

Empathizing with Enemies:

Establishing Good Practices for Patient-Provider Communication at Arkham Asylum

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Key Words: Mental health, popular culture, narrative inquiry, interviews, patient-provider  
communication

### Abstract

Arkham Asylum is the home of some of popular culture's most notorious super villains. The neglect and inadequate care these *villains* receive mirrors a real world context in which mental illness is surrounded by stigma, misunderstanding, and poor rehabilitation rates. Patients like the Joker present complex mental health narratives. These extreme characters would likely be high profile subjects for real-world researchers. This study explores the niches between the usual action-packed escapades on the surface of Batman stories. By pulling back the curtain over the routine treatment of Arkham Asylum's patients (also known as inmates), the researcher presents a set of good practices for improving their care through more effective communication.

A rich data set of recorded audio interviews from the video game *Batman: Arkham Asylum* serves as the foundation for this set of good practices tailored to the needs of the fictional facility. Narrative inquiry is used to pull these recommendations from the data. Current real world mental health policies and good practices for patient-provider communication, grounded in existing literature, provide the framework within which the researcher compares the fictional world. Based on the narrative elements found in the data, this study recommends an empathy-driven and preventative approach to treating Gotham's criminally insane population.

**Table of Contents**

1. Introduction	4
a. Statement of the Problem	4
b. Purpose of the Study	5
c. Significance of the Study	6
2. Review of Literature	9
a. Real World MHCPs	9
b. Real World Good Practices	11
3. Research Question	15
4. Methodology	16
a. Framework and Key Concepts	16
b. Data Analysis	19
c. Delimitations	23
d. Limitations	24
5. Findings	25
a. Good Practices at Arkham	26
6. Discussion	42
a. Comparing Good Practices	42
b. Other Discussion Points	44
7. Conclusion	46
8. References	48
9. Appendix A	54

## Introduction

Arkham Asylum, the home of Gotham city's abundant criminally insane population, has seen many artistic interpretations over the years. It has been notably featured in *Batman Begins* (2005), *Batman: The Animated Series* (1992), and *Arkham Asylum: A Serious House on Serious Earth* (1990). While it is known for housing familiar characters in Batman's extensive rogues gallery, the facility itself has become an established character in the DC comic book universe. In between the exciting action focusing on Batman, there have been numerous depictions of the day-to-day operations at the hospital. Graphic novels like *Arkham Asylum: Madness* (2010) place orderlies and nurses into the foreground as the main characters performing their rounds. These snippets of mundane fictional interactions provide more than simple narrative filler. Characters like Two-Face (Multiple Personality Disorder), The Riddler (Narcissistic Personality Disorder), and Harley Quinn (Dependent Personality Disorder) display a wide variety of mental health symptoms and conditions. These villains present a mental and physical challenge for the medical staff to communicate with in their attempts at rehabilitation.

## Statement of the Problem

The efficacy of mental health correctional treatment programs in reducing recidivism is a controversial and often debated topic. Patients "can present treatment dilemmas because they are inherently unpredictable, making them very difficult and frightening to treat" (Charles, 2010, p. 433). Researchers like Jacoby (2002) take a pessimistic stance on the issue, claiming that "we have become accustomed to the incapacity of the police to prevent crime, of courts to mete out justice, and of correctional institutions to rehabilitate" (p. 168). On the other hand, Dafoe and Stermac (2013) believe there is cause for some optimism, as a comprehensive review of

correctional programs in Canada suggests that treatment does in fact work to fight against violent relapse in patients. When patients do not *improve* their condition, they can become trapped in the system that was created to free them from illness.

Arkham Asylum is, not surprisingly, known for having a revolving door effect on the patients it treats, as they tend to be readmitted soon after their release. Pinpointing the source of this problem is not an easy task, but Shaw (2004) posits, “this process with respect to revolving-door patients might be linked to moral judgments about patients as bad or otherwise” (p. 1034). The criminally insane are often not able to distinguish right from wrong, yet they could be denied effective treatment on moral grounds. This study presents a detailed critical analysis of the medical communication setting—interviews between Mental Health Care Providers (MHCPs) and patients—in which such judgments might take place at Arkham Asylum. The researcher looks at what this correctional facility can do to fight the revolving door effect and get on the optimistic side of the treatment debate.

The video game *Batman: Arkham Asylum* (2009) presents the iconic establishment with painstaking levels of detail. Gamers can explore the cells of the patients, read about its history, and listen to audio recordings from medical interviews. The researcher explores this data for value beyond simple entertainment. Scholars such as Terrill (2000) and Langley (2012) have profiled these characters in the past, but none have taken a critical look at the quality of the health care they receive at Arkham.

### **Purpose of the Study**

The purpose of this study is to explore patient-provider communication as it is portrayed in popular culture. The researcher accomplishes this by interpreting audio recordings of patient-

provider communication found in Rocksteady Studios's popular video game *Batman: Arkham Asylum*. Applying narrative inquiry to the data allows the researcher to infer what works, what does not, and what could be done to more effectively treat Arkham's patients and mitigate the threat they pose to themselves and to others. Murray (2003) suggests that this narrative way of knowing "provides a means of integrating the strange and unknown into the realm of everyday life" (p. 97). The researcher's goal is to uncover a deeper understanding of these extreme villains as they appear in their everyday life at the asylum (as opposed to their usual depictions of sensational bank robbing, hostage taking, and bat fighting).

By applying a narrative perspective on the fragmented data, the researcher attempts to piece together each patient's case into a complete story. Establishing how a narrative begins, ends, and hinges in the middle leads to some significant lessons learned. This analytic process culminates with a set of hypothetical good practices for Arkham's health care professionals to follow when communicating with their patients. This set of good practices provides a mirror against which the researcher compares real world literature from the field of mental health care. The goal of this comparison is not to invoke any kind of real world policy change based on fictional data, but rather to spark a discussion that may have an impact on the reader's attitudes or perceptions surrounding the topics of villains and mental illness as they appear in popular culture. It is also hoped that this discussion may help inform existing mental health practices.

### **Significance of the Study**

One reason to look at these popular culture icons more closely is that it will hold a mirror up to our own societal beliefs and attitudes. As Uslan (2011) puts it, "the gods of ancient Egypt, Greece, and Rome still exist, although today they wear spandex and capes. After all, the Greeks

called him Hermes, the Romans called him Mercury, and we call him the Flash” (p. 101).

Culture and narrative are thus inherently connected, as “cultures maintain collections of normative meanings in their myths, fairy tales, histories, and other stories” (Harter, Japp, & Beck, 2005, p. 20).

Arts and popular culture provide an interesting lens through which researchers can gain insights into the real world responsible for producing it. The Batman mythology is famous for its rogues gallery and for their iconic home at Arkham Asylum. Batman’s villains fulfill strong archetypes to which their broad audiences are able to relate. Horton and Wohl’s theory of parasocial interaction suggests an “illusion of intimacy and familiarity between media personalities (personae) and audiences that can be established through routine use of radio and television” (Laughey, 2007, p. 203). Batman and his antagonists are household characters that have spanned various media over the course of decades. Taylor (2008) points out that it is perhaps the believability of these characters that keeps us coming back to them: “The most memorable, the most enduring, of Batman’s rogues gallery are the ones who are merely human. They are sociopaths, thieves, and gangsters to be sure, but they’re made of the same flesh, blood, and guts as Batman” (p. 8). While these dark and dangerous characters provide a source of entertainment through their twisted and elaborate crimes, the researcher is interested in the information to be gained from exploring the clinical (and not-so-theatrical) aspects of their lives.

Singhal and Rogers (2004) define Education Entertainment (EE) as “the process of purposely designing and implementing a media message to both entertain and educate in order to increase audience members’ knowledge about an educational issue” (p. 5). This study uncovers some valuable knowledge in the form of lessons learned by breaking down medical interviews designed to entertain. The researcher is not implying that the game developers had the goal of

building an educational message into the audio tapes, but rather that there is latent information resting beneath the surface. As, in response to any question regarding the quality of data found in a video game, Shen and Han affirm that “health information embedded in EE is effective regardless of the media vehicles and the health issues” (p. 612).

EE is proven to aid in the transfer of knowledge, but does it also have an effect on stereotypes? Ritterfeld and Jin (2006) found that an accurate and empathetic movie portrayal of a character suffering from schizophrenia, along with an educational trailer, helped reduce stigma surrounding the mental illness. The linchpin in the study was the educational trailer. Subjects who only viewed the entertaining film (without the educational component) had an increase in negative attitude toward the mental illness (mainly that people with schizophrenia are violent). Despite the fact that characters in the film did not exhibit any violent traits, the stereotype was reinforced in viewers. Interestingly, “attitude change occurred only if the movie was combined with the trailer supplement” (p. 260). Consider the current study as the educational trailer follow up to the entertaining video game; it provides a perspective that playing the game alone lacked.

Clarke (2013) points out the consequence of portraying this environment in a medium that is meant to excite and engage the player: “The narrative language used in this game [*Batman: Arkham Asylum*] reinforces many stereotypical notions concerning mental health issues” (p. 755). Clarke goes on to explain how referring to patients as “freaks” or “animals” can offend or stigmatize people based on their experience and perception of mental illness. If popular culture has a way of generalizing the mentally ill as violent and unstable, then the current study’s findings can yield broader significance beyond the specialized field of health care. The good practices inferred from this research present a new frame around which to discuss how we can all better navigate these issues.

According to Crawford and Brown (2009), treatment of mental health has historically favoured a “production line” model, in which rudeness and lack of effort are hallmarks of institutional treatment. Crawford and Brown developed the Brief, Ordinary, and Effective (BOE) model for MHCPs, which prioritizes communication skills in treatment. Their model uses small talk and non-verbal communication to create a “tardis effect,” through which MHCPs are able to make the most of their brief time spent with patients. The core features of this model include gestures that foster ordinariness or familiarity for patients (e.g. avoiding medical jargon) along with evidence-based policies. Their approach stresses the importance of the “everyday aspects of communication,” which this study seeks to examine at Arkham Asylum.

### **Review of Literature**

A comprehensive review of literature will establish a frame of reference for this study’s fictional findings that is based in the real world. In this section, the researcher will outline a set of real world patient-provider communication good practices. Some points are directly translated from existing clinical policies for communicating with patients suffering from mental illness; others are interpreted from evidence coming from scholarly studies focusing on similar clinical contexts. This frame of reference will inform the research questions from which the researcher approaches the data.

### **Real World MHCPs**

A brief review of real world studies into how MHCPs construct meaning through narrative will provide relatable context for this study. Morgan-Witte (2005) explains how during an ethnography study of two separate healthcare organizations, the nurses’ station served as a “backstage area away from patients, staff members vented, told funny stories, and mocked

patient behavior” (p. 223). Based on this observation of storytelling at the “hub of communication,” Morgan-Witte decided to approach the research from a narrative perspective. This research found that caregivers would regularly tell stories about their experiences, their challenges, their emotions, and the nature of their profession. According to Morgan-Witte, these stories not only contain lessons on appropriate behaviour and sociopolitical positions, but also “interweave to form a sensemaking structure that works as a grand narrative about caregiving” (p. 234). These findings make it clear to see how good practices could be inferred from this type of research, implying the potential for this study to uncover similar lessons by applying narrative inquiry to examples of Arkham Asylum’s caregiving procedures.

By peeling back the curtain to examine the lives of caregivers, previous researchers have found significant insights in what could be considered to some as insignificant moments: “These glimpses offer brief yet holistic backstage performances of what it ‘might be like’ to be a member of the culture” (p. 218). Through her ethnographic research observing occupational therapists, Mattingly (1998) posits that ordinary clinical visits themselves form a structure of a dramatic narrative, in which the actors engage in their own personal narratives to achieve healing through therapy. Mattingly’s reflexive and meta perspective of narrative mirrors this study’s approach of examining the meaning that echoes from a seemingly mundane interaction. In its most meta sense, this study examines the narratives of the patient-provider interviews, which are contained within the narratives of the interviewer’s and the subject’s lived experiences, which are contained within a bigger narrative of the video game’s plot, which ultimately embodies the popular culture of our own real world narratives and experiences. This interconnectedness allows the researcher to infer good practices on macro scales from micro events.

**Real World Good Practices (RWGP)**

Patient-provider communication involves more than the simple transfer of information. According to Schneider et al. (2004), building relationships is another important function of communication. Schneider et al. go on to claim that a lack of explanation of diagnosis, medication, and available support on the part of the MHCP leads to feelings of disrespect and denial in patients suffering from schizophrenia (and an overall perception of poor relationships).

- **RWGP 1:** Relationship building and information transfer should both be leveraged by MHCPs because they are complementary aspects of patient-provider communication.

In accordance with Shaw (2004) and Arrigo (2001), another important real world good practice is for MHCPs to avoid labeling patients with mental illness as “bad,” “immoral,” or “problematic.” According to Shaw, the model of an ideal patient is “someone who is polite, who takes good care of him- or herself, has an easily diagnosable condition, is strongly motivated to recover, complies with medication, and recovers quickly after treatment” (p. 1039). Shaw explains that this standard is not realistic to expect from patients with mental health problems, and that labelling them as problematic or judging them on moral grounds can exclude the patient from the treatment process. This practice on the part of the MHCP perpetuates a revolving-door phenomenon: “In excluding difficult patients, doctors might be helping to create the very behavior that they find so distasteful” (p. 1044).

Arrigo (2001) shows how mentally ill criminal offenders experience transcarceration within the penal system. Much like a “problematic” patient is shuffled from doctor to doctor, transcarceration describes the same revolving-door phenomenon through which the marginalized

group “live out their deviantly defined (i.e., “mad” or “bad”) statuses and are largely powerless to alter them” (p. 162). Whether they are a patient being treated or a prisoner being detained, people with mental illness do not benefit from these types of confinement discourse.

- **RWGP 2:** MHCPs should avoid moral judgment, dismissive labelling as “bad” or “problematic,” and other marginalizing classification because they can lead to exclusionary effects for the patient.

According to Ingram (1978), part of the cause of the revolving door effect (the relapse and readmission of many 'rehabilitated' patients) is poor family relationships. Ingram suggests that “it is in the patient’s interest for hospital staff to minimize any gulf that exists in order to reduce the likelihood of family resistance to further contact and in very severe cases rejection of the patient altogether” (p. 109).

- **RWGP 3:** MHCPs should maintain close relations with families of patients and appoint staff as family representatives because it improves the patient’s odds of successful rehabilitation.

Wilson (1998) describes suspicions between mental health professionals and patients as obtrusive to good treatment, which relies on trust and respect from both sides. She points out that when a mental health professional takes measures to preserve their own sanity (e.g., distancing themselves, hiring a secretary, delisting their home phone numbers, and so on), their patients can interpret this behaviour as indicative of a lack of compassion.

- **RWGP 4:** MHCPs should pay attention to how professional precautions and safety measures are interpreted by patients because they can lead to feelings of betrayal or disrespect.

Mechanic (1989) argues that an emphasis on real world social skills within psychiatric treatment would improve the patient's coping effectiveness: "Too often therapy designed to change patients is undertaken without giving careful consideration to the situation and problems to which they must return" (p. 201). This social dynamic (or lack thereof) could be a main contributor to the revolving door effect, and is therefore an important aspect of patient-provider communication.

- **RWGP 5:** MHCPs should manage a patient's social skills because—along with an awareness of the context(s) to which they may return to—it improves the patient's odds of successful rehabilitation.

Based on the function of mental hospitals and the circumstances of mentally ill patients, Jacoby (2002) developed the following comprehensive set of good practices for MHCPs:

- **RWGP 6:** The institution's physical and organizational structure should secure the safety of patients and staff because at least some of the patients have engaged in violent behaviour, whereas all have mental disorders.
- **RWGP 7:** All patients should be provided with a program of treatment that has a reasonable prospect of assisting them to regain mental health because commitment to such an institution is justified on the basis of a need for treatment of mental illness.
- **RWGP 8:** People qualified to provide mental health treatment should staff the facility because providing mental health treatment requires specialized skills and knowledge.

- **RWGP 9:** MHCPs should be carefully supervised to ensure that they do not abuse patients because institutionalized, mentally ill people are extremely vulnerable to abuse.
- **RWGP 10:** Patients should be regularly evaluated to determine whether they continue to require maximum-security confinement because violent behavior caused by mental illness may diminish over time.

The variety of patients at Arkham Asylum raises a dilemma for MHCPs when it comes to treating them individually. It would be easy to group the patients into a general schizophrenic category based on their symptoms, which include disruptions of their sense of self and psychotic experiences (World Health Organization, 2015). However, a cookie cutter approach would not suffice, as each patient has a unique background and story. Charles (2010) notes that “health care environments, including prisons and state hospitals, must have policies, procedures, instruction, and other support structures that embrace cultural diversity and the development of employee cultural competence” (p. 433). Kapoor, Dike, Burns, Carvalho, and Griffith (2013) explain that “when mental health professionals understand culture [language, ethnic background and identification, family relationships, child rearing, spiritual beliefs, social networks, past traumatic experiences, beliefs about mental illness], they are less likely to misinterpret cultural differences as signs of mental illness” (p. 273). Kapoor et al. offer an example of how an MHCP practicing cultural competence might recognize paranoia (an apparent mental illness) as the rational result of a patient’s experiences residing in a country with a corrupt government. According to Kapoor et al., these practices lead to tangible benefits, such as better understanding and more genuine respect at the individual level, which allows for more effective and tailored treatment. This idea

of recognizing cultural factors influencing a patient's past and present experience informs another real world good practice:

- **RWGP 11:** MHCPs should practice cultural competence when communicating with patients because it fosters better understanding, respect, and treatment outcomes.

Finally, literature suggests that MHCPs and patients can share common ground in their day-to-day operation. Deacon (2004) explains how “the professionals working within the hospital are as much subject to the regulatory balances as are the patients” (p. 90). The rules governing an asylum therefore apply to more than just its patients. According to Brooks, Gerada, and Chalder (2011), many mental health caregivers suffer from mental illness themselves, but refrain from seeking help in protection of their career interests.

- **RWGP 12:** MHCPs should regularly evaluate their own mental health because their professions expose them to a shared reality with their patients.

### **Research Question**

Based on the aforementioned real world good practices and the lack of current research on the subject of treating Arkham Asylum's patients, this study seeks to bridge this knowledge gap by exploring the following research question:

- **RQ 1:** Is a latent set of good practices for Arkham Asylum's mental health care providers (MHCPs) resting beneath their interactions with patients? If so, what are those good practices?

## **Methodology**

Since this question is concerned with the quality of care that the patients receive at Arkham, the researcher approaches the data using qualitative research, mainly narrative inquiry. Drafting a set of good practices for the MHCPs requires interpretive analysis of the audio interviews. According to Simmons-Mackie (2014), “qualitative research traditions fulfill this need to go beyond hypothesis testing and into the domain of discovery—to ask what’s going on? with the expressed intent of reinforcing or improving our clinical goings on” (p. 17). This section will outline the concepts and coding procedures that the researcher uses to answer the research questions.

### **Framework and Key Concepts**

The researcher relies on an inductive lens to discover patterns as they emerge from the data, and therefore avoids having theory informing the early research process. Using narrative inquiry allows the researcher to examine treatment for its communicative and narrative content: “studying caregiver storytelling in real time shows glimpses of the process of narrative knowledge development often discussed but rarely captured through empirical study” (Mattingly, 1998, p. 218).

The aforementioned real world good practices serve as loose elements to watch for, but are not strictly coded for during data analysis. Instead, they act as a means of comparing Arkham Asylum with real world mental health care facilities in the discussion section of this study. According to Clandinin and Connelly (2000), “for narrative inquiry, it is more productive to begin with explorations of the phenomena of experience rather than in comparative analysis of various theoretical methodological frames” (p. 128).

This study examines scenarios portrayed within Arkham Asylum that meet the criteria for patient-provider communication, defined by The Joint Commission—a health care accrediting agency—(2010) as “joint establishment of meaning wherein patients and health care providers exchange information, enabling patients to participate actively in their care from admission through discharge, and ensuring that the responsibilities of both patients and providers are understood” (p. 1).

Each patient of Arkham Asylum is considered criminally insane. That is to say that he or she is “a person who is convicted of committing a crime while impaired by a mental disease or defect so severe that at the time of the act he or she did not know the nature or quality of the act or that the act itself was wrong” (Charles, 2010, p. 432). This definition helps to frame morality as a key concept explored in this study. Daniels (2008) explains that the only two criteria likely to land a criminal in Arkham are that they wore a costume while committing the crime, and that the crime itself was centered on some kind of compulsion or theme (e.g. plants and Poison Ivy, the number two and Two-Face, birds and The Penguin, and so on).

Stories reflecting on human experience tend to have life lessons intended for the reader to learn. According to Martin (2007), “moral perception is also related to this sense of viewing one’s life as a narrative” (p. 240). These linear and moral features are evident in most superhero stories, which teach lessons about right and wrong through binary conflicts that tend to follow a simple chronological progression.

Fictional stories are often meant to mirror reality underneath their fantastic elements. Bickham (1993) goes a step further by claiming that in order register as believable for the reader, fiction often needs to make *more* sense than reality. For example, in reality, someone might take

the stairs instead of the elevator at work without there being any profound meaning or reason for it. Plot points in reality therefore do not always have to make sense in relation to some grander narrative. This type of randomness or lack of meaning rarely occurs in fictional stories, in which every narrative element reinforces a purpose (whether it is to advance plot, reveal character, or embody a moral message). If this example took place in a fictional novel, the reader might assume the employee is trying to lead a healthier lifestyle, or that perhaps the stairs symbolize the corporate ladder...

Given this hyper-significant aspect of narrative elements in fiction, the interactions taking place within the walls of Arkham Asylum begin to take on deeper meaning than the everyday mundane scenarios they appear to represent on the surface level. Letendre (1997) notes that for a patient living in a psychiatric hospital such as Arkham Asylum, a meal or a routine checkup become very meaningful events amidst the abundance of boredom. Interactions with staff are therefore incredibly significant for the patients. All of this adds up to suggest that the authors and actors playing out these scenes are not simply telling their individual tales, but rather they are saying something profound about the general practice of patient-provider communication when treating the criminally insane.

Connelly and Clandinin (1990) define narrative inquiry as the “study of ways that humans experience the world” (p. 2). Breaking down events for their story elements provides insights into human experience. Stories often portray complete pictures of the challenges and rewards of human experience, containing a beginning, middle, and end. According to Connelly and Clandinin (1999), to view a data set as narratively constructed is to take into account relevant histories, moral, emotional, and aesthetic aspects (as cited in Knowles & Cole, 2008). Pollio, Graves, & Arfken (2006) note that in the field of psychology, narrative analysis and case

studies allow the researcher to capture rich and nuanced understandings of what individual stories have in common. Clarke (2013) asserts that “video games provide opportunities for self-expression as well as valuable opportunities to ‘experience’ others’ lives and learn from their unique perspective” (p. 758), supporting the case for narrative inquiry’s applicability to the data.

The specific cases of Arkham Asylum’s patients are used to move toward a more nuanced understanding of good practices when interacting with the criminally insane. The findings that emerge from narrative analysis of these cases serve as the foundation for a set of good practices intended for Arkham’s MHCPs.

### **Data Analysis**

Before applying the detailed frameworks of narrative analysis listed above, the researcher performs a first pass of open coding and memoing inspired by Charmaz’s (2006) “code for coding” (p. 49) principles and guiding questions for line-by-line coding (p. 51). Strauss and Corbin (1990) define open coding as “the process of breaking down, examining, comparing, conceptualizing, and categorizing data” (p. 61). The idea behind this initial pass of coding and memoing is to capture themes, key words, and initial impressions of the data’s content before the researcher develops familiarity and bias that come with more interpretive narrative analysis of the data’s form. It is important to note that while this study is inspired by grounded theory practices, the researcher’s preexisting familiarity with the subjects and the aforementioned real world literature make the research more structured than typical grounded theory studies. The real world theory and practice gives the researcher an idea of what to look for in the data before coding it.

After an initial round of open coding, the researcher selectively codes for more specific areas of interest, beginning with Nowak's (2011) categories for indexing context, which provide background information for each interview's unique scenario:

- **Context 1:** Clinical context of the doctor–patient interaction (Hospital, departments, outpatient department, medical specialty resident doctor, and medical specialty)
- **Context 2:** Background of patient in the sample (age, sex, education, and diseases)
- **Context 3:** Background of doctor/caregiver in the sample (age, sex, medical specialty, position [chief physician/assistant/in training, and so on.])
- **Context 4:** Specific interactions in the sample
  - a. Length of interactions (in real time if measurable, but also in terms of word count, days between sessions)
  - b. Type of interaction (routine rounds; first consultation (history taking); follow up consultation)

After that, the interview transcripts are coded for overall narrative elements in accordance with Labov's (1972) six elements of a fully formed narrative:

- **Narrative 1:** Abstract (A): Introduction or pre-summary to the narrative.
- **Narrative 2:** Orientation (O): Who/what/where/when?
- **Narrative 3:** Complicating action (CA): What happened?

- **Narrative 4:** Evaluation (E): What is the point of the story?
- **Narrative 5:** Result (R): What finally happened?
- **Narrative 6:** Coda (C): Closing off/wrapping up narrative; nothing after this clause matters.

According to Berger (2000), these elements can be found in any given segment of conversation. Berger adds that judgments, criticisms, and evaluations are important to watch for, as they are indicative of important attitudes and beliefs. This exercise allows the researcher to interpret the big picture of each interview by breaking it down into its core chronological pieces.

Coding the data for narrative elements involved engaging with the data from both micro and macro perspectives. According to Simmons-Mackie (2014), “the micro perspective involves a detailed and focused study of a particular circumscribed event, such as a particular conversation, text, or interaction” (p. 19). Each patient’s group of taped interviews (usually a set of five brief audio recordings) act as the specific interactions in question. These smaller scale interviews fit into what Simmons-Mackie explains as the macro perspective in qualitative research, which “involves a focus on the social, cultural, political, or historical contexts and meanings of a particular event, group, or phenomenon” (p. 18). Therefore, the micro perspectives of specific interactions within Arkham’s walls combine to paint a macro perspective of attitudes and practices when treating a group of Gotham’s most infamous patients.

The idea of macro narrative elements of an interaction at Arkham Asylum suggests an overarching theme or frame that can summarize a given interaction (i.e. Labov’s concept of an abstract). Examples of these narrative elements found in the data include repeating cycles, role reversals, and patients escaping. At the micro level, consideration is given to more minor aspects

of the stories that play out. Such elements include patients affecting, threatening, or manipulating MHCPs (i.e., Labov's complicating actions). Pollio, Graves, and Arfken (2006) stress the importance of relating parts of a text to the whole data set: "The rationale for looking across interviews is not to produce generalizability but to improve interpretive vision. By looking both within and across interviews, the group is able to consider diverse experiences and to recognize how one situation resembles another" (p. 258).

Dimensions three and four of Dent et al.'s (2005) qualitative coding structure for medical interviews are used to fill in any gaps left by Labov's narrative model, which prevents the researcher from overlooking meaning in the data. Dimension three (function) provides more specific logistical context to the interaction by considering the tools and techniques used by the MHCP (e.g., leading questions, criticisms, and checking for understanding) as interpreted by the researcher. Dimension four (emotion) applies Ekman's (1992) six basic emotions (happiness, sadness, anger, fear, disgust, and surprise), which the researcher codes for by interpreting the vocal tone and word selection found in the interviews. Keeping the emotional categories broad in nature allows for easier recognition of patterns and similarities across interviews.

The researcher uses analytic memoing (documenting ideas, thoughts, and attitudes about the data) in order to create a foundation upon which to build the emerging set of good practices. This new set of good practices for Arkham's MHCPs serves as the study's main findings, all of which are based in examples from the data for context. For the purposes of engaging in a discussion that bridges the gap between the fictional popular culture and reality, the researcher compares and contrasts these findings with the real world good practices outlined in the review of literature. Real world good practices and theory from experts in the field will inform a model

of “good” patient-provider communication, which may or may not agree with the model born from the fictional data.

### **Delimitations**

This study focuses on Batman villains as they appear in *Batman: Arkham Asylum*, the video game. The primary data set is limited to the audio interview tapes between these patients and the MHCPs of Arkham. This research is not concerned with how these characters are portrayed within the main campaign story arcs of the games (Batman’s point of view), nor with how their tapes serve the broader narrative of the video game. The interview tapes represent the lived experiences of the patients and MHCPs from which meanings and insights are interpreted by the researcher. Despite this realistic treatment, the researcher does not disregard the fictional and scripted nature of the data in order to account for the heightened significance of fictional events addressed by Bickham (1993).

This study does not address the ethical implications of forced treatment upon the criminally insane and the deprivation of their autonomy. It is assumed that treatment of the patients of Arkham Asylum is both necessary and beneficial to the patients and to the city of Gotham as a whole. This way, the researcher can focus on the interaction at hand and the results produced without having to tackle broader humanitarian or political controversies that a correctional facility like Arkham Asylum might raise.

When coding the data, the researcher’s focus is on the interaction between MHCPs and patients. Anything outside of the interaction in question (e.g. background noise, secondary plot devices, and so on) is not be coded for or analyzed. Guards are considered MHCPs, and their interactions with the patients is both coded for and analyzed.

Despite the prominence of mental health as a major topic in this study, psychological diagnosis does not play a major role in framing or analyzing the data. Some psychological considerations are made when looking at the histories and mental conditions of the patients, but the interviews are framed in terms of their narrative and conversational elements.

Some bias does inevitably influence the interpretive process, as the researcher is unable to escape a preexisting familiarity with both the game in question as well as many other Batman stories featuring iterations of the same characters. This bias is not likely to have a major impact on the findings of this study, which are rooted in the specific interactions featured in the audio interviews. If anything, this bias helps the researcher when coding the data for context in some instances.

### **Limitations**

Any practical insights derived from data analysis are confined to Arkham's fictional walls. More specifically, the findings and their implications for real world practice are limited to food for thought. The findings therefore have no bearing on real world patient-provider communication policies. Instead, they are used to call attention to how popular culture uses storytelling to shine a spotlight on real world issues such as the day-to-day treatment of people with mental illness.

The audio format of the raw data means the loss of many visual cues for the researcher to code for and interpret. Adler, Rosenfeld, Proctor II, and Winder (2006) state that although social scientists dispute the degree of importance of non-verbal communication, “it is a fact that non-verbal communication contributes a great deal to shaping perceptions” (p. 157). Dent, Brown, Dowsett, Tattersall, and Butow (2005) address this issue in their study of the reliability of

Cancode, a computer software for analyzing patient-provider communication during cancer consultations: “Seeing non-verbal elements whilst coding doctor behavior does not significantly alter coding of verbal information using Cancode, supporting previous findings that audio taped material is adequate for analysis of verbal content of a consultation” (p. 43). While some interesting findings may be lost due to the data’s lack of visual non-verbal communication, the overall meaning contained in the audio recordings should nevertheless be reliably coded for.

### **Findings**

The following is a summary of the main discoveries from the researcher’s coding journal, which have been evaluated and refined into a concise and comprehensive set of good practices for Arkham Asylum’s MHCPs. Recommendations are accompanied by examples from the data that are informing them. Whereas the aforementioned real world good practices for patient-provider communication in mental health care environments are rooted in peer-reviewed scholarly literature, these findings derive from the narrative data found in the audio recordings.

The key players featured in the data are as follows, beginning with Arkham Asylum’s MHCPs on staff:

- **Dr. Penelope Young** (Chief Psychiatrist)
- **Dr. Sarah Cassidy** (Psychiatrist)
- **Dr. Stephen Kellerman** (Psychiatrist)
- **Dr. Harleen Quinzel** (Psychiatrist); later becomes villain Harley Quinn
- **Aaron Cash** (Security Guard)

Six patients are featured in the data, all of whom are well-established villains in the DC Comics universe:

- **The Joker** (Legal Name: Unknown)
- **Killer Croc** (Legal Name: Waylon Jones)
- **Mr. Zsasz** (Legal Name: Victor Zsasz)
- **The Scarecrow** (Legal Name: Jonathan Crane)
- **Poison Ivy** (Legal Name: Pamela Lillian Isley)
- **The Riddler** (Legal Name: Edward Nashton AKA Edward Nigma)

It is important to reiterate that this research is not concerned with profiling or diagnosing the patients, but rather focuses on evaluating the data's communicative content. For additional context on the patients, please refer to Appendix A, which contains Dr. Young's notes, outlining treatment and diagnosis records of each patient featured in the data.

### **Good Practices at Arkham (GPA)**

The researcher noticed a significant pattern in the data, in which patients call attention to their positions as outcasts or others and pass judgment on members of society. Out of this us vs. them dynamic comes the need for empathy, a theme around which these good practices revolve. If MHCPs at Arkham Asylum tried to see things from their patient's perspective and approach problems accordingly, they may promote better understanding of not only their patients and their illness, but also of the distance between these villains and society. Without an attempt to bridge

that gap, the MHCP reinforces the patient's liminal position as an other/monster, which contradicts the facility's correctional mandate.

The appearance of a moral outburst is a recurring event in the data. Patients deliberately take a moment to express their otherness, distinguishing their beliefs from "you people" (the general public), in disgust. Edward Nigma is known to have an inferiority complex, so for him to scoff at the public, claiming that "most people are idiots" is expected. That said, Zsasz, Isley, and Joker also have similar outbursts, referring to people as "zombies," "horrible fleshy sacks," and "sacks of walking meat" respectively. Note the similarities in their choice of words. The patients must be utterly convinced of and devoted to their moral beliefs, calling attention to (if not proud of) their liminal position as others. Joker and Zsasz both claim to be some form of saviour. In their eyes, Batman is a villain; Joker and Nigma both make reference to this belief in their interviews. Crane is the only one who does not have one of these specific moments, but there are some hints at a similar relationship. If people are simply food to Jones, then they are simply research subjects to Crane. Looking at how these instances are handled by MHCPs offers specific examples around which to build a set of good practices for patient-provider communication.

**Acknowledge and explore the patient's beliefs.** Patients seem to be perfectly willing to share their beliefs and ideologies ad nauseam. There should plenty of value in exploring these ideas and value systems in order to understand each patient's mental illness and how to tailor diagnostic and treatment sessions accordingly. The data, on the other hand, shows a tendency of MHCPs to dismiss or abruptly denounce patients sharing their beliefs. MHCPs who take the time to explore a patient's beliefs, rather than dismissing them and ending the interview, tend to get more information and insight into these beliefs.

**Remember that patients can and will act on these beliefs.** Acknowledging a patient's beliefs is not only important for acquiring more information, but it also can provide some foresight into the patient's plans or possible actions. Zsasz is very clear in stressing how important acquiring tally marks from his murder victims is to him. When Dr. Cassidy goes on stress leave in response to his stalker-like threats, Zsasz becomes depressed, and is left "thinking about the one that got away." When Zsasz escapes, it is implied that he immediately goes to Dr. Cassidy's apartment, putting her in danger. Knowing he had previously set his eyes on Dr. Cassidy, and knowing of his powerful urges to kill again, Dr. Whistler could have taken better preventative measures to protect Dr. Cassidy in the event of an escape.

**Criticism and judgment are not effective ways of addressing a patient's beliefs.** Arkham's patients already see themselves as others, and based on their actions and villainous status, are presumably treated as such by society. To treat them the same within the hospital's walls would stifle the facility's correctional mandate. There are no instances in the data of patients reacting by feeling any sort of guilt, remorse, or even reflection in the face of criticism and judgment. All it does is frustrate the doctor when they do not get the desired reaction (or any reaction) from the patient, or get the patient wound up and angry.

**Try to see things from the patient's point of view.** When Zsasz starts talking about "liberating" his victims, Dr. Cassidy does not immediately judge him. She tries, for a moment, to see things from his perspective. However, after seemingly experiencing some cognitive dissonance while framing things in Zsasz's terms, she takes a judgmental and reprimanding tone shortly thereafter. In response to Dr. Cassidy taking a moment to consider his side of the story, Zsasz states that his victims "were all lucky to be chosen to receive my gift." This is more useful

information for the purposes of his treatment than the threats Dr. Cassidy receives for passing judgment on his beliefs.

- **Good Practices at Arkham (GPA) 1a:** MHCPs should practice empathy when communicating with patients because it counteracts existing ostracizing forces and perceptions, which act as boundaries to rehabilitation.

Despite the potential benefits of following the previous recommendations, they come with risks that should be taken equally seriously. MHCPs should watch for the following warning signs of empathy's adverse effects:

**MHCPs adopting their patient's beliefs.** Seeing things from a patient's perspective can lead to the patient's beliefs becoming convincing for MHCPs. In extreme cases, MHCPs actually adopt the beliefs of their patients. Dr. Quinzel's interest in Joker's beliefs leads to a complete initiation into his villainous paradigm.

**MHCPs complying with patient's requests on a regular basis.** This recommendation is not suggesting any kind of cruel treatment of patients. Complying with a patient's request can build trust and respect. For example, when Dr. Young plays along with one of Nigma's riddles, it puts him in good spirits and seems to make him more agreeable. That said, unfettered compliance can lead to cases in which the inmates are literally running the asylum, as the saying goes. What starts out as minor favours for Isley quickly escalates up a compliance ladder until Dr. Kellerman is letting her out of her cell. Similarly, Dr. Quinzel receives a gift of flowers from Joker, which should be cause for concern. By the time she returns the favour, she is also helping her patient escape.

- **GPA 1b:** MHCPs should beware of the pitfalls of empathy because patients can manipulate MHCPs into becoming their criminal accomplices.

Once an MHCP has gained an understanding of their patient acknowledging their beliefs and trying to see things from their patient's perspective, they should then make an attempt to speak to their patient in terms that resonate with them. Making this effort can lead to increased responsiveness and engagement in notoriously uncooperative patients. Knowing a patient's history, along with observation of their behaviour during interviews (engagement levels, word choice, and so on), allow the MHCP to recognize a particular theme that strikes a chord with their patient.

**Discover what motivates and interests the patient.** Observation of the data reveals the following themes that are carried throughout each patient's interviews:

- **Crane:** Fear
- **Isley:** Compliance
- **Nigma:** Knowledge
- **Jones:** Food
- **Joker:** Jokes
- **Zsasz:** Collecting

**Frame your discussions around the patient's beliefs and interests.** The idea here is not to aggravate or exploit a patient's compulsions, but rather to subtly reframe interactions on a patient-by-patient level.

The main emotion Crane displays is happiness, which he exudes when he is immersed in his “research” (drugging others with his fear toxin). He tends to lose interest when Dr. Kellerman tries to address other subjects. With the knowledge that Crane’s main interest is in fear, MHCPs would benefit from reframing a question or problem around that concept. Dr. Young tries to talk to Joker about his fears, and it confuses him. Perhaps that would be a better question to ask Crane. When approaching the subject of Joker’s fears, it may connect better if it was framed within jokes or funny ironies that resonate with him.

Zsasz seems to take more interest and perk up during the interview when he is able to toy with Dr. Cassidy by revealing he knows many personal details about her. While there is a stalker-like aspect to his obsession, it seems like his main motivations are those of a compulsive collector. Discussing personal details like her home address would not be in Dr. Cassidy’s best interests, but she may have success framing interactions around themes of possessions or acquiring things.

Dr. Young uses a lot of probing questions, but it does not seem to bother Nigma. He enjoys both asking and answering questions, which of course lines up with his identity of The Riddler. This question and answer, cat and mouse dynamic persists through his interview tapes. Dr. Young could be intentionally holding this frame in order to speak in a language that resonates with Nigma.

**Give patients the option of being addressed by their alias name.** If acknowledging a patient’s beliefs is considered a good practice, so should acknowledging their identity. Many of Arkham’s patients made the conscious or unconscious decision to leave their real names and identities behind. Addressing them under these former aliases could create unnecessary

resentment or disengagement. Dr. Kellerman makes appeals to both Isley and Crane's former identities, mentioning how they were esteemed doctors in the past in an attempt to dismantle their villainous ideology. He even refers to Crane as Dr. Crane when introducing their first interview. Neither instance succeeds in rekindling any sense of their former selves (Crane becomes disinterested and Isley blows it off); the patients show no remorse or resonance with who they were in the past. If the patient believes himself to be The Riddler, then referring to him as Edward or Mr. Nashton is a subtle rejection of his beliefs, which would conflict with the previous good practice of acknowledging a patient's beliefs.

- **GPA 2:** MHCPs should frame interaction in terms and themes that resonate with the patient because it promotes engagement and cooperation.

Asking patients how they would like to be addressed not only supports the theme of practicing empathy, but it also calls attention to the need for MHCPs to practice professionalism. The previous good practices touch on the importance of restraint, whether in topics to discuss or in compliance with a patient's requests. The following section breaks down this idea of restraint into various components of professional conduct for Arkham Asylum's staff.

**Practice patience; progress is often slow.** While none of the patients show any dramatic improvements during their interviews, some MHCPs do make small steps toward a more cooperative relationship with their patient. Nigma's interviews are very spaced out, chronologically, with tens of interviews and months at a time omitted from the data set of five tapes. Dr. Young comes across as very patient when this timeline of almost a year is taken into consideration. Even when she is tired and Nigma tries to test her patience, Dr. Young remains keen on treating him. The fact that the number of sessions is approaching one hundred with the

same MHCP suggests at least the possibility of some progress. Even when admitting that she is giving up on treating Nigma, Dr. Young is professional and methodical about it, explaining that she has gone as far as she could with him. This particular case represents the most progress shown in the data. If this is a best case scenario, then MHCPs should mentally prepare for the long haul.

**Avoid showing emotion (especially disgust) around patients.** Coding for emotion revealed an apparent a relationship between disgust and happiness in the interviews; patients appear to take pleasure in making the MHCP's feel disgust. Nigma, for example, revels in the crude dead baby solution to his riddle, which garners a reprimanding reaction from Dr. Young. When asked how he could joke about such things, Nigma responds, "easily, Doctor. It's not my baby." These situations make a strong case for MHCPs to practice putting on a good poker face.

The MHCPs who tend to show less emotion have more productive interactions with their patients. Dr. Whistler remains calm and neutral—almost to the point of being disengaged—in the face of imposing patients like Zsasz and Jones making death threats. Codes in the data labelling Dr. Whistler's emotions are few and far between, as she hardly shows any in her tone. Her ability to maintain compliance from patients who consistently answer her questions in a seemingly truthful way represents commendable progress when compared to the other interviews in the data set.

Despite Dr. Whistler's multiple warnings, Quinzel never displays any kind of fear when interviewing the Joker. Despite how things turned out for Quinzel, the interviews showed promising breakthroughs in engaging Joker better than Dr. Young, the chief psychiatrist.

Surprisingly, no MHCPs show fear when dealing with Jones, who is disfigured and imposing in stature (not to mention his constant threats of eating them). MHCPs are likely taught not to show fear around the patients. Cash's unnecessary force and rudeness could be a defence mechanism to mask his true fears of Jones.

**Avoid knee-jerk reactions to a patient's actions or words.** Cash displays unprofessional behaviour in the presence of Jones, who is constantly antagonizing the guard into angry reactions. He begins one of the sessions by telling Jones to "sit down and shut up!" They are there for an interview. It would not be much of an interview if Jones obliged this demand. In this sense, Cash is acting as an obstacle to the task he is overseeing.

There are at least two instances of MHCPs attempting to shame the patient in reaction to their words or actions. One instance is the aforementioned dead baby joke, which Dr. Young questions in disgust. Another instance is when Jones jokes about choking on Aaron Cash's hand after biting it off. Dr. Whistler has a very similar reaction as Dr. Young's, declaring "that's disgusting. He could have died." Professionalism in the form of some restraint would likely be a better recourse than reacting with knee-jerk appeal to guilt, as neither patient shows any remorse for their words or actions.

**Avoid divulging personal information.** As is evidenced in the case of Victor Zsasz, a patient knowing too much about an MHCP's personal life can be life-threatening. Crane also leverages information about Dr. Kellerman's personal life to scare him into stopping the interview. When Nigma sees a family portrait on Dr. Young's desk, he starts asking questions, which makes Dr. Young uneasy and defensive. Personal trinkets, family photos, or other potentially compromising clues into an MHCP's personal life should remain outside of

Arkham's walls. The focus of an interaction between patient and MHCP should stay on the patient and their treatment.

**Begin sessions by exchanging courteous pleasantries.** It is common practice in the data for MHCPs to begin interviews by exchanging some form of pleasantries with the patient (usually simple courteous greetings and ice-breaking questions). Dr. Whistler skips the pleasantries when greeting Jones, and the dynamic between them is always standoffish and hostile. Dr. Kellerman, on the other hand, is always courteous and welcoming in his greetings with Isley, and is better received. His courtesy is reciprocated and he appears to receive more compliance from his patient.

**Use the title “patient” over “inmate” in clinical contexts.** While it may be accurate to refer to Arkham's residents as “inmates,” the MHCPs in the data tend to use “patient” instead. Dr. Whistler insists on referring to Jones as a patient, despite Cash asserting “that thing's not a man.” Not only is this practice a professional one, but it also agrees with previous good practices attempting to close the distance between these liminal characters and the societies they exist outside of. As Dr. Young stresses to Nigma, “I am here to help you. We all are.” Recognizing the inmates as patients implies a relationship revolving around treatment, not incarceration.

- **GPA 3:** MHCPs should practice professionalism when interacting with patients because reacting to them by showing disgust only solidifies their positions as others.

The existence of a tug-of-war like power dynamic is common across the data. Patients use both harmless and harmful tactics to gain an upper hand when interacting with MHCPs. Almost all patients use their own petty means of contesting power during interviews. These

instances can foreshadow bigger transgressions with higher stakes further down the road of the narrative. Based on the current balance of power, MHCPs should respond accordingly.

**Recognize petty attempts to undermine or overtake the power dynamic.** The first step for MHCPs to practice is awareness. These subtle shifts in power are the early warning signs to watch for. Nigma provides many examples of these kinds of contests. For example, he takes pleasure in knowing something that Dr. Young does not. He is at his happiest in his interviews when withholding important information about the Joker's plan and whereabouts. Another subtle display of power during interviews is Nigma's tendency to end interviews on his terms, either by crossing a line and having the guards called on him to cut the interview short or by simply getting the last word in.

Joker uses other manipulative means of controlling interviews. By fabricating false stories when asked about his past, he is able to evade Dr. Young's questions. He also has a tendency to try and dictate the topic of conversation, forcing Dr. Young to keep changing the subject in order to maintain control of the interaction.

Another way that patients posture for power is through name calling, whether through the titles patients use to address MHCPs, or through more derogatory name calling. Jones introduces himself to Dr. Whistler by calling her a curse word. During one of his angry fits, Nigma references Dr. Young's "stupid, gawking face." These forms of minor transgressions are more direct, whereas the data reveals a more subtle form of power contention through name calling. Crane refers to Dr. Kellerman by his first name in a patronizing tone when playing the role of the MHCP in the interview. Also, Joker and Jones both use the term "doc" to address their MHCPs in an underhanded, disrespectful way. It appears as though their use of the short form is an

attempt to devalue or discredit the usually respected title of doctor in society. Isley uses a different form of name calling, telling Dr. Kellerman to “call me Ivy” in an effort to build rapport with her MHCP. When Dr. Kellerman falls in love with Isley, she holds all the power in the relationship.

Patients will employ tactics aimed at flipping the script, framing the MHCP as the subject of the interview. When Dr. Kellerman and Dr. Young fail to greet their patients (Crane and Nigma respectively) with the polite approach established in the previous good practice, the patients take the opportunity to do it themselves. Failing to set the tone for the interaction opens the door for a role reversal, in which the patient acts as the MHCP and frames the interview early on with a power struggle for who is leading.

Normally the MHCP is the one reassuring the patient in a supportive role, but Isley reverses this dynamic with strategic flirting. She uses fear and reassurance as a means of manipulating Dr. Kellerman. Her reassurance is almost always followed by a request or a flirtatious remark of some kind. She appears to be leveraging reciprocity by offering reassurance then asking for a favour in return. When Dr. Kellerman asks if she likes the flower he procured for her, Isley assures “oh yes, Stephen, I love it. Such a beautiful flower,” following immediately after with a request: “Do you mind if I keep it?” Isley uses her flirting and reassurance as a bargaining chip. These small favours can lead to a total takeover of the MHCP, as is shown in the case of Dr. Kellerman.

**Avoid acknowledging when patients are in a position of power.** When patients are either posturing for or leveraging their power, MHCPs should make an effort not to play into their games. When Nigma greets Dr. Young in what appears to be an attempt at a role reversal,

Dr. Young greets him calmly and takes control of the session. When Nigma then starts hinting at the insider information he is withholding, Dr. Young lets him take control of the interview and she begins pleading with him to tell her what he knows. This final interview concludes with Nigma asserting his powerful position, boasting “you forget, Doctor. I'm the one who asks the riddles.” In this case, pleading with the patient reinforces their position of power.

One of Crane's interview with Dr. Kellerman begins similarly, with the patient trying to take over through a role reversal. However, this time Dr. Kellerman reacts in a defensive manner, asserting that he is the one conducting the session. Crane then responds in a patronizing tone: “Of course. If that helps you cope, I wouldn't have it any other way.” By reacting to a simple attempt at a role play, the MHCP acknowledges a power dynamic in which he needs to prove himself to the patient.

**Use pacification methods if a patient's power gets out of control.** There is a point at which the petty contests can escalate into a power dynamic that MHCPs can no longer control with words alone. This is the reason why Jones is constantly wearing a shock collar, ready to pacify the patient if needed. Dr. Whistler tries to avoid using the collar, but recognizes its necessity; without it he hospitalizes the guards.

The interesting thing about the shock collar is that it reveals how patients themselves use the previous recommendation of ignoring power in order to take it away. Despite it sounding very painful, Jones does not plead with Cash to stop shocking him. Instead, he says “strap on whatever you like, Doc. This thing just tickles.” Downplaying this obvious power they hold over him allows Jones to offset the power dynamic, thus diluting the MHCP's power. Another example of this principle in action is when Batman crashes in to rescue the MHCPs from Crane's

attack. When Crane cannot believe that his fear toxin is not affecting Batman the way it does his other victims, Batman remarks “who says it’s not?” Batman is likely experiencing some of the drug’s hallucinogenic effects, but he knows that showing fear in front of Crane would mean conceding his power. When both parties try to frame the interaction, the first one to accept the frame loses a measure of power.

- **GPA 4:** MHCPs should be aware of the power dynamic when interacting with patients because patients are capable of taking over interviews.

Interacting with Arkham’s patients is dangerous. Patients can become violent and incidents do occur. MHCPs should take precautions to have additional security on standby based on patient history along with records of prior communication. The warden has approval authority for any additional security measures. The following recommendations, while not entirely communicative in nature, are safety considerations that have an impact on the interviews.

**Treat threats seriously.** Jones makes good on his threat to Cash, punctuating their rivalry by nearly killing him. Also, after escaping, it is implied that Zsasz immediately visits Dr. Cassidy in order to fulfill his promise of “liberating” her. These patients are very capable of actualizing their threats, which should not be taken lightly.

**Avoid underestimating a patient’s capabilities.** There are two or three guards in the room with Victor, and when he attacks them, they need even more security to subdue him. Crane neutralizes multiple MHCPs at one time with his toxin. Before he was fitted with a shock collar, Jones hospitalized three guards in a single incident. Isley and Joker both manage to escape their cells. The data speaks for itself; Arkham’s patients are a cunning and capable group.

**Conduct risk assessment when assigning MHCPs to patients.** Attention needs to be paid as to which MHCPs are assigned to which patients. Assigning a female MHCP to the serial killer who recently murdered 20 women and a male MHCP to the patient known for seducing and manipulating men seem like questionable decisions. More strategic assignment of MHCPs could help in mitigating some of the risks involved in treating Arkham's patients.

**Avoid unnecessary use of force when escorting patients.** Cash uses unnecessary force by shocking Jones with a collar during a moment when he was not posing any immediate threat; no pacification was needed. Later, Cash has his hand bitten off by Jones during a breakout attempt. There is a fifty-fifty chance the hand he lost was the one he used to trigger the collar. The data suggests that unnecessary violence can incite revenge plots, which do not help anyone.

**Be proactive in anticipating potentially violent scenarios.** The following are warning signs that may occur during and between interviews:

*High turnover of MHCPs.* There is a connection between incidents and MHCP transfers. Usually patients are transferred to a new MHCP following an incident.

*Poor response to medication.* Zsasz's poor response to medication is immediately followed by a knife attack injuring one of the guards.

*Change in usual behaviour or demeanour.* Zsasz's depression highlights his obsession with Dr. Cassidy, foreshadowing his eventual pursuit of her.

*Uncooperative or difficult behaviour.* Crane is persistent in his role playing as the MHCP conducting the session, which he realizes through violent attacks at both the beginning and end of his story arc.

*Verbal abuse.* Jones is particularly crude and threatening in his use of language. His use of the title “doc” when referring to Dr. Whistler comes off as insulting in tone. His vocal attacks are followed by physical ones.

*Pushing boundaries.* Across the data, there is a recurring phenomenon of boundaries being pushed and broken. The moments when lines are crossed by the patient usually culminates in a “get him out of here” reaction from the MHCP. That is, the patient will say or do something that causes the MHCP to call the guards and cut the interview short. Examples of these moments include:

- Crane explains his belief, which causes emotional distress in Dr. Kellerman.
- Nigma inquires about a photo from Dr. Young’s desk, making her feel uneasy.
- Jones references his cannibalistic habits, which upsets Dr. Whistler.
- Zsasz ignores Dr. Whistler, repeating “cutting and cutting” catatonically.

Isley and Joker do not display these specific moments in their interviews. However, these are three cases (Joker deals with both Dr. Young and Dr. Quinzel) in which the MHCP is actually an accomplice to the patient’s plot, so it makes sense that the patient would not be trying to cause any abrupt transgressions.

If one or more of these occurrences arises during or between interviews with a patient, then consult security protocols or the warden for ways to proceed as safely as possible.

**MHCPs should regularly evaluate their own mental health.** Protection from physical violence is only part of the support that is required for Arkham’s MHCPs. Based on the emotions expressed by MHCPs during interviews (mainly disgust) and the abuse they take from patients

(including name calling, manipulation, and threats), MHCPs are encouraged to attend to their own therapy sessions or psychiatric evaluations. This way, they can process their emotions and cope with anything that might be bothering them. Dr. Kellerman is clearly affected by Crane in a way that haunts him. Dr. Young gets more and more frustrated with Nigma as time goes on. Dr. Cassidy ends up taking leave because of comments made by Zsasz. Arkham's MHCPs need protection from mental abuse they regularly face when interviewing patients.

- **GPA 5:** MHCPs should take safety precautions because of the many threats that Arkham Asylum's patients pose to their physical and mental health.

### **Discussion**

The purpose of the study is not to make any clinical breakthroughs at the policy level. Following these good practices may garner more compliance from Arkham's patients, but this is not a guarantee of more effective treatment. In fact, too much empathy may only serve to feed into the narcissism of many patients. The real goal of drafting good practices for a fictional facility is to explore how stories in popular culture frame real world problems like treating the criminally insane. Considering how these fictional MHCPs might better handle these exaggerated comic book characters is interesting in of itself. Taking it a step further by comparing these new good practices for Arkham Asylum's MHCPs with existing real world good practices for MHCPs in similar situations highlights the exaggerated nature of the fictional world.

### **Comparing Good Practices**

RWGP 1 stresses the importance of relationship building along with information transfer, whereas GPA 1 recommends ways of building the relationship in a balanced way using empathy.

RWGP 11's call for cultural competent practice is also mirrored in Arkham's detailed approach to empathy. Both sets of good practices warn of the ostracizing effects of judging patients. Interestingly, RWGP 3's suggestion of maintaining close ties with a patient's friends or family is nowhere to be seen in Arkham's good practices, as there is never any mention of a patient's connections to the outside world in the data. This shows just how disconnected Arkham's patients are. When Zsasz escapes and immediately seeks out Dr. Cassidy, he is trying to reconnect with one of his closest relationships. This discrepancy highlights the extreme challenge involved in treating Arkham's patients. RBP 5's focus on managing a patient's social skills in order to prepare them for reintegration into society is likely a valid good practice for Arkham as well. However, Arkham's patients present such extreme cases that simply sitting them down for a session without anyone getting injured qualifies as progress; their social skills are low on the priority list of things to manage.

GPA 3, outlining how MHCPs should practice professionalism when interacting with patients, is somewhat at odds with RWGP 4, warning of the damage professional precautions can have on relationships with patients. Arkham's good practices suggest that the risks associated with professional precautions are worth taking on. Much like how GPA 1 comes with a caveat, this discrepancy could reinforce the need for a balanced approach to professionalism.

Both sets of good practices agree on the potential for violent encounters and therefore stress the need for safety precautions. Whereas Arkham's good practices frame the problem within a patient vs. MHCP paradigm, RWGP 6 points out the need to protect patients from other violent patients. RWGP 9 goes a step further in recognizing how vulnerable these patients are to abuse from MHCPs. These additional considerations suggests that in reality, things are not as simple as a comic book dynamic of good guys vs. bad guys.

Another theme resonating across the RWGPs and GPAs is the expectation of eventual rehabilitation. What distinguishes these hospitals from simple prisons is their purpose in treating patients. Therefore, both sets of good practices revolve around a logic that needs to support effective treatment as a top priority.

Both sets of good practices suggest that the lines between MHCP and patient can become blurred. The real world good practices warn of the effects of MHCPs taking precautions to preserve their sanity. That said, both RWGPs and GPAs recognize the importance of regular psychiatric evaluation for MHCPs. Patients of Arkham Asylum, like the patients of real world psychiatric hospitals, display the ability to physically and mentally traumatize the MHCPs on staff.

### **Other Discussion Points**

Reflecting back on methodology, it is interesting to note that the researcher initially saved the data files under the patients' villainous aliases. This could be a display of stigma in how these patients are perceived. Even after adopting the practice of referring to the subjects by their real names (as is the practice of Arkham's MHCPs), the researcher still ended up referring to Edward Nashton by his more commonly used alias last name Nigma (E. Nigma). To refer to him as Nashton, for the researcher, would feel like talking about someone else. In this way, the villainous alter egos of patients represent their dominant identities. While Edward Nashton is intertwined with his character, the researcher instinctively sees him as The Riddler first. Much of this has to do with how the narrative frames the characters; nevertheless, it raises an interesting question concerning the nature of these characters. Future research focusing on identity issues

could explore how different personalities are expressed, perceived, and managed at Arkham Asylum.

During the proposal writing stages of this study, the researcher referred to the subjects as “inmates” (as informed by both existing literature review and their own preexisting bias). However, during the coding stages, the researcher adopted the term “patients,” which falls in line with the practice of Arkham’s MHCPs. Both “inmate” and “patient” are accurate titles, as Arkham Asylum is a correctional psychiatric hospital. However, if these villains were simply meant to be incarcerated, then they would be sent to Blackgate Penitentiary. The distinguishing characteristic of Arkham Asylum is that it also serves to treat an inmate’s mental illness in a clinical setting. It could be argued that framing these violent criminals as patients is overly forgiving, as there are victim connotations behind the term, but titles and terminology are not the focus of this study.

At one point during analytic memoing, the researcher wrote “criticizing or judging the patient brings the MHCP down to the patient’s level.” The operative word “down” infers a subtle form of judgment on the part of the researcher, implying that the villains exist on a lower rung of the ladder than the MHCPs.

Going into the coding, the researcher was expecting to see a theme of moral superiority from the doctors as they judged or criticized the patients. While some of this dynamic is present in the data, the patients actually display this trait much more often; all of them take strong positions of superiority against the MHCPs and the general public. The patients see themselves as “other” to “everyone else,” which is a dynamic that could be explored in greater detail. It would be interesting to apply conventional aspects of monster research to this data, as there are

many similarities between how these villains are portrayed and how the motif of the monster appears in folklore (an earlier form of popular culture). Both groups carry with them the same themes of liminality and otherness to society. Much like traditional monsters, Batman villains have a hero against which they are juxtaposed.

It is worth noting that all of the data from this study is pulled from a single source. It would be interesting to see if a similar set of good practices would emerge from other sources of data, such as interviews from *Batman: The Animated Series*, or from the graphic novel *Arkham Asylum: Madness*.

Arkham's good practices puts additional emphasis on anticipating violence in patients. The researcher's review of real world literature acknowledged the behaviour of mentally ill patients as unpredictable, but did not find studies focused on predicting patient violence based on real world data. Future research could look into applying the same methodology to real world interview data to see what kinds of recommendations are produced. Even applying the same methodology to the same data set with a different focus (security protocols, MHCP's mental health, identity theory, and so on) could produce a thought-provoking set of good practices.

### **Conclusion**

The findings generated from this study are not intended to revolutionize the fields of patient-provider communication or criminal psychology, but rather they are intended to create a space for discussion about a topic that was once a point of stigmatization. According to Clandinin & Connelly (2000), "the contribution of a narrative inquiry is more often intended to be the creation of a new sense of meaning and significance with respect to the research topic than it is to yield a set of knowledge claims that might incrementally add to knowledge in the field"

(p. 42). The set of hypothetical good practices produced by this study is not only a contribution to the growing field of comic book studies, but it also provides an alternative perspective for researchers in the field of patient-provider communication to consider. The pervasiveness of superhero stories in current popular culture adds to the relevance of this research.

The deeper understanding of this infamous yet overlooked corner of popular culture allows for the reflection and consideration of our own practices regarding mental illness. These stories “not only present complex narratives of social characters and their psychological challenges, but also a running metanarrative in which the character collective explores the human condition” (Crutcher, 2011, p. 67-68). Is the exaggerated and sensationalized nature of these stories leaving its audience with similarly skewed perceptions of mental illness? How engaging would this fictional story be if it was more representative of the realities of treating mental illness? Such a video game might not sell as many copies or win any awards. This study shows the many ways in which popular culture can mirror reality, as the good practices for real world patient-provider communication bear many similarities to those in *Batman: Arkham Asylum's* fictional interviews. That said, it is important not to let our understanding of reality be shaped by narrative devices used to drive plot and character development. The narrative of this hospital is one of perpetual recidivism, in which a revolving door effect plagues its patients. Ultimately, the lessons learned for the MHCPs of Arkham Asylum should be confined to this fictional world.

### References

- Adler, R. B., Rosenfeld, L. B., Proctor II, R. F., Winder, C. (2006). *Interplay: The process of interpersonal communication*. New York: Oxford University Press.
- Arrigo, B. A. (2001). Transcareceration: A constitutive ethnography of mentally ill “offenders.” *The prison journal*, 81(2), pp. 162–186.
- Batman: Arkham Asylum [PC, Xbox 360, & Playstation 3 console software]. (2009). London, England: Eidos Interactive Ltd.
- Berger, A. A. (2000). *Media and communication research methods*. Thousand Oaks, CA: Sage Publications, Inc.
- Bickham, J. M. (1993). *Elements of fiction writing: Scene & structure*. Cincinnati: Writer’s Digest Books.
- Brooks, S., Gerada, C., & Chalder, T. (2011). Review of literature on the mental health of doctors: Are specialist services needed? *Journal of mental health*, 20(2), pp. 146–156.
- Charles, C.E. (2010). Providing culturally competent care for the criminally insane inmate. *Issues in mental health nursing*, 31, pp. 432–434.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage Publications, Inc.
- Clarke, L. (2013). Wham, sock, kapow! Can Batman defeat his biggest foe yet and combat mental health discrimination? *Journal of psychiatric and mental health nursing*, 20, pp. 752–760.
- Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational researcher*, 19(5), pp. 2–14.

- Connelly, F. M., & Clandinin, D. J. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass Inc.
- Crutcher, P. A. (2011). Complexity in the comic and graphic novel medium: Inquiry through bestselling Batman stories. *Journal of popular culture*, 44(1), pp. 53–72.
- Crawford, P. & Brown, B. (2009). Mental health communication between service users and professionals: Disseminating practice-congruent research. *Mental health review journal*, 14(3), pp. 31–39.
- Daniels, B. J. (2008). Arkham Asylum: Forensic psychology and Gotham’s (not so) “serious house.” In Rosenberg, R. S. & Canzoneri, J. (Eds.), *The psychology of superheroes: An unauthorized exploration*. p. 201-212. Dallas, TX: Benbella Books, Inc.
- Dafoe, T., & Stermac, L. (2013). Mindfulness meditation as an adjunct approach to treatment within the correctional system. *Journal of offender rehabilitation*, 52, pp. 198–216.
- Deacon, J. (2004). Testing Boundaries: The social context of physical and relational containment in a maximum secure psychiatric hospital. *Journal of social work practice*, 18(1), pp. 81–97.
- Dent, E., Brown, R., Dowsett, S., Tattersall, M., & Butow, P. (2005). The Cancode interaction analysis system in the oncological setting: Reliability and validity of video and audio tape coding. *Patient Education and Counseling*, 56, pp. 35–44.
- Ekman, P. (1992). An argument for basic emotions. *Cognition and emotion*, 6(3–4), pp. 169–200.
- Harter, L. M., Japp, P. M., & Beck, C. S. (2005). Vital problematics of narrative theorizing about health and healing. In Harter, L. M., Japp, P. M., & Beck, C. S. (Eds.), *Narratives, health,*

- and healing: Communication theory, research, and practice* (pp. 7–30). Mahwah, NJ: Lawrence Erlbaum Associates.
- Ingram, J.A. (1978). Who cares? *The Journal of the Royal Society for the Promotion of Health*, 98(3), pp. 108–112.
- Jacoby, J.E. (2002). The endurance of failing correctional institutions. *The prison journal*, 82(2), pp. 168–188.
- Kapoor, R., Dike, C., Burns, C., Carvalho, V., & Griffith, E. E.H. (2013). Cultural competence in correctional mental health. *International journal of law and psychiatry*, 36, pp. 273–280.
- Kieth, S., & Madsen, M. (2010). *Arkham Asylum: Madness*. New York: DC Comics.
- Knowles, J. G., & Cole, A. L. (2008). *Handbook of the arts in qualitative research*. Thousand Oaks, CA: Sage.
- Labov, W. (1972). *Language in the inner city: Studies in the Black English vernacular*. Philadelphia: University of Pennsylvania Press.
- Langley, T. (2012). *Batman and psychology: A dark and stormy knight*. Hoboken, NJ: John Wiley & Sons, Inc.
- Laughey, D. (2007). *Key themes in media theory*. Berkshire, England: Open University Press.
- Letendre, R. (1997). The every day experience of psychiatric hospitalization: The users' viewpoint. *International journal of social psychiatry*, 43(4), pp. 285–297.
- MacCurdy, J., Ruegger, T., Burnett, A., Dini, P., Radomski, E., & Timm, B. (Producers). (n.d.). *Batman: The animated series* [Television series]. Fox Broadcasting Company.
- Maple, M., & Edwards, H. (2009). Locating and understanding voices in narrative inquiry. In Minichiello, V. & Kottler, A. J. (Eds.), *Qualitative journeys: Student and mentor experiences with research* (pp. 34–48). Thousand Oaks, CA: Sage.

- Martin, J.F. (2007). Children's attitudes toward superheroes as a potential indicator of their moral understanding. *Journal of moral education*, 36(2), pp. 239–250.
- Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge, England: Cambridge University Press.
- Mechanic, D. (1989). *Mental health and social policy* (3rd ed.). Englewood Cliffs, NJ: Prentice Hall.
- Morgan-Witte, J. (2005). Narrative knowledge development among caregivers: Stories from the nurses' station. In Harter, L. M., Japp, P. M., & Beck, C. S. (Eds.), *Narratives, health, and healing: Communication theory, research, and practice* (pp. 217–236). Mahwah, NJ: Lawrence Erlbaum Associates.
- Morrison, G., & McKean, D. (1990). *Arkham Asylum: A serious house on serious earth*. New York, N.Y.: Warner Books.
- Murray, M. (2003). Narrative Psychology and Narrative Analysis. In Camic, P. M., Rhodes, J. E., & Yardley, L. (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (pp. 95–112). Washington, DC: American Psychological Association.
- Nolan, C. (Director). (2005). *Batman begins* [Motion picture]. Warner Home Video.
- Nowak, P. (2011). Synthesis of qualitative linguistic research: A pilot review integrating and generalizing findings on doctor–patient interaction. *Patient education and counseling*, 82, pp. 429–441.
- Pollio, H. R., Graves, T. R., & Arfken, M. (2006). Qualitative methods. In Leong, F. T. L. & Austin, J. T. (Eds.), *The Psychology research handbook: A guide for graduate students and research assistants* (2nd ed.) (pp. 254–274). Thousand Oaks, CA: Sage.

- Ritterfeld, U., & Jin, S. (2006). Addressing media stigma for people experiencing mental illness using an entertainment education strategy. *Journal of health psychology, 11*(2), pp. 247–267.
- Schneider B, Scissons H, Arney L, et al. (2004). Communication between people with schizophrenia and their medical professionals. *Qual. health research, 14*(4), pp. 562–577.
- Simmons-Mackie, N. (2014). Micro and macro traditions in qualitative research. In Ball, M. J., Müller, N., & Nelson, R. L. (Eds.), *Handbook of qualitative research in communication disorders* (pp. 17–38). New York, NY: Psychology Press.
- Singhal, A., & Rogers, E. M. (2004). The status of entertainment-education worldwide. In A. Singhal, M. J. Cody, E. M. Rogers, & M. Sabido (Eds.), *Entertainment-education and social change: History, research, and practice* (pp. 3–20). Mahwah, NJ: Lawrence Erlbaum Associates.
- Shaw, I. (2004). Doctors, “dirty work” patients, and “revolving doors.” *Qualitative health research, 14*(8), pp. 1032–1045.
- Shen, F., & Han, J. (2014). Effectiveness of entertainment education in communicating health information: A systematic review. *Asian journal of communication, 24*(6), pp. 605–616.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques* (1st ed.). Newbury Park, CA: Sage.
- Taylor, R. B. (2008). Keeping it real in Gotham. In O’Neil, D. (Ed.), *Batman Unauthorized: Vigilantes, Jokers, and Heroes in Gotham City*. p. 7-16. Dallas, TX: BenBella Books.
- Terrill, R. E. (2000). Spectacular repression: Sanitizing the Batman. *Critical studies in media communication, 17*(4), pp. 493–509.

The Joint Commission (2010). *Advancing effective communication, cultural competence, and patient- and family-centered care: A roadmap for hospitals*. Oakbrook Terrace, IL: The Joint Commission.

Uslan, M. (2011). *The boy who loved Batman: A memoir by Michael Uslan*. San Francisco: Chronicle Books.

Wilson, V. S. (1998). *Mental illness: Survival and beyond*. Victoria, BC: Trafford Publishing.

World Health Organization. (2015). *Schizophrenia*. Retrieved March 5, 2016, from [http://www.who.int/mental\\_health/management/schizophrenia/en/](http://www.who.int/mental_health/management/schizophrenia/en/)

## Appendix A

These are the private notes of Dr. Penelope Young, which were included in the collector's edition of *Batman: Arkham Asylum* (2009). They contain background information concerning the treatments and diagnoses of Arkham Asylum's patients:

### **The Joker (Real Name: Unknown)**

**Psychological profile.** My most challenging patient at Arkham. The Joker's derangement defies easy classification. His rapidly changing mood swings hint at borderline personality disorder, but he has no trace of associated identity problems. He also displays signs of deep narcissism, but nonetheless he has a well-developed sense of others, as his ability to manipulate everyone from orderlies to doctors in Arkham is extraordinarily well-developed; he also shows all the signs of a highly functioning sufferer of antisocial personality disorder. At times I almost wonder if he is actually insane at all...

**Additional notes.** His criminal record makes clear that he is an unrepentant homicidal maniac. He is extremely manipulative; the file detailing Harley Quinn's associations with him is fascinating reading. It's unfortunate I was not on staff at the time to witness his seduction of her first hand. His past is unknown, and his answers to my questions about it are wildly inconsistent and frequently fantastical.

### **Killer Croc (Real Name: Waylon Jones)**

**Psychological profile.** Jones was born with a rare mutation that created a series of physical disfigurements, which have worsened intensely with age. His skin is green and scaly, and his body has grown to grotesque proportions. While these disfigurements are unquestionably the source of Jones's various psychosocial disorders, his intense misanthropy seems to also

derive from an understandably difficult childhood, which included alcoholic relatives and social rejection by his peers. He increasingly embraces an animalist, subhuman self-conception.

**Additional notes.** His acute misanthropy makes him difficult to treat; he refuses to respond to socialization, reacting only when he is acknowledged as a dangerous beast, which is clearly how he views himself. It may be that his physical disfigurements are so severe, he will never be able to truly reintegrate into human society. This challenge is made clear by his repeated (and occasionally successful) attempts to maim and kill the asylum's orderlies and doctors.

**Mr. Zsasz (Real Name: Victor Zsasz)**

**Psychological profile.** A psychopath, Zsasz would fit perfectly into the disorganized, asocial category of serial killer if not for his special fixation on the Batman. His motives are power and control, which he expresses quite literally by carving a scar into his skin to make each of his victims. His obsession with the Batman is also manifested in a physical way: he is saving a special spot to scar when he kills the Dark Knight.

**Additional notes.** It's rare that an asocial serial killer motivated by control would have no history of childhood trauma; the exact reason for Zsasz's behavior remain a mystery. His low IQ further hampers my attempts to treat him. He spends hours at a time ritualistically counter the marks on his skin.

**Harley Quinn (Real Name: Harleen Quinzel)**

**Psychological profile.** Transference is a professional danger that every psychiatrist must be ready for, but Dr. Harleen Quinzel experienced what might be classified as delusional transference when she convinced herself that she and the Joker were in love. Displaying symptoms of bipolar disorder, with the Joker's mood swings as the causative agent for her manic

and depressive episodes, Quinzel also shows a high level of dependence on the Joker. His maltreatment of her gives this dependence a dimension of sadomasochism.

**Additional notes.** She shows signs of extreme regression in the Joker's presence. The excessive and invasive psychological screening I had to undergo here at Arkham was largely due to her earlier fall from grace. At times I'm resentful of this; the mere idea that I would have become inappropriately involved with the Joker or any other inmate is preposterous.

### **The Scarecrow (Real Name: Jonathan Crane)**

**Psychological profile.** Possibly one of my greatest successes here at the asylum. Despite his tendency for extensive role play (oddly common among Gotham City's criminals), it's unclear to me why Dr. Crane was ever considered insane. In our long discussions, I've been impressed with his genius for psychology and biochemistry, and I fully believe that if presented with a stock of his fear-inducing gas, he would feel no compulsion to use it. He seems to have entirely turned away from his former life of crime as the Scarecrow.

**Additional notes.** He's valiantly battled a history of anxiety disorder, due to a difficult childhood and adulthood traumas, through an intense study of psychology and the causes of fear. I've come to believe that the accusations that he experimented on human subjects are wildly exaggerated.

### **Poison Ivy (Real Name: Pamela Lillian Isley)**

**Psychological profile.** Yet another patient whose treatment is complicated by a bizarre medical condition, Isley has a modified genetic code that incorporates plant DNA and renders her physically toxic to others. She is essentially deeply antisocial, believing herself to be not only inhuman, but superior to others; this diagnosis is tied into her hypersexuality, which takes the

form of a constant attempt to seduce others to do her bidding. She also displays a narcissistic belief in her role as a protector of the entire natural world.

**Additional notes.** Oddly, Isley is another former doctor who is now an inmate. She seems resentful during our treatment sessions; I believe the fact that I'm a woman frustrates her erotomania. She desperately believes all male residents of Arkham are at least partly in love with her. I've been looking through her old research papers, many of which were never published. There is some fascinating work there...

### **The Riddler (Real Name: Edward Nashton AKA Edward Nigma)**

**Psychological profile.** As with many of the inmates here, Nashton has an abnormally high IQ, but this is tempered by his intense narcissism and obsessive-compulsive need to devise and disseminate his (surprisingly ingenious) riddles and puzzles. If there were a way to break this histrionic behavior and its underlying egomaniacal causes, he could be cured. It's a puzzle only I am truly capable of solving.

**Additional notes.** I cannot help but admire the complexity, and yet apparent simplicity, of the many conundrums and riddles Nashton regularly presents me with in his treatment sessions. Often I find myself working through them in my (infrequent) free time. His obsession with displaying his own intelligence is the central trigger for his many personality disorders.