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⁵On July 1, 1996 the Ministry of Radio, Film and Television, the regulatory agency that then oversaw the activities of the Film Bureau and the Film Distribution Corporation, issued a new 64-article system of regulations. In order explicitly to prohibit work outside of the official studio system, the regulations required that no film could be produced, distributed, exhibited locally or abroad, or imported without prior approval at all censorship levels. While vague, the 1996 regulations do outline seven content areas that would be forbidden: anything that endangers the Chinese State, discloses state secrets, libels or slanders others, or promotes pornography, feudal superstition or excessive violence. As if the vagueness of the first six prohibitions were not enough to give the censors free reign, the seventh taboo was listed simply as "other content forbidden by state regulations." Punishment for those filmmakers who violate the regulations include fines ranging between five to ten times any profits gained from illicit productions and the possibility of criminal prosecution.

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THE NAME OF THE ROOM: CHILD PSYCHIATRY AND ECONOMIC RATIONALISM

Michael Plastow

In public child psychiatry in Victoria, Australia, we are currently having to justify to those who fund our services even the most basic requirements for the conditions in which we and our allied health colleagues are able to carry out our clinical work. Currently we are undergoing a process of having our services divided into smaller teams and re-located to small clinics in community settings. While the advantages of this process for better accessibility of our services is evident, this process occurs with insufficient thought and planning as to what constitutes a critical mass for a team that is sustainable. The needs of professional contact with our child psychiatry and other medical and non-medical colleagues have essentially not been considered.

In this context of re-location, it has been put forward that child psychiatrists or clinical staff working in the field of child psychiatry do not need an office or designated space in which to perform their clinical work. From the point of view of the policy makers who determine our funding, it is sufficient to have an office space that is shared with other clinicians and a few designated interview rooms. Part of the rationale used to justify the assertion that we do not require designated offices is the idea

that in fact we should be spending most of our time out in the "community" where the "real" work is, along the lines of some specialized outreach and crisis services.

Thus the logical extrapolation of such policies is that it is sufficient for the clinician to have a car and a mobile phone in order to go to where the patients, or rather, "consumers" are. Furthermore, it implies that all clinicians are the same and work in the same ways, and thus fails to recognize the diversity and specialization in clinical practice. So why do child psychiatrists and other clinicians insist on having not just their own room to work in, but their own designated room, and that the room be a stable and a predictable one?

In many Child and Adolescent Mental Health Services (CAMHS) in this state, clinical staff are already required to share offices and have access to only a limited number of de-personalized interview rooms to see their patients or clients. Such rooms, moreover, may or may not be available at the moment in which the child psychiatrist or other clinical staff wish to use them. In some country centers the CAMHS staff are obliged to share interview rooms with their colleagues from the adult mental health services whose requirements for the clinical encounter are far different from that of the clinician working with children and adolescents. Moreover, the traumatizing effect of the behavior of certain adult mental health patients on these children is not considered.

Additionally, the funding for the re-fitting of premises of the new de-centralized locations has at times been so inadequate as to fail to provide sufficient sound-proofing so that walls, nominally the borders or limits to the structure of a room, have become efficient mechanisms of sound transmission, ensuring the failure to guarantee the privacy of the clinician's work, including that of the clinical encounter. All this in the name of cost cutting, which is now re-named as "enhanced service provision" or "innovative service delivery."

In addition, smaller clinics in community settings are more vulnerable to security problems, as some recent episodes of violence and theft at a small metropolitan CAMHS clinic have shown. This increased threat due to such security problems underlines the fragility of the therapeutic setting.

The changes to our services are occurring in an era of economic rationalism that remains the principal political environment, despite changes of government in many states of Australia in recent times. The methods of economic rationalism, through its language or jargon, have pervaded the manner in which things are spoken about and thought of, including by some clinicians.

However, if we are proposing that the some of the difficulties with which we are currently confronted derive in some way from the economic rationalist approach to the administration and funding of our services, then we need to discern specifically what it is in

that approach that produces this effect. I would put forward here that the *ratio*, or reason, of economic rationalism is that of reducing the issues that are addressed to their purely functional or economic value. In this, what is lost is the symbolic value of what is at stake.

Just as our services and their components are reduced to their economic value, so too are our patients or clients. Indeed, our patients are now referred to as "consumers," stripped of their suffering as they are converted into individual economic units.

If patients are now re-named "service consumers" and the child psychiatrist is a mere "service provider," then surely this service could be delivered just anywhere, and why not "delivered to your door" or even a drive-through service in the McDonald's mode? After all, the primary sense of the verb "to consume" is that of an oral function: *Would you like to consume fries with that?*

This re-naming of patients or clients as "consumers" is a deliberate act in which a term from economics is applied to the clinical setting. A perverse act, which, I am proposing, erodes a symbolic function. I am using this name of "consumer" as an archetypal example of this process, but we easily could produce a glossary of such terms that are currently imposed upon our practice.

In addition to the re-naming of our patients as "consumers," I would also like to consider another type of re-nomination to which we are witness clinically. By

addressing, in clinical practice, the question of the loss or failure of a symbolic function, rooted as it is in language, I intend to emphasize the importance of the symbolic value of the clinician's room in the assessment and treatment of children and adolescents.

Recently I conducted a secondary consultation session with a Child Protection worker who consulted regarding a twelve-year-old boy to whom I shall refer as "Jheysson." I made a comment at the end of the session regarding the frequency with which, in the more disturbed cases with which we deal, such as this one, the child or adolescent involved, as well as other family members, have either names that are made-up, or made-up spellings of accepted names. We find upon taking a history that these names or their spellings, freely adapted or invented, are given on the whim of the parent or parents without any external reference or anchoring to received names or spellings.

To my surprise, the protective worker told me that it is a type of standing joke in the child protection service in which she works, that a made-up name or spelling is an essential criterion for the child protection service to accept involvement in a case. The fact that this is labeled as a "joke" indicates that it is a type of knowledge that is not seriously recognized as such.

In "The History of the Psychoanalytic Movement," Freud speaks of how he came upon the knowledge of the sexual etiology of the neuroses in such a manner. Three of his teachers, Breuer,

Charcot and Chrobak, whose opinion Freud said commanded his deepest respect, in different ways made allusion to the symptoms of their hysterical patients in reference to the question of sexuality, by way of a joke or an aside. This knowledge of their patients, though, was *unacknowledged*, and in fact later denied by them.

But what does this unacknowledged knowledge of the child protection workers signify? In any case it alerts us to the frequency with which these children have names that are outside the usual names or spellings that are reference points within our culture. What I am putting forward here is that such names indicate that something of this child's existence falls outside of culture. Elsewhere I have written of the way in which the specifics of the parents' desire in relation to the child might be conveyed in the naming of the child (Plastow). In the case of Jheysson it is a question of the desire of the mother being unconstrained by the received given names and use of language, or spelling, that are customary in our culture.

The fact that we see such names in association with child protection involvement gives an indication that there are many other ways by which such families are not constrained by the social and cultural environment in which we live. Jheysson's relatively short existence up to that point had been punctuated by numerous disruptions in his place of abode and school, inconsistent and intermittent care by a mother who was

a user of illicit and prescription drugs, and a multitude of "step-fathers," as well as being subject to violence and sexual interference. Little was known of his own father, but he was thought to be in jail, possibly for murder. His mother lived in a caravan park with his half-brother Tahla and had chosen her relation with her current partner over that with Jheysson.

Here we find a family that lies on the fringe of society, in many ways outside of culture—that is, outside of the customary social codes and conventions that regulate, support, and orient our lives and our interactions with others.

The term "family," even in the diversifying configurations that we currently find, is difficult to apply in Jheysson's case. He was in fact temporarily residing with the family of a friend from school. The structure of the family, a structure that is given the sanction of society, is a structure that fails Jheysson, a structure that might have provided a real and symbolic support for him. It seems self-evident, but nevertheless necessary, to say that chronic instability, violence, and sexual interference are transgressions of a certain cultural code by which our society exists.

THE NAME IN ITS RELATION TO CULTURE

The transgression by use of the child as a sexual object, a form of transgression of the incest taboo by one who is in *loco parentis*, is crucial and exemplary here. Among such troubled cases as these, it is not uncommon. None

of us, though, would argue with Freud's assertion that "respect for [the barrier against incest] is essentially a cultural demand made by society" (Three Essays 225). What is important here is the prohibition of incest as the prototype of a social rule by which culture is constituted.

In his work "The Elementary Structures of Kinship," the ethnologist Claude Lévi-Strauss demonstrates that the prohibition of incest, in its multifarious forms, is a universal feature of all societies. He states that it "constitutes the fundamental step thanks to which, by which, but especially in which, is accomplished the passage from nature to culture" (29). Furthermore, the essence of the prohibition of incest is that of a "social rule" that not only constitutes but also structures society.

Lévi-Strauss notes in his conclusion to the aforementioned work, from his analysis of the many societies that he studies, that the prohibition of incest is also grouped together with a number of other heterogeneous and, on appearance, difficult to comprehend prohibitions. Here he states:

All these prohibitions are thus brought back to a common denominator: they all constitute an *abuse of language*, and they are, on this account, grouped together with the prohibition of incest, or with acts that evoke incest. (568)

Thus:

The prohibition of incest is not a prohibition like the oth-

ers; it is the prohibition in its most general form, that, perhaps, to which all the others can be reduced . . . like so many particular cases. The prohibition of incest is universal like language. (565)

From Lévi-Strauss' account then, the prohibition of incest, as well as other prohibitions that constitute the rules which structure society, are underwritten by the structure of language. We have already noted that it is language that carries culture and that is at the basis of man as a social being.

Here we can make an association between the failure of the prohibition of incest and the other transgressions that accompany this, transgressions that ultimately constitute the failure of a structure, with the transgressions of the customary code in the naming of children as manifestations of such an "abuse of language."

To follow the logic of Lévi-Strauss, and extrapolating this "ethnological analysis," there is something in Jheysson's case that lies outside of culture. We might define culture here as the symbolic system that structures society. Culture, then, is what forms the social bond, something that unites us and in which we partake. It is something that transforms us from the animal state into that of social beings. Culture is also something essentially carried by language as that which also makes possible the differentiation of man from other species.

Cases such as Jheysson's are surely among the most difficult

that we deal with in clinical practice. Nevertheless, to varying degrees, what is frequent among cases that we see in child and adolescent psychiatry is in some way a failure of a structure around the child or adolescent, even a failure or "abuse of language" as articulated by Lévi-Strauss. This is precisely what I am theorizing here as a failure of culture, or a falling outside of culture. Of course, this is conceptualized by clinicians of differing orientations in various ways such as neglect and abuse, difficulties in "limit-setting," problematical parenting, faulty cognitions, or even putative neurocognitive deficits.

But how do we address such failures of a structure around the child or adolescent? Certainly not with the further introduction of instability through a moveable feast of impersonal clinical rooms at odd hours, as available. Such rooms, no doubt, are adequate for crisis interviews when it is a question of an assessment of risk or a brief intervention.

However, when it is a question of a thorough assessment in the context of the family or that of ongoing work with the child or adolescent, the account that the family members give of themselves can only begin to unfold in the context of a number of important reference points. These reference points include the clinic itself, including its name and reputation, the structure of the assessment that the clinician brings to bear through his or her training and experience, the time, duration, and frequency of the appointments,

and surely, even more basically, the room, the space in which the clinical encounter takes place.

The room is not just four walls, a window, and a door, but it is also that. In one sense the room is a real limit to what is possible—that is, a barrier to or prohibition of a transgression articulated by a "no": the interview takes place in the privacy of the adequately sound-proofed room, *not* in the corridor or waiting room or other public space, *not* audible to others. Moreover within the room there is also a limit to what is possible: the people in the room are *not* to be hurt, and the furnishings and toys in the room are *not* to be damaged (something less likely to be enforced in an impersonal shared interview room).

In order that the room be protected from transgression from without as well as from within, it is essential that the security arrangements be adequate in the smaller, more isolated clinics in community settings.

In this way the room—the stability, reliability, and non-violability of the room—is able to function in the clinical setting as that which permits the recognition of the very rule that promotes the establishment of culture. Hence, the clinical encounter of the interview of the clinician with the child, adolescent, and family is a form of social bond, through which the clinician and the patient both participate in society. This is something far beyond any conception that "service provision" can encompass, no matter how "enhanced."

The room, though, is also a symbolic space, and these same four walls, as well as what they contain, constitute stable reference points as a backdrop to the telling of a history, or to a child's play. It is only on the basis of these stable reference points, or anchoring points, that the child, adolescent, or family members are able to allow something of themselves to be articulated, or a history to be reconstructed.

The room can be, for the patient, a periodical place, through the play between the *Fort* and the *Da* (Freud, Beyond the Pleasure Principle 15) of the coming and going of the sessions.

The objects in the room—the objects of the clinician's choosing such as his or her books, posters, and artifacts, plants that the clinician tends to, the toys, drawing materials, and so on that the child psychiatrist selects for the child—all constitute not so much the personal world of the clinician, but rather his or her insertion into culture as individual subject and as a child psychiatrist, or other specific discipline. This is essential if the room is to serve a therapeutic function. It is certainly difficult or impossible to achieve with a shared interview room.

It is said that Freud himself did not need a consulting room with a couch and armchair in order to analyze, that he analyzed in trains, on a mountain, etc. But this denies the fact that almost all

the work that Freud performed was conducted in his customary consulting room. And if he did analyze from time to time in other spaces, we could say that this was the exception that proves the rule, the exception to the rule in Freud's usual practice, but also the function of the exception of Freud as founder of psychoanalysis, as father of psychoanalysis.

It is useful to recall that the economic rationalist principles that reduce rooms to their mere functionality and economic value, are the very same principles that reduce other geographical spaces to their functional value, stripped of their symbolic weight. Thus we find that the local Post Office has been made into a jazz bar, the Fire Station has become a café, and the old Bank building has converted into . . . private psychiatrists' rooms!

Why did our ancestors erect grand edifices for public buildings? These buildings were not just constructed for their functional value of selling stamps or putting out fires. They also represented important institutions that were, and remain, cornerstones of our society. If the new Post Office in the shopping mall is more functional, nevertheless something less tangible, less economically viable no doubt, is lost.

We are at risk of losing the symbolic value that the consulting room affords. This is a value, however, that cannot be calibrated in

economic terms and which is seemingly irrelevant to those who fund our services. It is a value, though, that is the very basis of the room's possibility of functioning as a therapeutic space. For a child, it is the name that anchors him or her in language and thus in culture. The symbolic function of the room is the name of the game, to extract something from an expression that circulates, the name that promotes the game or play of the child, the name or symbolic value that serves as a reference point for the child or adolescent. It is this name through its reference to the word, to culture, that effects the very possibility of the treatment of a child.

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