Symbolic Violence and Social Control in the Post-Total Institution Era

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Subsequent to the passage of the Community Mental Health Act in 1963, the "Total Institutions" described by Goffman have for the most part disappeared. Nonetheless, many writers charge that social control is still the primary function of mental health programs, even those that are identified as community-based. The new methods of control have not received widespread attention. In community-based programs control is operationalized in the form of "symbolic violence." This paper examines the various factors that contribute to this style of violence.

Clearly mental hospitals have never been very pleasant places. In the early days, these institutions were openly barbaric. Persons were placed in chains, beaten, and involved in dehumanizing experiments (Scull, 1979). There is little doubt that these activities were not therapeutic. The aim was primarily to prevent the mentally impaired from spreading their affliction to the remainder of society.

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Due to the efforts of eighteenth and nineteenth century reformers, these conditions abated somewhat. In fact, various humanitarian themes were given some credence. Improved environmental conditions within hospitals were thought to contribute to helping the mentally disabled. Patients appeared to improve when placed in commodious surroundings, provided with a systematic behavioral regimen, and given medical attention.

Even though patients were no longer controlled through physical abuse, newer and more subtle techniques of control were developed. Michel Foucault (1965), for example, claims these less obtrusive means of restraint were invented under the guise of science. Consequently, ostensibly rational and tested practices were adopted to subdue patients. Although these strategies may have some medical justification, they are just as intrusive and dehumanizing as those used in the past.

During the 1950s in the United States, a host of writers confirmed Foucault's allegations (Kovel, 1980). Dehumanizing acts against the emotionally impaired were tolerated because of their alleged scientific nature. Thousands of lobotomies were performed, while the use of chemical and electrical shock was quite common. Additionally, the invention of Thorazine and other psychoactive drugs allowed patients to be systematically anesthetized. A sort of chemical straitjacket was now available. And due to the increasing prescription of these drugs, hospital wards became warehouses for those with emotional disabilities.

As Goffman (1961) illustrated, hospitals had become "total institutions." All that had changed was more sophisticated modes of constraint became generally accepted. Accordingly, the therapeutic worth of these institutions was certainly questionable. This state of affairs prompted President Kennedy to announce in 1963 that a "bold new approach" was needed to treat those suffering from mental illness (*Mental Illness*, 1963). For research seemed to suggest that mistreatment and hopelessness were still the norm on many wards (Pardeck & Murphy, 1992).

Following the passage of the Community Mental Health Act in October of 1963, care for the mentally ill is supposed to be more humane. Patients are to be treated in the "least

restrictive environment." instead of confined to hospital wards. To facilitate this change, community mental health centers have been built throughout the country. In this way, therapy can be provided close to home, possibly in a patient's neighborhood.

Furthermore, input is supposed to be sought from patients throughout the therapeutic process. For example, needs assessments are supposed to be regularly conducted, so that a community's view of a problem can be adequately understood. As a result, services can be provided in a socially appropriate manner.

At the institutional level certain policies are supposed to be operative. For instance, clients are to be informed of their rights upon entering therapy. And in order to insure that they have consented to the course of remediation outlined by the therapist, patients are required to sign their individualized treatment plans. Additionally, quality assurance teams are to be created to monitor care. Such scrutiny is designed to prevent clients from languishing in inappropriate and ineffective treatment modalities.

Subsequent to the passage of the Community Mental Health Act, clients have the latitude to freely initiate and terminate a therapeutic relationship. But as writers such as Scull (1984) maintain, this "decarceration" has not been complete. Although the total institutions described by Goffman may no longer be as widespread, social control remains a key function of mental health agencies. In this regard, Stanley Cohen (1985) contends that control mechanisms have become more subtle and inclusive. For the most part patients are not overtly accosted, but instead are entrapped within a procedural and symbolic web. Control is unobtrusive but just as effective as in the past.

Critics of community-based intervention have charged that the control net is currently wider than ever before (Pardeck & Murphy, 1993). While the proliferation of community mental health programs has been chronicled and their capacity for repression suggested, not much time has been devoted to discussing the actual mechanisms of control that are prevalent. Clearly the vehicles of control have been altered, but in what ways? The purpose of this paper is to address this question.

The Nuances of Symbolic Violence

Social control is sustained in the modern world, according to Pierre Bourdieu and Jean-Claude Passeron (1977), at the symbolic level. This demarche is thought to be much more effective than traditional methods. After all, physical displays of force tend to arouse the ire of the public, particularly in societies that claim to be democratic. For in this type of polity, no one is supposed to have the power to dictate how others will behave. Therefore, control must appear to be rational, innocuous, and support the common wealth.

But to say that control is symbolic does not mean simply that symbols are used to enforce order. Significantly more is accomplished through symbolism than focusing persons' attention, channeling emotions, and soliciting public support for an issue. Much more important, reality is manipulated and opposition to the status quo is subverted. Control is secured, in other words, through symbolic violence.

This kind of violence occurs when persons are cajoled to abandon their own views and accept another outlook. Overt force does not provoke this shift, nor does the free exercise of volition. Instead persons accept that their present orientation is indicative of irrationality or some other dysfunction. In this regard, little choice is involved in selecting new options, unless clients want to be known as abnormal. Moreover, because the basic values of these individuals are presumed to be problematic, any challenges from those who receive treatment pose to the dominant reality are discredited.

Fundamental to symbolic violence is that a particular interpretation of reality is given a seignorial status. A specific outlook is reinforced in such a way that it becomes almost inviolable. Mental illness, for example, is circumscribed through the use of medical protocol and identified as the complete absence of reason. And anyone who has the particular configuration of symptoms indicative of emotional disability is deemed incapable of voicing meaningful opinions and interacting sensibly. Presupposed by this entire process is a conception of reality that is never doubted.

Clearly, appreciably more is encompassed by symbolic violence than the application of labels. First, different conceptions

of reality are placed in an asymmetrical relationship. Second, the dominant viewpoint is allowed to determine the meaning of the rest. And third, the inferior views are stripped of legitimacy and rendered impotent. When persons are symbolically violated, their actions are not simply categorized and responded to in a unique manner. Instead, and far more devastating, their existence is eviscerated.

A definition of symbolic violence, therefore, must contain several elements. Building on the work of Bourdieu and Passeron (1977), symbolic violence occurs when a person's outlook is inferiorized and an asymmetrical relationship is established between this individual's worldview and competing conceptions of reality. This undermined viewpoint is abandoned out of logical necessity. The only reasonable action, in short, would be to suppress an inferior position.

As should be noted, symbolic violence is not just a version of coercion. Symbolic violence works from the inside out, while the reverse is the case when behavior is coerced. When symbolic violence is operative, persons may choose to have their values, beliefs, or principles dissected and repressed. In fact, this outcome is a regular part of many approaches to therapy. Such a result is truly violent, because self-destructive behavior is the end product. Demeanor that a patient feels comfortable with may be rejected, for example, because it conflicts with a clinically established norm. The self may be systematically dismantled and reconstructed according to a clinical ideal. Certainly such reconstruction is violent, due to the symbolic violence against the person's identity.

In actual practice, symbolic violence is often witnessed during the standard therapeutic encounter (Vega & Murphy, 1990, pp. 61–83). Psychiatrists and psychologists who possess a variety of diagnostic devices, drugs, and esoteric theories are easily able to regulate their patients, without overt coercion. In point of fact, many persons volunteer for treatment, in the hope of gaining some insight into their fears and desires. Nonetheless, the patient and therapist do not interact as fellow human beings, who regularly share information and give each other advice. Instead, therapists are expected to modify behavior and normalize persons.

Behavioral change is based on a diagnosis that is believed
to represent an objective assessment. Politics, racism, or sexism
is unimportant. The facts of a case are evaluated and a judg-
ment is made. Indeed, patients are believed to be biased, while
therapists are value-free. What this means is that criticism is
deflected away from the psychological or medical establishment
by a scientific diagnosis. Additionally, due to the exalted posi-
tion of the therapist, any disagreement with a diagnosis calls
into further question a patient's credibility.

Obviously symbolic violence is a means of control that is
congruent with the tenets of community mental health, for the
direct manipulation of clients is supposed to have ceased. But
what about indirect coercion? If a patient's views are thoroughly
inferiorized by a diagnostic scheme, does this procedure consti-
tute the basis of social control? If patient input is believed to be
uninformed due to certain theoretical considerations, can the
claim be sustained that services have been truly humanized?

Inserting clients into a symbolic cage can be equally as dam-
aging as physical violence. Subverting patient input symboli-
cally and treating medical protocol as sacrosanct are inconsistent
with the spirit and the letter of the Community Mental Health
Act. Yet these and similar practices are present in mental health
agencies today (Vega & Murphy, 1990). Therefore, these means
of control must be illustrated and curtailed, if socially sensitive
care is to be delivered.

Contributors to Symbolic Control

Dualistic Theories

Both the sociological and psychological theories that have
dominated the intellectual scene prior to and since 1963
have been dualistic (Vega & Murphy, 1990, pp. 21–41). And due
to this shortcoming, real community-based treatment could not
be inaugurated. Remember that citizen involvement is supposed
to be sought at every stage of program planning. But how can
this occur when subjectivity is severed from objectivity, and the
former is thought to block access to valuable information?

Niklas Luhmann (1982, pp. 353–55) notes that traditional-
ists adhere to a "centered" image of society. In other words,

order has been thought to be based on a foundation that is devoid of situational contingencies. Durkheim (1983, pp. 82–85), for instance, refers to this primordial condition as a "reality *sui generis.*" Without this absolute standard, the belief is that the social world would rapidly devolve into chaos. For a vital activity such as the maintenance of reality should not depend on something as capricious as interpretation.

According to this view of order, social reality must be unassailable. This is possible only if objective norms and laws are available to socialize persons. Therefore, subjectivity or opinion must be kept from defiling objectivity. If this approach is successful, universal sanctions can be imposed on society.

The role citizens play in organizing services is seriously curtailed, however, when the differentiation is made between subjectivity and objectivity. And why should these persons be consulted? According to this form of dualism, rational planning can only be impaired by recognizing their opinions. Because subjectivity embodies various values, beliefs, and commitments, placing clients or other citizens at the center of an intervention would be considered a sign of incompetence. Surely no one wants to earn this unflattering reputation.

As a result, those who are thought to be objective, due to their managerial skills or expertise in research, have retained control of planning (Pilotta, Murphy, Jones, & Wilson, 1983). This situation will not likely change until the subjective-objective bifurcation is abandoned. Actually, many contemporary critics insist that this dualism is outmoded, because an essential relationship exists between knowledge and interpretation. For someone such as Jean-Francois Lyotard (1984, pp. 9–10), nothing escapes the impact of language. Every style of knowledge, even that associated with science, reflects a "language game." And once the human presence is understood to mediate thoroughly everything that is known, information is relativized.

Since all knowledge is shaped by interpretation, no source of input can claim to be inherently more objective than any other. Therefore, the worth of information must be judged in terms of its utility, as opposed to its pedigree. Hence citizen participation is not necessarily antagonistic to rational planning. Contacting citizens or allowing patients to formulate a treatment

regimen does not automatically call into question the validity of an intervention.

Professionalization

The introduction of multidisciplinary treatment planning was also a part of the movement toward community-based intervention. The purpose of this strategy is to diversify the information available to practitioners and patients. As a part of expanding the range of input, the advocates of clients could be members of the treatment team. In some instances, particularly in ethnic neighborhoods, those who are bilingual serve as translators for the therapist. At other times, "cultural brokers" are invited to provide insight into a patient's background and social milieu (Lefley, 1984).

Yet this undertaking has had only marginal success. One of the reasons why multidisciplinary treatment planning has not worked as anticipated relates to the emphasis that has been placed on professionalization (Vega & Murphy, 1990). The recent proliferation of new disciplines, degrees, and licensing and accreditation requirements has been phenomenal. Almost daily, new regulations are unveiled.

Yet in a significant way, the growth of these professional standards has been detrimental to patients. That is, patients are pushed to the periphery of the treatment team. Why this is happening is understandable. Most of those who receive services are not well educated, are often inarticulate, and do not possess a wide variety of social skills. Simply put, most clients are not professionals, and thus their ability to contribute meaningfully to the formulation of a treatment plan is viewed with skepticism. In contrast to practitioners, the knowledge possessed by citizens and patients is considered to be unreliable.

One of the key purposes of professionalization is to reduce discretion. Similar protocol are to be followed by trained practitioners in every situation. As a result, standardized actions are encouraged. But what would happen if patients were included in evaluations? Due to their lack of professional socialization, their responses would not be predictable. Consistency would thus be threatened.

As a consequence of professionalization, particular knowledge has been elevated in importance. This information, however, is not distributed throughout society. Clients and citizens are thus diminished in importance, because their knowledge base does not usually contain input that is valued by practitioners. Undermined by professionalization, in short, is knowledge that is outside of the limited realm created by this process of formalization.

Science and the Inferiorization of Clients

During the 1960s and 1970s the medical model was constantly under attack (Ingleby, 1980). This challenge to the dominance of medical science in the treatment of clients has abated during the past 10 years. At the National Institute of Mental Health, for example, planners who have a sociological orientation have become almost extinct. In fact, the majority of funding nowadays is directed to discovering the underlying physiological causes of mental illness. Genetic and psychopharmacological research has become quite popular (Pardeck & Murphy, 1993).

Accompanying this shift in emphasis is the belief that becoming increasingly scientific is crucial for making advances in the study of mental illness. Some critics even go so far as to charge that progress is delayed by wasting time and money on the development of social, as opposed to medical, interventions. Obviously in this environment not much effort will be devoted to understanding how patients or communities view their problems.

The stress that is now placed on becoming scientific is also manifested in other ways. The computer, for example, has become part of practically every area of service delivery. Many tasks, including in some cases the therapeutic relationship, have been completely computerized (Pardeck & Murphy, 1986). The purpose of employing this technology is to improve the accuracy of clinical judgments, as a result of organizing a vast amount of information in a systematic way. With the adoption of "expert systems," for example, the interrater reliability of clinicians is cited to be greatly enhanced (Murphy & Pardeck, 1989).

To use Max Horkheimer's (1982, pp. 132–189) phrase, this adoption of computer technology represents the most recent "attack on metaphysics." By this he means that the social or interpretive side of any venture is obscured. At the peak of the anti psychiatry movement, during the late 1960s to the middle 1970s, clinical diagnoses were assumed to be replete with political motives (Sedgwick, 1982). Women, ethnic minorities, and a myriad of other groups were beginning to question the legitimacy of these decisions. Stated differently, these judgments were no longer thought to be value-free.

But once the computer enters the scene this criticism is minimized. For most citizens are enamored of logic and mathematics, and thus have difficulty believing that computers are biased. While criticizing this commonly held view of computers, Ashley Montague quips that the GIGO principle should be interpreted to mean "Garbage in, Gospel out" (Roszak, 1986, p. 120). For by following the schematics utilized in computer programs, making decisions is not thought to involve gaining critical insight into a problem. Doubtless, a person would have to be an expert at programming to understand how information can be distorted by computerization. But most clients and their families and friends do not have this skill. Therefore, in many ways treatment has been reified through computerization.

Due to the alleged comprehensiveness, accuracy, and objectivity of the information generated by computers, everyday experiences pale by comparison. As a result, computers are often treated as providing an unquestionably valid "second opinion" (Murphy & Pardeck, 1986a). Instead of consulting a variety of sources, clients rely mostly on computer printouts to verify a practitioner's diagnosis. Considering the public's fascination with technology, this finding should not be shocking. Nonetheless, the different experiences, belief systems, and commitments involved in making clinical decisions are ostensibly neutralized.

What can a client add to the data compiled by a computer? Most professionals appear to suggest little (Pardeck & Murphy, 1993). Therefore, data processing requirements have begun to dictate the type and amount of information that is included in clinical activities (Murphy & Pardeck, 1986b). At one time, long and complex interviews were conducted regularly to obtain a

holistic view of a client. But this approach to data collection has lost popularity since the onset of widespread computerization. For these so-called soft instruments are not considered to be very reliable by a large segment of practitioners. The knowledge that is procured is often ambiguous and subject to a variety of interpretations. Such uncertainty is not thought to be conducive to making sound judgments.

This desire to be objective has resulted in evaluation coming to be almost synonymous with testing (Matarazzo, 1986). Compared to ethnographic interviews, tests appear to be rigorous and thus unbiased. This perception has been reinforced by the development of computer programs that are able to administer, score, and interpret tests. Through the computerization of testing, the illusion has been perpetrated that tests provide decision makers with the most accurate and comprehensive information available. Additionally, those who control these tests have gained enormous status in agencies, because of their close association with scientific knowledge that is deemed to be extremely valuable (Pardeck & Murphy, 1986).

Through computerization the separation of fact from value has been encouraged. Since computers are machines and supposedly impervious to values, information that is computerized is used to counteract the influence of opinions. Thus the suppression of knowledge that is not programmable is thought to be entirely justified, because this input lacks exact parameters and is not scientific. Because science is presumed to be the paragon of rationality, all other kinds of knowledge are treated as superficial. Following this truncation of knowledge, patients cannot be allowed to influence significantly the organization of services.

Bureaucracy

Most mental health agencies are bureaucracies and thus are structurally organized in a manner similar to the older state hospitals. A major difference between these institutions is that community-based programs are not as expansive as hospitals. Nonetheless, the continued presence of bureaucracy has fostered the implosion of knowledge, in a manner identical to dualistic theories, professionalization, and computerization.

In order to appreciate this critique, bureaucracy must not be viewed simply as an organizational or management style. Rather, as explained by Max Weber (1958, p. 54), bureaucracy represents a unique conceptual scheme or "cosmos." Therefore, changes in organizational size may not have any impact on reducing bureaucracy. This mode of conceptualization can thus be found in practically every organizational setting.

Given the negative view of the bureaucracy, what are the benefits to be derived from this way of conceiving organizations? Claude Lefort (1986, p. 222) answers this query succinctly when he states that bureaucracies appear to be "ahistorical." His point is that because every activity is formalized as a result of bureaucratization, exact categories are available to process information and make job assignments. For example, due to the rigorous division of labor in bureaucracies, redundancy is thought to be avoided and efficiency improved. According to Lefort, criteria for decision making are introduced through bureaucratization that do not appear to be influenced by situational exigencies. Hence regulation is believed to be ultimately rational.

Yet this increasing rationalization, according to Weber, can also begin to cripple an organization. This is particularly the case if input is supposed to be sought from throughout an agency. For job assignments are made on the basis that requirements are not randomly distributed. Stated differently, strict adherence to the division of labor must be enforced, or persons will not be aligned to the proper jobs and efficiency will be compromised.

As long as organizational rationality is conceived in this manner, citizens and patients will exert little control over the intervention process. Why? Both of these groups are tangential to the operation of a bureaucracy, for they lack the training necessary for them to occupy influential positions. And if their role in an agency would be changed simply by fiat, no one would benefit. The rationale for this conclusion should be obvious: persons would be placed in jobs for which they are unqualified. Therefore, the operation of the entire organization may be jeopardized.

As long as bureaucracy and rationality are equated, the knowledge essential for planning will remain within a cabal of experts. Disassembling the rigid division of labor, in short, will not be viewed as prudent. Alternatives to bureaucracy have been proposed, but these options will not receive serious attention until organizational efficiency is rethought. Flat organizations, for example, must no longer be understood to decrease discipline and rationality. But the decentralization of authority is crucial, if citizens and patients are to influence significantly intervention activities. Novel input must not be curtailed by an outmoded division of labor.

Symbolic Violence in Practice

In both theory and practice the dualism that supports symbolic violence is difficult to overcome. After all, the prospect of discovering and possessing an unadulterated—apolitical, neutral, and thus valid—knowledge conception is what sustains symbolic violence. Recent talk about holistic intervention, systems theory, and constructivism, for example, circumvent this issue. Therefore, the door is left open for certain knowledge bases, methodologies, or images of the organization to retain a seignorial status, thereby curtailing attempts on the part of practitioners to become more inclusive.

For example, a lot of discussion has taken place during the past few years about TQM or Total Quality Management (Berwick, Godfrey, & Roessner, 1991). In a variety of health care settings, this practice is thought to be a panacea for organizational difficulties. The problem is that drastic managerial change is required if the widespread worker (or client) participation is to occur that is vital for TQM to succeed. For a variety of reasons—professionalism, fear of power shifts, or a lack of confidence in staff workers—the traditional bureaucracy has not been seriously challenged. An analysis of most organizational charts found in social service agencies will confirm this claim (Murphy & Pardeck, 1986a). The result is that staff input barely touches the core of organizational life, not to mention what clients have to say. Most staff persons are peripheralized because of the perceived need to retain a managerially sound and objective image of order.

The same dualism is found in much of the research on mental health issues that is currently funded (Vega & Murphy, 1990). It is no secret that during the 1980s the biomedical model was resurrected. Although biochemical considerations were supposed to be viewed simply as one set of factors among others, a pluralistic approach to comparing knowledge bases was not encouraged. Due to the prestige of biomedicine, and the accompanying positivism, non-medical variables and opinions were diminished in importance. Clients were either expected to relent and accept invasive treatments, based on physiological causality, or pursue alternative remedies that are heavily stigmatized.

In point of fact, Pardeck, Murphy, and Chung (in press) found recently that patients were unable to question extensively the judgements of treatment professionals. Even though patients are supposed to have an integral role in developing their treatment plans, this involvement is not often present. Clients reside at the margin of the treatment planning process and express hostility about the manner in which they are treated. Conversations with professionals, in sum, tended to be short, laden with jargon, incomprehensible, and thus insensitive to the client's wishes. Treatment accordingly turned into nothing more than custodial care.

Clients were not approached in their own terms, but instead their complaints were transformed into diagnostic idiom. Furthermore, practitioners felt uncomfortable believing a client until his or her descriptions were compared to laboratory or psychological tests. Once these objective measures were received, practitioners exhibited some confidence about making an assessment. A patient's insights could not be trusted until a reliable or scientific evaluation could be made.

In the end, the organizational and clinical status quo is preserved without firing a shot, so to speak. Any opinions that do not fit nicely into the body of conventional wisdom are systematically inferiorized and overshadowed by input that is allegedly more trustworthy. Only an unreasonable person would refuse to recognize that difference in quality between those two sources of information continues to give credence to unscientific views.

What practitioners must begin to understand is that allow-ing diverse types of information, along with different persons, to be introduced into the treatment setting does not necessarily culminate in pluralism. A proper environment must be fostered, accordingly, where disparate kinds of input can receive a fair hearing. In other words, the marketplace of ideas must be de-mocratized, thus enabling every type of information to be in-troduced into a discussion without bias. The source or pedigree of data, for example, should not determine the utility of certain knowledge (Pardeck, Murphy, & Callaghan, 1994).

With regard to the use of computers by practitioners, for example, recent research has revealed some interesting insights (Pardeck, Umfress, & Murphy, 1990). Despite the fact that prac-titioners have minimal contact with computers and do not com-prehend how they really function, intervention was thought overwhelmingly to be upgraded by the use of these devices. A halo effect was found, due possibly to the apparent scientific character of computerized knowledge bases, that resulted in a favorable attitude toward this technology. In short, computer-ized knowledge has more face validity, and possibly inherently wider applicability, than other forms of knowledge. But such a predisposition contributes to imploding the search strategy used by practitioners to discover the knowledge that will be included in their decision-making processes. The imagery of the computer, therefore, was able to subvert ostensibly less objec-tive sources of data. This prospect is the hallmark of symbolic violence.

Conclusion

According to Foucault (1965), social control in the modern world has become more rational and less obtrusive. For the most part, control is not enacted through the use of brute force. In-stead, science, technology, and reason have been enlisted for this purpose. Subsequently, practices that are inoffensive reinforce reality and undermine critiques of the status quo. This seems to be the case in mental health agencies (Vega & Murphy, 1990).

The dehumanization of clients does not necessarily extend from incompetence, malicious intentions or actions, equipment

failure, or a general lack of humanness. Hence challenges are posed for those who want to study how patients are restrained in community-based programs. Specifically, attention must be directed to comprehending how reality is truncated by practices that are not overtly political or pernicious.

In the case of community mental health agencies, through rational and well-orchestrated maneuvers clients remain marginal to the administration of services. Reason and irrationality are juxtaposed in such a way that patients are effectively disarmed. Due to the recent professionalization of services, along with the emphasis placed on science and computer technology, these persons have become viewed as impediments to rational management. In Lyotard's (1985, p. 98) words, nonpractitioners have been symbolically "terrorized".

As is noted by Lewis and Darling (1990), the rhetoric of community-based treatment has obscured what is actually occurring in these programs. Community agencies may be smaller, located in neighborhoods, and less overtly barbaric than the mental institutions of the past, but these newer facilities are just as coercive and intrusive. Conflict with citizens and clients is neatly resolved, while attention is diverted away from the mental health system. The range of discourse and criticism is simply restricted, because science and technology are anathema to the ethical or political issues that are related to controlling persons. Why would criticism be counseled, when the scientific pursuit of truth is underway?

But as long as the focus is maintained on technique, writes Baudrillard, a lot may appear to change while everything remains the same (Kellner, 1989, p. 11). In other words, advances will be made in technology while the de facto manipulation of clients goes unchallenged. Simply because intervention programs are rationally administered, procedures are scientifically monitored, and the latest assessment techniques are used does not signal automatically that mistreatment has ceased. Neither patients nor citizens should be silenced by the apparent neutrality of science and technology. The ideology of science should not be allowed to restrict patients input and their control of mental health services.

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