of representing all patients in need of antidepressant medication as 'lazy or unmotivated' merely homogenizes and misrepresents all patients with depression as having this characteristic (2003: 13).

Dolan's response as to whether antidepressants cause suicidal or homicidal thoughts results this is a 'myth' and that, 'Antidepressant medication is *unlikely* to create new suicidal or homicidal ideation' (Dolan, 2003: 13, emphasis added). Here, I draw upon Hilary Allen to argue that this is a classic use of a discursive manoeuvre where Dolan is using a particular discourse to delete the agency that taking antidepressants could cause suicidal/homicidal behaviour (in Carlen and Worrall, 1987). Dolan continues by saying, 'families and friends of these individuals find it difficult to see their relatives "at fault" for this behaviour ... medication becomes an easy scapegoat' (Dolan, 2003:13,14). A brilliant performance of victim blaming! Dolan automatically directs the focus and blame away from medication, and the prescribing practitioner, and onto the individual and their friends/family. He is forcing the victim to share the responsibility. The dangerousness of the situation is eliminated, rendering the practitioner harmless. Interestingly, Dolan contradicts himself when admitting that antidepressants can cause akathisia, 'a very disturbing physical inner restlessness' and that:

'Patients with akathisia have been noted to have a suicide rate above that of the general population. It is possible that the small percentage of patients who do develop akathisia while on medication could be at some increased risk for self-injury'.
(Dolan, 2003:14)

Put in plain English then, there is a chance that taking antidepressant medication can increase suicidal or homicidal thoughts or behaviour.

The dangers of taking antidepressant medication has been expressed in October 2004 by the Food and Drug Administration (FDA) who ordered all antidepressant manufacturers to add a 'black box warning' to the label of their product. The aim of the warning is to make the public aware about the increased risk of suicidal behaviour and thoughts in children and teenagers taking antidepressants (FDA, 2004). A black box warning is the most serious warning that can be applied to prescription medication (McManamy, 2004). This warning cites that children and adolescents taking antidepressant medication have been found to be at an increased risk of suicidal thinking and behaviour (McManamy, 2004). This is alarming considering that children under the age of three are being prescribed anti-depressants (Murray et al, 2004). The decision for the need of such a warning derived from a number of enquiries in 2003 into a paediatric trial that involved the use of the antidepressant, Paxil. During this trial it was revealed that a number of children taking Paxil had shown signs of suicidal

behaviour and the public began to realise that drug companies were consistent in their suppression of negative trials and only reporting positive trials (McManamy, 2004).

As a focus of this dissertation is subjugated knowledges, with a focus on children, I would now like to turn to two accounts of survivor discourse of children. These are accounts of children who have experienced the adverse effect of antidepressant related suicidal/homicidal behaviour. The first account is from a young boy, Corey Baadsgaard, who had been diagnosed with social anxiety disorder. He was initially prescribed an antidepressant Paxil and when it had no effect was prescribed Effexor. The dose was eventually increased to 300 milligrams a day (Pringle, 2005). Considering that the Committee on Safety of Medicines (CSM) advised Effexor as one of the drugs unsuitable for individuals under the age of 18, and the maximum dose for adults is 375 milligrams, this administration is alarming (British National Formulary, 2006). Upon taking the increased dose, Corey felt unwell and went to bed. He woke up in a juvenile detention centre with no recollection of what had happened. He later learned that he had taken a high-powered rifle to his school and had taken 23 of his classmates and his teacher hostage (Pringle, 2005).

Jamie Tierney was 14 years old when he was prescribed Effexor for the treatment of migraines (Pringle, 2005). He had no history of depression before taking the drug. However, after taking the medication he reported thinking about suicide and self-harm on a daily basis, felt empty of any emotion apart from rage and felt that he had little control or inhibition. He reports that these feelings stopped once he stopped taking the medication, which implies the possibility that it was the effects of the drug that altered his behaviour so drastically.

The point to make from these survivor accounts does not stem from a positivistic argument that the administered medication caused adverse behaviour, but that subjugated discourses often hold more knowledge about an event/issue than 'expert' discourses. To the 'expert', accounts such as the ones outlined above would be considered trivial and counterproductive because not only do they counteract 'expert' discourse but also, from a statistical point of view, these findings would not be considered significant enough to warrant acknowledgement. Survivor discourse is focused upon by Alcoff & Gray (1993) who argue that although this subjugated discourse can be empowering it can also unintentionally serve to recuperate dominant discourse – it can have a double effect. Survivor speech is generally prohibited, its credibility denied. Those in powerful positions obtain this exclusion through 'silencing strategies', or failing this, 'strategies of recuperation' (Alcoff & Gray, 1993: 264-268).

'Silencing strategies' operate to invalidate the discourse of the survivor and are deployed by those in powerful, hegemonic positions (Alcoff & Gray, 1993). These strategies discredit subjugated speech through 'formation rules' that disqualify the assertion that the dominant party could harm the subordinate (Alcoff & Gray, 1993: 266). I use this analysis to argue that these rules forbid the idea that a medical 'expert' could prescribe harmful medication to an individual, especially a child. These discursive strategies also consider children incapable of giving a credible account of

events and through this children are consistently silenced. After all, who are the majority likely to believe – a medical ‘expert’ or a child diagnosed with a ‘mental disorder’? I draw upon Alcoff & Gray to argue that the idea of a medical ‘expert’ diagnosing incorrectly, or prescribing medication unnecessarily, challenges the ‘positivity’ of dominant discourses that ‘experts’ are rational beings (1993: 267). This results in a resistance to and a silencing of child survivor discourse – their discourse is considered belligerent, it is a threat to dominant discourse. Child survivor discourse is ‘transgressive’ in that it challenges ‘conventional speaking arrangements’; within these arrangements children have no authority (Alcoff & Gray, 1993: 267). Dominant discourse will always strive to silence and discredit child survivor discourse.

If ‘silencing strategies’ do not work in the favour of dominant discourse, Alcoff & Gray argue that ‘strategies of recuperation’ are then deployed in order to channel the discourse to a ‘non-threatening outlet’ (1993: 268). These strategies recuperate hegemonic positions by dis-empowering survivor discourse and categorizing it as mad or hysterical. Due to feminist work providing a space for survivor discourse in journals, magazines and through support groups, hegemonic discourses are increasingly turning to ‘strategies of recuperation’ rather than ‘silencing strategies’. An example of recuperation can be found in Dolan’s (2003) dismissal of anti-depressants being linked to suicidal/homicidal behaviour as a ‘myth’. He immediately gives the impression that even considering the possibility is ridiculous, which discredits any survivor discourse on the subject.

Another point of clarification I would like to make is the unfortunate and troublesome situation of the child’s outlet of discourse. Generally, if an individual has an adverse reaction to medication their first point of call may be to return to the medical ‘expert’ who initially administered the drugs. Alcoff & Gary refer to this kind of situation stating that, ‘The relationship between the expert mediator, or the person to whom one confessed, and the confessor was one of domination and submission’ (1993: 271). Here, the child will be reliant upon the medical ‘expert’ to interpret the behaviour and experience. This further subjugates the child, as it is the ‘expert’ rather than the child who determines the legitimacy of the discourse – the ‘expert’ determines ‘truth’ and credibility. This depicts an unequal power relation where the ‘expert’ channels the discourse to coincide with ‘dominant cultural codes’ (Alcoff & Gray, 1993: 271). This in turn reinforces the privileged position of the ‘expert’ as although they are privileged to not have experienced the unfortunate event, they are still the ones dominating the discourse.

Although the medical ‘expert’ may dominate discourse surrounding mental health (and health in general), the use of drugs to control children’s behaviour is an issue that is facing increased criticism. For example, prescriptions for Ritalin (medication used to treat Attention Deficit Hyperactivity Disorder, ADHD) in England had dramatically increased from 3,500 prescriptions in 1993 to 126,500 in 1998 (Atkins, 2000). Prescriptions for the drug then increased from 215,000 in September 2001, to 384,000 in August 2006 (United Kingdom Parliament, 2006). The increasing use of Ritalin to control children’s behaviour can be seen with these figures; the diagnosis however, is

not definite. Tracy (1999) investigated a concern regarding the use of Ritalin to control children's behaviour and discovered that many 'expert's administering the drug actually rely on the drug's effects to determine the diagnosis of ADHD. If the medication is successful in controlling the disruptive behaviour then ADHD is diagnosed. However, it is argued that anyone taking this drug may have his or her concentration and focus improved which implies that using a drug to determine diagnosis is not an effective and reliable means from which to work from.

Arguments, such as the one outlined above, increase the concern that Ritalin is being used on children as a quick fix solution. This notion of making 'difficult' or 'disruptive' children easier to manage seems to appeal to parents and teachers. An example of this management strategy can be found in an investigation carried out by Los Angeles Times. They discovered that thousands of children in California who were in care had been administered psychiatric drugs, predominantly for the purpose of making the children easier to manage (Pringle, 2005). This type of occurrence can easily be related to Sim's (1990) argument that drugs are increasingly being used as a form of control rather than for therapeutic purposes in prisons. Likewise, children who are perceived disruptive, and whose parents and/or teachers find difficult to handle, are increasingly being prescribed drugs such as Ritalin in order to be controlled more easily. As my introduction argued on page 1, the medical establishment is increasingly deploying this strategy of control and management for use on the general public who do not comply with the established social 'norms'. Referring to Deleuze's argument (on page 19) I would like to point to the accelerated movement towards a control society in which drugs are seen to be an easy quick fix solution to regulate undesirable behaviour. I argue that they are not used to treat the individual, but rather to control or modify behaviour deemed socially unacceptable. Furthermore, to do so 'in situ' and in so doing, they avoid the expense and intrusion that previously characterised the institutions of correction and confinement.

Throughout this chapter, I have highlighted the problematic nature of diagnosis guidelines and the clear negligence of medical 'experts' that taking anti-depressants can result in the adverse reaction of suicidal or homicidal thoughts and/or behaviour. The importance of de-subjugating the discourse of the patient has been made with reference to the problem of speaking for others (Alcoff, 1991). Also strategies deployed by 'experts' of powerful positions to silence patient discourse, or failing this to use the information to recuperate hegemonic discourse, has been investigated (Alcoff & Gray, 1993). Significantly, I have explored whether the argument of Sim (1990), that the PMS use drugs as a technique of control rather than a technique for therapeutic regime, is comparable with the medical practitioner's use of drugs to control disruptive individuals, especially children who are considered troubled/troublesome. The next chapter consists of my overall conclusion reached from this dissertation. I will briefly highlight the key arguments and the relevance of these arguments for my dissertation.

Conclusion

Throughout this dissertation I have critically analysed medical 'expert' discourses about mental illness, as well as the construction of mental illness itself. The work of Sim (1990) has been an essential basis for my dissertation as I have argued that the PMS reflects the practices of the medical profession in general. This, and the use of prescription drugs as a technology of control, has been a thread that has followed throughout this dissertation. The idea of managing a society with guidelines of what is considered the social 'norm' has been problematized and the problematic nature of asserting a universal truth has been revealed.

The works of Michel Foucault, Alcoff, Gray, Gavey and Allen have been a fundamental part of my methodology. Foucault's analysis about the construction of discourse has enabled me to understand how medical discourse is constructed with a hegemonic pattern that subjugates and marginalizes the voice of resistance. It would not have been possible to analyse medical discourse without the knowledge gained by Allen's theory about discursive manoeuvres. This theory has allowed me to recognise a denial of responsibility within a particular expert's acknowledgement of antidepressant induced suicidal/homicidal thoughts or behaviour. Finally, I have used Alcoff and Gray's theory to highlight the importance, and sometimes the danger, of survivor discourse.

The second chapter has revealed the changing construction of mental illness and the development of the doctor-patient relationship. Within this chapter I have also introduced how the formula of governmentality has changed overtime and how this has affected what we perceive as freedom. The distinction between strategies of discipline and control has been investigated, and how control comes into force after the individual fails to adhere to disciplinary rules has been argued. The invisible technologies of governing take particular forms that ensure we have a sense of autonomy while at the same time ensuring that we follow a specific route that is productive to a society as a whole. In this case, we can see how we govern ourselves with the aid and guidance of establishments, such as the medical establishment, and rely on their perspective of what the social norm is. Non-compliance of these social norms results in the application of the deviant label, and strategies of control are applied, which increasingly rely on the use of drugs. With the examined theories, we can see how we are increasingly becoming a society that strives on efficacy, perfection, responsibility and productivity. Individuals who appear to fail at these tasks are singled out as troubled/troublesome.

The third and final chapter has consisted of discourse analysis on a piece of medical discourse. Discursive manoeuvres have been highlighted and prescription guidelines have been problematized. Within this analysis, the danger of antidepressant related suicidal/homicidal thoughts and behaviour have been examined with reference to survivor discourse. Alcoff & Gray's work about survivor discourse, silencing and recuperative strategies have been elaborated on. Finally I have used the example of Ritalin, a drug to control ADHD patients, to argue that there is an increasing trend in

Western medical practice to control disruptive or difficult behaviour with the use of drugs. I have backed my argument using the work of Sim (1990). With this I have made a comparison of the PMS with the medical establishment in the outside world. I have concluded that, like the PMS use drugs to control unwanted behaviour, there is a dramatic increase in the numbers of individuals who are becoming part of the 'chemical generation'. These individuals can be understood to have failed in their compliance to disciplinary strategies, and instead have become subjected to strategies of control.

Overall, the main objective of this dissertation was to explore whether practitioners, parents and guardians are using drugs, such as antidepressants, as a technology of control rather than for therapeutic means. I have found the work of Sim (1990) extremely insightful for this investigation, as the assertion that drugs are being used in the PMS to control inmates is alarming, but the fact that this practice maybe going on in our daily lives is more so believable. Even when resistance does arise silencing strategies, or strategies of recuperation come in to play. I am not proposing that all medical practitioners have this as their motive, but this idea of an efficient and docile but at the same time happy individual is so engrained in our society, especially within 'expert' professions, that they may not even realise their normalizing objectives. As Deleuze argues, we are moving towards a control society in which drugs are perceived as a means to gain further control over the individual. Rather than being concerned with individual treatment we seem to be further and further advancing towards medicating the groups who are causing disruption for the majority. Prisoners, depressed teenagers and hyperactive children are amongst those who have now become part of the 'chemical generation', which is rapidly growing. This group of individuals cannot, or will not, be part of the disciplinary society and are therefore pushed into environments of further control.