The Psychiatric Gaze – Artist's Statement

Who are we?

Alistair, a psychiatric patient with a host of diagnoses ranging from "angst" (honestly, this from a nomadic civil psychiatrist circling Northern BC) to schizo-affective disorder and many, many things between. I do become psychotic under stress, developing very convincing and frightening auditory hallucinations with a fairly strong delusional base. Reality testing gradually fails as the stress (and the sickness) continue. Dana has a long standing eating disorder with body dysmorphia, major anxiety, depression. In her words "Just your basic crazy anorexic."

We think that diagnoses are valuable. If, for example, a patient presents with little bruises all over them, bleeding gums with a couple of loose teeth and jaundice, you can diagnose scurvy and recommend they eat some oranges…The problem is when the patient is defined by their diagnosis: The person is a —uh—Scurvish(?) And that means… A whole host of possibly statistically valid but unfair assumptions and generalizations. These sorts of judgements are a constant babble in the back of most people's minds, but we *must* learn to ignore them.

The Psychiatric Gaze

In feminist film theory we can thank Laura Mulvey for the Male Gaze; the monster born of Lacan's adventures in psychoanalysis. We don't want to debate the relevance of this esoteric concept—let it suffice to mention our concern that it may be too general and introduce our variant.

The Psychiatric Gaze idea developed over years as we noticed a consistent pattern in our interactions with mental health professionals: a feeling that there was a glass wall separating our side of the desk from the clinician. While they could see and hear us somehow they remained detached, they weren't *listening* to us. We were not present for them in any real way. The possibility that we were individuals with intelligence and sensitivity and all the things we like to think are mostly human traits, the fact that we *might be equals* is absolutely out of the question.

The patient starts to feel that the clinician can or will not see them, only another faceless representative of a syndrome, a walking diagnosis—sometimes with a couple of notes… "Drug User" is a very typical example. If psychoactive drug use **not prescribed by a psychiatrist** is anywhere in the file further communication is impossible or pointless; the patient has a drug problem, the rest is irrelevant. On the other hand prescription is often so casual; Dana was prescribed Seroquel and Zopiclone for at least a year. I

spoke with a psychiatrist at my VCH clinic who told me candidly that they consider Seroquel a trivial drug and prescribe it primarily to “Get people out the door.” My experience has suggested this may be accurate.

So we have a double standard, on the one hand, self-medication is always **the** problem, but a drug as dangerous as Seroquel is given out to chemically restrain non-psychotic anorexics and to discourage the sick from trying to get help.

After being prescribed a large overdose of Risperidone for two weeks my psychiatrist at the time was visibly offended that I had stopped taking it after ten days; I asked “Have you ever taken an antipsychotic?” They suggested that my question was ridiculous, and I almost bought it. Then I remembered that they had been telling me that my side-effects were trivial for some time, and designing my drug therapy based on these opinions…I’d like to think that my point is self-evident.

Note that I’m not biased against prescription psychoactives, just how off-handedly they seem to be prescribed; something I think is directly related to this ‘glass wall’ problem. Years ago saw a sex-therapist through VCH; after a few interviews she confided that she had been shocked by the indifference the other doctors at the clinic showed toward the crippling sexual side effects of their prescriptions. She ‘moved on’ shortly after bringing this up at a general meeting.

The sculpture

The central sculpture is a face made of bandages imposed on a generic styrofoam head casting, we wanted to emphasize the sense of wounded illness and depersonalization the patient feels, of being an invalid. Invalidation.

We advance the glass wall concept—it’s not just between the patient and the clinician—it’s around the patient themselves; permanently attached, bolted to them. Hence the cage. We can’t escape these judgements, we can’t get through, no matter the milieu… The large screen with the transparencies is pretty blunt; as is the giant funnel full of psych pills leading to regulator-thing in the mouth, unfortunately we couldn’t find an equally poetic (?) way to clarify our position visually: Psych meds are OK, but they're overly casual prescription underlines the fundamental issue.

R.D. Laing made this point repeatedly, the *presence* of the clinician effects the cure, the mentally ill are almost by definition alienated. We understand that the system is often to blame for this awful distance, after all the average psychiatrist at a hospital only sees a given patient for about ten minutes a week, what *can* we be but things? A friend in the business agreed with me, but explained that there was enormous pressure to detach herself to maintain her own sanity.

Regardless: please try, you can really do a world of good. No matter the terminology you, you are in the business of saving souls. If you can remember you are dealing with someone who could be you or your wife or child you might save your own as well.

Thanks.

Dana Allan and Alistair Scott-Turner