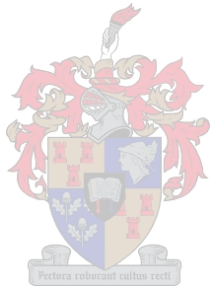
Towards justice and care: Deconstructing stories of personhood and patienthood

Lindie Beatrix Cloete



Assignment presented in partial fulfilment of the requirements for the degree of Master of Arts (Clinical Psychology) at the University of Stellenbosch

Supervisor: Mr C. Petty

December 2002

Stellenbosch University http://scholar.sun.ac.za

Statement of original work

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

Stellenbosch University http://scholar.sun.ac.za

Abstract

This assignment uses the theory of deconstruction to reflect on some discourses that underlie the practices of psychology and psychiatry. The language of the psychological professions is analysed in terms of its political implications. A number of linguistic power hierarchies that are central to the practice of psychology are deconstructed: the individual and the social, reason and unreason, normality and pathology, form and content, theoretical categories and real life, professional and lay views, and non-psychotic and psychotic language. The concepts of justice (as understood within the Derridian paradigm) and care are analysed, with specific emphasis on their practical implications in the interactions between therapists and patients in real life psychotherapeutic situations. This deconstructive process takes place in the intersection of my own story as an intern clinical psychologist with the stories of some of the patients I have worked with during this year. The outcome of this process is a deepening and broadening of the meaning of providing just and respectful mental health care to every patient.

Stellenbosch University http://scholar.sun.ac.za

Opsomming

Hierdie werkstuk benut die teorie van dekonstruksie om te reflekteer oor sommige van die diskoerse onderliggend in sielkundige en psigiatriese praktyk. Die taal van die sielkundige professies word ontleed in terme van moontlike politieke implikasies. Daar is 'n dekonstruksie van 'n paar magshiërargieë wat sentraal staan tot die taal van die sielkunde: die individu en die samelewing, rasionaliteit en irrasionaliteit, normaliteit en patologie, vorm en inhoud, teoretiese kategorieë en "die regte lewe", professionele en leke-posisies, en die taal van nie-psigotiese en psigotiese pasiënte. Die konsepte van geregtigheid (soos verstaan binne 'n Derridiaanse paradigma) en sorg word ontleed, met spesifieke klem op die praktiese implikasies hiervan in die psigoterapeutiese interaksies tussen sielkundige en pasiënt. Hierdie proses van dekonstruksie vind plaas in die kruising tussen my eie storie as intern kliniese sielkundige en die stories van sommige van die pasiënte saam met wie ek hierdie jaar gewerk het. Die gevolg van hierdie proses is 'n verdieping en verbreding van die betekenis van geregtigheid en respek in die sisteem van geestesgesondheidsorg.

Stellenbosch University http://scholar.sun.ac.za

Acknowledgements

I would like to thank the following people who have assisted and encouraged me in my work:

- Chris Petty, my supervisor, for endless energy, patience and new ideas;
- My colleagues and friends, for conversations and books that always stimulated further thought;
- The people, who by being patients, have allowed me the privilege to share in the richness of their life stories;
- My family, for their constant support and interest in my work.

Stellenbosch University http://scholar.sun.ac.za

Stellenbosch, June to October 2002

Dear Chris

> "Would you tell me please, which way I ought to go from here?" Alice asked.
> "That depends a good deal on where you want to get to," the Cheshire Cat replied.
> "I don't much care where –", said Alice.
> "Then it doesn't matter which way you go…" said the Cat. (Carroll, 1994)

I have decided to write you a letter to tell you a story, or rather, stories. Stories of people: of therapists, patients and all those involved in psychology and psychiatry… These stories are also of myself, my thoughts, feelings and experiences as a "neophyte therapist", taking my first steps in the language and practice of psychology. Many things in my own narrative have sparked this writing off. On a theoretical level, the philosophies of meaning making, language and hermeneutics grasp my attention. On a practical level, I experience a sense of wanting to be a "better" therapist, a "better" psychologist. In a postmodern, post-structuralist era I understand this as meaning that I need to deconstruct, "read again" and look again at how I use language, how I "speak politics", and how I make decisions. Only by taking such a reflective stance will I be able to provide a just and caring service to the patients I work with.

I will take this stance by using the theory of deconstruction to reflect on the concepts of justice and care in the practice of psychology. I cannot but interweave the theory with my own story, and with the stories of some of the people I have worked with this year. I will have to tamper with some of the assumptions and power hierarchies that are often taken for granted within the psychological disciplines. This letter is about sharing with you my thought processes around some of the concepts that stand central to the current practice of psychology: postmodernism, deconstruction, power, psychosis, reality, justice, caring, giving, and the possibilities of dialogue between therapists and patients. I want to emphasise that these are my readings, my "makings of meaning", my interpretations, my co-writings, and do not represent a master narrative on any of the

Stellenbosch University http://scholar.sun.ac.za

concepts I have mentioned. Rather, it is a picture I am painting of a part of my world. This picture is painted with words like "deconstruction", "justice" and "care". The frame that "holds" these concepts is that which inspired me to go on this journey in the first place: my need to be a "better" therapist.

My story

It is 2002. At this stage in my life and career, I am working as a clinical psychology intern in a state hospital in the Western Cape province of South Africa, that serves both in- and outpatients, adults, children and families. These patients usually do not have medical aid benefits, and often struggle to get by financially. Mostly they belong to a different socio-economic class than the professionals and students working in these wards. The economic divide between the haves and havenots is therefore quite pronounced within this microcosm.

I have a small, yellow-walled office on an outpatient ward, and I also work with people who are in the open (as opposed to locked) inpatient wards. Since this year's training consists of rotating between different firms, I have also worked on the lock-up wards. Around me are supervisors, psychiatric consultants and registrars, occupational therapists, social workers and nurses. This is the first time in my training that I not only learn about therapy, but actually also do therapy. Thus, my workplace is a place which entails uncertainty as well as growing confidence, naiveté as well as exposure, finding my own voice, yet listening to the voices of all the other members (often older and more experienced) of the team on the psychiatric ward.

I am taking uncertain steps in and into the realities of "mental illness" and the discourses of illness and health as spoken by "patients" and "health" "care" "professionals". Sometimes it is a place of confusion for me, where I am continually faced with a dilemma. On the one hand, I am learning the language of jaded cynicism (mostly spoken by the more experienced professionals), on the other hand, I am feeling the need for another, perhaps idealistic, language that is more hopeful, more liberated and liberating. It is difficult trying to find words in this new language, yet simultaneously grappling with

Stellenbosch University http://scholar.sun.ac.za

the need to have a distanced, self-reflective stance on these words. This seems to be the dilemma that led others to adopt the position of jaded cynicism in the first place. This dilemma contains others: being in a role that demands that answers be known, but hardly ever knowing for sure, and acknowledging being in a more powerful role than the patient, yet not abusing this power in any way.

In the hospital where I work, I find myself in the transitory stage where I still perceive people as people... but where they are becoming patients. My instinctive response pattern to people is still shaped predominantly by the discourses I have learned while growing up, discourses that centre around the "normal" everyday conducting of interpersonal relationships and person-to-person communication and conversation. What is emerging, however, is a "psychological discourse" that removes the "patients" from the contextual fabric of everyday interpersonal life, and constructs them in the discourse of mental illness. Subtly, over time, with enough exposure, this might become the default language, my default language.

But this language seems to be flawed. It often uses limited, generic, "woolly" terms. These terms (for example, diagnoses like Major Depressive Episode or Paranoid Schizophrenia) force us only to want information from a patient that "fits in", that will not escape this name. The stories patients bring are "shrinked" (Swartz, 1996) by translating their words into the language of psychology. In this sense, with sufficient exploration of the nuanced complexity of an individual, he or she will always become a diagnostic problem. The complexity and multiple layers of personhood inevitably corrupt the identity of patienthood. The diminished and diminishing nature and language of patienthood often throws me, as a neophyte therapist, into an uncomfortable space, where I feel confused, sad, angry. This discomfort makes me want things to be different, better.

Adam and Annie

This need to be "a better therapist" also happens in the intersection of my story with the stories of the some of the people, the patients, I have had the privilege to work with during this year. One of the first patients I worked with (I will call him Adam), is 26 years

Stellenbosch University http://scholar.sun.ac.za

old. To me, he seemed to be a gentle and soft young man who often had difficulty to stand up for what he wanted, both at home and at his work as a mechanic. He disliked confrontation, and was going through a time where it seemed to him "as if everyone just walked over him". This lead to his feeling abused and under-valued by those closest to him.

This was translated into the language of psychology as follows: Adjustment Disorder with Depressed Mood, according to the criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th edition) (DSM-IV) (American Psychiatric Association, 1994). However, throughout the further course of his treatment, Adam presented with such ambiguous symptoms that he was seen as being a constant diagnostic difficulty. As I have mentioned, he presented initially with what were termed "dysphoric feelings following work-related conflict". After a week of being treated as an inpatient, Adam was discharged. However, at outpatient follow-up a week later, he presented with "manic symptoms": not sleeping, euphoric, elevated mood, laughing for no apparent reason and grandiose ideas about his own strength and invincibility. Again he was admitted to the ward. A few days later he started complaining about hearing voices (apparently they have been speaking to him for over a year by then): Schizophreniform Disorder was now considered as differential diagnosis. Even later he started swallowing pieces of iron which he got from the desks in the ward, "because the voices told him to". Then he reported visual hallucinations: three people coming to visit him once in a while. He was also experienced as being "aggressive" and "agitated" with a very "labile mood" on the ward. Pre-admission substance use (mostly cannabis) was suspected. Different psychiatric drugs were tried – eventually the patient became quite sedated with "blunted affect" at times, but even this fluctuated.

One day in a ward round discussion about Adam a nurse said to the doctor: "He is a psychopath. He must go home. It is just behaviour, nothing else. I have never met such a manipulative patient in my life". This statement, and others like it, bother me.

"It is just behaviour" seems to imply that this patient's "illness" is not really pathology, it is something of less importance, and therefore too trivial to warrant treatment on the ward.

Stellenbosch University http://scholar.sun.ac.za

Somehow Adam becomes marginalised and is shifted to the periphery by this statement. The nurse's point of view seems to become the central narrative. "It is just behaviour" Adam was said to be "acting out". Here "acting out" refers to a type of action that has a negative connotation, that should be "kept in". The word "acting" also implies some sort of pretence, as opposed to someone whose illness or need is real. This in turn carries the implication that there could be simulation of symptoms and malicious intent on Adam's part, thereby reinforcing the allegation of "manipulation".

Adam was seen as disruptive, a problem, both diagnostically and behaviourally. Little effort was made to understand the possible complex layers of Adam's behaviour. He was not asked to share his opinion on the origin and meaning of his symptoms. Because he was troublesome, because he did not fit the moulds that were pre-shaped for him, because he did not have the vocabulary to articulate exactly how he feels and experiences things, he was pushed aside. Literally sometimes: in seclusion. Figuratively sometimes: all people who attended this ward round now knew him as the "problem patient" with the diagnosis of "just behaviour".

What happened with Annie concerned me in a similar way. She is a teenage girl who was admitted with a history of severe traumatic life events: rape, assault and the death of a parent. Emotionally she was, in her words, "in a very dark, cold and hopeless place", considering suicide as means of escape. After some time on the ward her behaviour was occasionally labeled as "manipulative": her tears still flowed freely in some situations and in others not. She sometimes wanted to participate in group activities, but sometimes not. She vacillated between "socialising well" and "isolating herself". Occasionally she complained of physical symptoms such as headaches, stomach aches and vomiting that did not quite fit in with the clinical picture of the Major Depressive Episode (MDE) and Post-Traumatic Stress Disorder (PTSD) that had been diagnosed. At one stage Annie told me that she was worried about the stomach ache and nausea she had been experiencing for the past few days. When I asked the nursing staff to notify a doctor so that Annie could be examined medically, I was told that "it would not really be necessary since she is probably only manipulating, and only imitating some of the symptoms an eating disorder patient in the ward was presenting

Stellenbosch University http://scholar.sun.ac.za

with". This opinion, in my mind, may have been an accurate observation... but may also have not. I did not know. However, ignoring Annie's complaint and refusing her a physical examination may have had a profoundly negative impact on her perception of the quality of care she was receiving, whether she was somatising or simulating or not.

When reflecting on the stories of these two patients, I again find myself in the middle of the difficulty in positioning myself: feeling the discomfort and wondering what to do about it. Do I keep quiet? Do I speak? What do I say? Do I trust these professionals, who have years and years of experience and speak with such authority, or do I open my mouth and place myself in the role of the fresh-eyed, naïve critic, and the idealistic, neophyte psychologist? Do I choose to expose myself to the same risk of being dismissed or patronised? Do I try to convince myself that I am indeed too young and sensitive, and agree quietly to adopt the language flavoured with jaded cynicism?

I still do not really know, but my discomfort with the glib way many words ("manipulating", "behaviour problems", "borderline" or "passive aggressive") are used, leads me to pause and reflect on some of the unexamined discourses in the practice of psychology. I hear the words describing those patients that abscond, who rebel against the system, who are non-compliant, who want to go home, and I wonder if we are aware of what we do when we say these words, and what saying them leads us to do.

Then someone says: "Perhaps I would do the same if it were me in there", and for a brief moment we all recognise and acknowledge the possibility of becoming a patient, confined to the locked ward, confined to patienthood and the names that describe it. It moves like scared fingers, this feeling of "There but for the grace of God go I...". Then it passes and I talk about other things: the weekend, the next patient, and I choose to forget. I choose not to stand still and not to push the pause button on my pre-recorded actions.

For me, the unsettling factor in this notion of "moving on quickly" is linked with the tensions implicit in the ethics and standards of care. What does "care" mean? To "handle with care" implies both fragility of that which is being handled, and a cautious,

Stellenbosch University http://scholar.sun.ac.za

thorough carefulness on the part of the caretaker. To "take care" in the (mental) health care system means to be conscious of not doing any harm or damage. "Being careful" would also imply taking enough time to pay close attention to individual items or units, individual people and the differences between them.

Even when the motivation behind working as a psychologist is noble and just (wanting to care and to help), I sometimes seem to mess it up. In my work with inpatients, outpatients, families, individuals, depressed, anxious, happy, well-functioning, malfunctioning persons, I am often not careful enough... This seems to happen when I assume the expert position, the role of the master diagnostician, who classifies and who has the answers. It happens when I unthinkingly speak the language of a system which seeks for the "lowest common denominator" in order to make clear diagnoses, and implicitly shrinks the uniqueness and autonomy of those for whom it is designed.

Deconstruction

Before taking the time to reflect more deeply on some of these disquiteing discourses, I need to say something about the philosophy of deconstruction, and describe the tools I will use to tamper (maybe in the same way as a troublesome and difficult patient!) with some of the unquestioned constructions in the practice of psychology. (Between brackets: in this letter I will mostly refer to "psychology", rather than "psychiatry". This is in contrast to the way the profession of psychiatry is often highlighted above psychology, especially in "psychiatric wards", where psychology is often seen as a supplementary service. Yet psychiatry and psychology also function alongside each other, both in state hospitals and in private practice. In the current mental health system there are overlaps between psychology and psychiatry – for example, the use of the DSM-IV for diagnostic purposes. Therefore the references to and discussions on psychology are also relevant to psychiatry.)

However, before discussing the tools I will use to tamper with some of these unexamined discourses, I need to say a few things about the toolbox. Postmodernism often is described as a reaction to the idolatry of reason, rationality and the militaristic

Stellenbosch University http://scholar.sun.ac.za

desire to "make everything fit nicely" by using the hard compartmentalising practices associated with modernism. Sometimes postmodernism is conceptualised as the natural evolutionary development of modernism itself. The term can also have a more qualitative ring to it, so that postmodernism could well have existed before and during the heyday of modernism itself (Culler, 1983). Whichever way it is viewed (and all are legitimate viewpoints that can co-exist in a postmodern world!), postmodernism brings to mind associations of playfulness, of stretching boundaries, of blurring great divides, of troublesomeness, of looking again, and reading and re-reading and re-re-reading. Everything is "read" and interpreted as a text with many authors, readers, co-authors and accompanying discourses. Nothing is cast in stone. There is not only one voice.

One criticism of deconstruction is that it is too theoretical, and has no practical, outcome-based relevance. This argument fails to understand that deconstruction is philosophy in the market place at its best. Deconstruction is politically active. Deconstruction cannot take place in the abstract, that is, without substantial, practical and relevant content, a "real world" text, that lends itself to be deconstructed, that auto-deconstructs. For example, deconstructing the way gender discourses operate has consequences for our ideas on the position of women and men in society, in terms of voting rights, salary policies, motherhood, fatherhood, womanhood, manhood. Deconstructing the way psychological terms function on a theoretical level has implications for the way future clinicians will go about the politics of the profession, which eventually impacts on practice.

It seems that people are often averse to terms such as "deconstruction" and "postmodernism", because these words conjure up images of a lawless society where "anything goes". It seems as if deconstruction is somehow equated with destruction. Then it is understandable that a fearful attitude of "I'd rather have nothing to do with this postmodern deconstruction" originates. I agree with Derrida, that this fear and shut-eyed avoidance of deconstruction, might be an indication exactly of its practicality and its political nuances (Cilliers, Degenaar & Van der Merwe, 1999). The resistance against deconstruction also might have something to do with the way a deconstructing stance

Stellenbosch University http://scholar.sun.ac.za

makes things more difficult. When things are more difficult they take more energy, thought, care and time…

Then there is the difference between deconstruction and critical psychology. Anyone can be critical of anything, anyone can argue for or against something in sound, logical rhetoric. In the arena of critical psychology one standpoint replaces another, one argument is refuted by another. Deconstruction is different. Its agenda is different. Rather than providing solutions, it is more interested in questions: "[I]t stays around long after the party is over, it stirs and liquefies, and doubts itself and its methods…" (Morss, 2000, p.109). It is like the multi-headed monster Sloan (2000) describes as follows:

> [It is] tearing with its claws and teeth at the sides of [dominant psychology], ripping at its theories, its practices, its impact on common sense, its failure to address social problems in a significant way… [But] the monster's claws and teeth also tear at itself, for it senses that it cannot be sufficient. (p.233)

Back to the tools. Deconstruction means (among other things!) looking in the margins. Reading between the lines, seeing also the "negative space", looking at how that what is said takes on meaning also in terms of that which is unsaid. What is omitted in psychological conversation (by both patient and clinician) also bears meaning. When I ask Adam certain questions (for example, "Are you hearing voices today?"), I choose not to ask other questions (for example, "How do you feel about the conflict between you and your brother?"). Of course, these questions can both be asked, and many more questions can be asked. But due to practicalities like time constraints the therapist and the patient are forced to choose only a few of the questions and comments from the pool of a myriad possibilities. The same holds for the therapist's writing of process notes. From all the words spoken in the session, I deduce a few themes, I choose which were the "important" parts of the session, and these I write down. I might choose to comment on Adam's "clinical picture", on his report of hearing voices, on his mood. I might write only about Adam, and omit my own feelings in the session. I might choose to omit what he said about his attraction to a girl in the ward and what he said about his frustration in the ward. Paradoxically, I find myself sometimes choosing not to write down in the free-

Stellenbosch University http://scholar.sun.ac.za

for-all hospital file that which I view as the important parts. The precious and intense moments, such as an honest and vulnerable letter of sadness Annie has written to me at the end of therapy, I sometimes want to keep "sacred", and thus choose to omit them from my process notes.

Deconstruction would then mean to listen also for what is said in the silences, in the unwritten, unspoken words. This means looking beyond what is in the centre, reading the footnotes and flashing the light onto that which is supposed to be of less importance. What a deconstructing reading does, is to show how these "subordinations" are of utmost importance for the "better", the "privileged" terms to function in a semantic system. There is a so-called "double movement" once such an opposition (where one term is privileged and another subordinated) has been found in a text: (a) a turning around or "reversal" of the opposition and (b) a "displacement" of the whole dichotomy between the two terms (Culler, 1983, p.85). In this way deconstruction is not just criticism, but moves on another level as well.

Reading, writing, speaking

Derrida (in Culler, 1983) provides an example that makes this more tangible: he deconstructs the opposition of speech and writing, where speech is the "privileged term" and writing is the "subordinated term". The "text" in which this opposition is eminent, has to do with the way philosophers, and especially thinkers who have been concerned with the way meaning is conveyed through language, have "written" a text of what kinds of language are trustworthy and good, and what kinds of languages are not (Culler, 1983). When I speak to you, it is presumed that there is a "presence of meaning": I am here, you are here, we are at the same place at the same time, and meaning can flow easily and straightforwardly from my consciousness to yours.

However, when I write to you (like now), this presence of meaning is of course not there: you might read my letter months after I have written it, you might not be sure of the meaning of some of the words I used, you might wonder about "what I am trying to say". There is an absence of immediate meaning. In your reading, you have to co-write. You

Stellenbosch University http://scholar.sun.ac.za

have to be an active participant in the meaning making process, because my consciousness is not readily available to yours, thereby constructing the opposition where speech is privileged over writing. But language and communication always implies meaning that is not readily available. Both speaker and listener are constantly caught in an absence of meaning. This is often forgotten when we speak to each other: we speak and listen and "understand" under the illusion of direct availability of meaning. However, when we write and read, we are aware of this meaning-making process. In this sense, the term that has been subordinated (writing) is now privileged over the term that was originally seen as the "better term" (speech). There has been a reversal. But there is also a displacement. Speech and writing are not viewed as one being "better" than the other (whichever way around). They are in a sense qualitatively "equated" as both being processes of active, dynamic meaning making where there is a "generalised absence" of direct meaning (Culler, 1983, p.95). There is a new way of looking at this opposition – a liberating new mindfulness of the functioning of language in both speaking and writing.

This manifests in the text I am reading in the setting of the practice of psychology in different ways. On the one hand, speech is privileged over writing. If I want to confer with a colleague or supervisor around a problem or patient that really worries me, I would be hesitant to do the "consultation" in the form of notes or quick letters written to each other. I would feel that I will not be able to communicate my specific concern as well and as seriously as I would when talking about the problem or patient. On the other hand, writing is often privileged over speech. Referrals are often written and not only spoken about. Written suicide contracts bear more value than verbal ones. In privileging either speech or writing, we might find ourselves in a place where "pure meaning" is assumed, both in speaking (conversations with patients and colleagues) and writing (process notes and referral letters).

In therapeutic interactions with patients, the presence of meaning is also often assumed. When I speak to a psychotic patient, for example, I might take for granted that her consciousness and the meaning she attaches to the words she uses, is readily available to my consciousness, without mediation. When she says, "two voices are speaking

Stellenbosch University http://scholar.sun.ac.za

loudly in my ears", I might fall into the trap of believing that I know exactly what she means. When I read the process notes my predecessor has written, I might believe I "know" the patient she has written about. (Ironically, this picture I form in my head when reading up on a patient before I see him or her, is sometimes proved wrong and always proved skimpy when I then actually meet the person.) When I listen to Adam telling me he is "stressed", I might assume, prematurely, that his definition of this term is the same as mine when I say "I am stressed". When Annie cries with me, or she complains of nausea, or she speaks to me about her darkness, I might think I understand completely, thus, that there is a direct "presence of meaning" in our interaction. However, after the deconstruction, this "sorted out" way of interpretation becomes jeopardised. As I do when reading poetry, letters or any other form of written language, I am interpreting, mediating, and dynamically creating meaning when I interact with patients and colleagues.

Différance

This idea of the absence of meaning takes form in one of Derrida's most used terms, *différance*. For the development of a term such as *différance*, the scene is set by De Saussure's structuralist approach, in which he developed a linguistic theory of the interplay between sound and meaning (Kenny, 1994), placing specific emphasis on the arbitrary relationship between signifier (the sound) and signified (the thing it is meant to represent). De Saussure introduced the notion of linguistic meaning being constructed, not in the inherent "meaningfulness" of each sound, but rather in the system of differences between sounds that enables us to make meaning. Derrida would agree that meaning is worked up by a system of differences, yet he argues that there is no such one-to-one correspondence between signifiers and signifieds as De Saussure has proposed. "There is no fixed distinction between signifier and signified... meaning is not immediately present in one sign" (Jarup, 1988, p.33). Meaning is thus always relational and relative to some other signs, some other meanings. As mentioned, Derrida coins the term *différance* - partly referring to De Saussure's point of difference and relationship as being the locus of meaning (Culler, 1983). (The discussion of the other dimension of *differénce* will be deferred for the moment.)

Stellenbosch University http://scholar.sun.ac.za

This notion of meaning being born in a system of differences can be interpreted both linguistically and more in terms of "stories and things". When Annie speaks of the rape she has experienced, she speaks not only of the rape as one thing on its own. Her story of the rape takes on meaning in relation to her other experiences of trauma (for example, this trauma is "the worst of them all", and "the other things that happened made me even more vulnerable to the effects of this rape"). The rape is conceptualised in relation to other possible traumas such as being robbed or being murdered. It takes on meaning in relation to the meaning she attaches to being a male or a female, and in relation to the discourses her family and cultural group hold regarding rape. The times Annie has experienced as being non-traumatic also shape her understanding of times of trauma. The "one" story holds in it traces of a myriad of other stories or ideas against which it is compared, other narratives which help shape the meaning of this one.

The meanings Annie has attached previously to words such as "love", "sex", "making love", "penetration", "violence", "victim" and "violation", shape her understanding of the word "rape". For Annie, who associates closely with a church group that positions itself against pre-marital sex, sex was semantically related to a committed marital relationship for which one is supposed to "spare one's sexuality". Therefore, for her, being raped also bears the meaning of now, in her words, "being spoiled for marriage one day", which leads to tremendous feelings of guilt. For her, rape is nuanced in terms of contamination. Her understanding of the rape can also be framed within her conceptualisation of the word "victim". Annie has grown up in a house where her family often responded to crimes like rape or assault with comments such as "maybe the victim deserved it, maybe he or she was asking for it". These comments were imprinted in Annie's system of meaning making, with the expected consequence that she kept ruminating about whether she was perhaps too skimpily dressed on the day of the rape, whether she was actually the one who was at fault... Her story of the rape is thus co-authored by her other stories.

In a similar way, the words Annie uses to describe the "place" she is in emotionally ("it is dark", "it is cold", "I am helpless", "I am hopeless") take on meaning in relation to their "opposites". Annie feels darkness (not light, not sun), she feels cold (not warm, not

Stellenbosch University http://scholar.sun.ac.za

secure, not held close to someone). She feels helpless (not helpful, not with help), hopeless (as opposed to hopeful). There are lacks. If, in her mind, therapeutic change would mean a movement from this place, it will surely be useful not to concentrate only on taking away darkness, but also working on that which is written between the lines, on a shaping of a sense of light and warmth.

On a more linguistic level, "each word or concept carries within it all other words and concepts that are different from it... each word differs from, is evaluated against, and also incorporates its opposite in a fluid and contextual sense" (Hepburn, 1999, p.634). However, these other words get lost or forgotten somewhere along the line in the process of our construction of meaning. This subordination gives rise to the oppositions I have written about earlier: the illusion of one term being the "superterm" and the other terms as being pushed out further and further out into the margins. One term gets to be "privileged", its "opposite", the one that helps to constitute meaning, becomes of lesser worth, the "supplement" (Culler, 1983). The reliance of each term upon its opposite is obscured in its everyday use. "Normality", for example, gets privileged over its "opposite", "abnormality", in such a way that, in our everyday use of the terms, we almost forget how these two concepts shape and form each other. The same holds for "having a DSM-IV Axis I diagnosis" and "not having a diagnosis". When it comes to the warranting of therapy, having a "real diagnosis" might privilege a certain patient above one who does not. What would it mean for the legitimacy of psychotherapy, for example, if Annie was either diagnosed with a Major Depressive Episode, or not diagnosed at all, conceptualising her misery as "going through a difficult and sad time"? V-codes and "normal reactions" often get marginalised and subordinated. It is forgotten that both "diagnosable pathology" and "normal reactions" conceptually mould each other into meaningful terms. Deconstruction is then about finding these oppositions, turning them around and displacing them.

As mentioned, *différence* also contains another meaning apart from "difference". "Deferral" is also included in this neologism. Signs defer to each other: "every meaning contains traces of other meanings" (Culler, 1983, p.96). There is an infinite play of differing and deferring. Jarup (1988) writes: "Each sign in the chain of meaning is

Stellenbosch University http://scholar.sun.ac.za

somehow scored over or traced through with all the others, to form a complex tissue which is never exhaustible" (p.36). The implication of this "deferral" is that meaning is not always readily available. According to Maze (2001),

> ...before an incoming idea could have meaning, we would have to compare it with the trace we retained from its predecessor. Its meaningfulness would be deferred... [This means] that the only way we can say what a term means, is by referring to its relation to other terms, which in their turn need further explanation, and so on. (p.409)

Again, to come back to the stories of Adam and Annie, to do therapy within the framework of deconstruction would mean not to assume that "true and absolute meaning" is always available here and now. For the patient (as well as for the therapist!), the meaning of therapeutic conversation or dialogue is often deferred. In my mind this deferral is both "backwards" and frontwards". By "backwards" I mean into the past, into the labyrinth of previously made meanings and experiences. Annie might understand my way of engaging with her trauma in different ways (for example, as patronising, respectful, permissive, or anything else). This understanding emerges from the traces of previous meanings she has in her mind, previous experiences with other therapists, previous ideas and discourses around how people treat or should treat traumatised persons. Also, there is a "frontwards" deferral, a deferral into the future. The meanings Adam and I attach to the therapeutic conversation we enter into now, will not necessarily be the one and only meaning that will be attached to it forever. "[E]arlier meanings are modified by later ones" (Jarup, 1988, p.36): the story of the time spent with Adam might take on new meaning for me as I come into contact with more patients, as I read more, learn more, hear more stories and live more stories. It might take on new meaning for him as he continues his life, as he comes into more contact with more people, read more, learn more, have more life experiences... Maybe, in a few years time, he will attach more positive value to our encounter. Maybe, in a few years time, he will think more and more of it in a negative light. Even when the distinction between positive and negative is discarded, his feelings and rememberings, his ascribed and mediated meanings, might just be different from the way it is constructed now. It is not

Stellenbosch University http://scholar.sun.ac.za

fixed, neither for him nor for me. There is a "backwards" and "frontwards" deferral. Every meaning contains traces of other meanings...

This is a whole mouthful on the "tools" of deconstruction I am going to use when I turn to deconstructing some oppositions found in the text of psychology. The notions of "absence", "trace", and "marginilisation" become important when we speak about the way we speak about patients. It takes no special insight to see how the terms "subordinated" and "margins" and "oppression" are related to the psychological professions. Historically, psychiatry has been associated with straight jackets, both physically and metaphorically. It was not a liberating profession. It often chained people down, it was often a way and means of social control, a kind of special police keeping everyone more or less from being too disruptive, too scary. Many things have changed. But many things have not changed. Injustice, and even cruelty, have become more subtle, more sanitised by politically correct speech, and therefore less detectable. The words of Bos (1995) come to mind: "There was a time when you paid with your life, but the times have changed, and now you are simply silenced to death".

In our everyday use of language it happens that some terms get "silenced", while others gain linguistic strength to be in the privileged position of standing above these supplementary terms. This sets up the hierarchies that come into play in our everyday politics, and also in the politics of the mental health care system. There are many hierarchies in this system that I can choose to deconstruct. I know that even by choosing to deconstruct only some, I am already giving privilege to these "chosen few" above all the others that are also at play and can also be deconstructed. However, if I were to choose everything, it actually would not have been much of a choice! So I am choosing my "frame" here, and in this frame I am going to look only at a few hierarchies: the individual and the social, reason and unreason, pathology and normality, form and content, theoretical categories and real life, as well as professional and lay views. The hierarchies that I choose are all ingrained in the therapeutic encounter and conversation. Unpacking these hierarchies is emblematic of the way the power imbalances implicit in the language that labels different groups of people (for example, those who are "normal"

Stellenbosch University http://scholar.sun.ac.za

or "pathological") can be deconstructed as a way to providing a more just, caring and respectful service.

Individual and social

According to Parker, Georgaca, Harper, McLaughlin and Stowell-Smith (1995), the opposition of "individual and social" reproduces a Cartesian dualism inherent in modern Western culture. Psychology tends to individualise problems, to make the locus of mental illness one patient. This has the (quite convenient) implication that society does not bear blame and does not carry responsibility for its "mentally ill". But when we look closer at how we understand the term "individual" semantically, this point of view becomes problematic. There can be no "individual" if there is no society, no "abnormal population" if there is no "normal population" to compare them to. This links with the notion of meaning making in a Saussurian system of differences. For example, if I were the only person on an island and there were no other people to compare myself to, I would not be tall or short, fat or thin, old or young... in fact, no adjective describing me would have meaning if there were no comparative group. (This is also evident in the way statistical research is done with control groups and experimental groups.) In the same way I cannot locate a certain kind of pathology in one patient (for example, agoraphobia) if I do not have a control group, other people who also experience milder and worse agoraphobic anxiety symptoms. Annie's reaction to her life stressors can only be conceptualised as PTSD when it is compared to how other people react to traumatic events. Adam, who is seen as "mad", "bad" and "sad", only gets these descriptions in comparison to what is supposed to be "the norm" (sane, good and happy). The fact that "pathology" is planted in everyone, on a very broad continuum, in fact makes differences apparent and comparisons possible. This makes it more difficult to think of "individual pathology" in a strict, either-or, compartmentalised way. The boundary between the "healthy" psychologist and the "sick" patient is thus opened by the embeddedness of pathology (for example, the tendency to be "mad, bad or sad") in the fabric of the human condition.

Stellenbosch University http://scholar.sun.ac.za

One response to the opposition where the individual is privileged over society, could be simply to turn this around and to privilege the societal over the individual. Examples of such a response could be family approaches or feminist theories. Annie's mother, stepfather and sisters can be called in to look at the way family interactions might "feed the pathology" or have an ameliorating function. In this way, both "illness" and "recovery" are not necessarily fixed in only one individual. However, this movement away from pathologising only one person can be sabotaged if there is a conceptualisation of one family member (for example, Annie) as "the index patient". Then again would there be a scapegoating, a pathologising of one person, a (negative) privileging of the individual above the societal. Paradoxically, in the bigger context of the whole of society, a family (consisting of more than one individual) can be viewed as being a unit, "one thing", an individual entity with its own characteristics and set identity. Subsequently, one family can be pathologised as been dysfunctional... which again situates abnormality in one unit, one family. Indeed, the boundaries between the individual and her societal context become blurry.

Moving away from the tendency to pathologise one individual, Annie's rape and subsequent "illness" can be defined within the language of feministic cultural critique. Feminist theory broadens pathology to a phenomenon that originates and grows in societal power imbalances between the different sexes. Annie's rape can be conceptualised as being the result of a man living up to societal discourses around issues of masculinity (for example, "a man is just a man with normal instincts", or that it is acceptable for a man to be the aggressor, also on a physical level). Her helplessness and depression can be conceptualised as being part of a female identity. Her feelings of responsibility and guilt regarding the role of her dressing style in the rape, fit in with the gender stereotype of the woman as "seducer", therefore, as the one initiating (and taking responsibility) for further sexual advances by the man. Feminist theories would thus approach Annie's "illness" from a critical stance against this kind of "societal pathology".

When privileging the individual, and when privileging society, there is a breakdown. If we privilege the individual only, the opposition crumbles. This happens since the individual is always an individual as compared to others, always an individual against the backdrop

Stellenbosch University http://scholar.sun.ac.za

of society, always someone whose pathology and meaning is constructed in relation to others. Adam can not be seen as Adam the island: his symptoms take on meaning only in relation to how the majority of people ("the normal population") function and conduct their walk and talk. His "pathology", or lack thereof, is constructed in comparison to what I and other team members, for example the nurses, have previously experienced from other patients, as well as from the our interaction with the "normal population out there". Yet there is also a breakdown if we think of society as being the privileged term: this just becomes too abstract. If some intervention need to be made, and we say the "problem lies within society", then society should be the focus of our intervention. However, to state that "society must change" will change absolutely nothing, exactly because it is so very vague. The only way to bring about change, whether for one person or more generally in a society, is then to make the individual (even if it is many individuals) the object(s) of intervention, the locus of change.

This leaves us with a kind of Heideggerian "under erasure" state of both individual and society, where both exist, but in such a manner that each term cannot stand on its own semantically. Annie is an individual, but her identity is also shaped by her family, her society, and the *Zeitgeist* in which she finds herself. The way her "illness" is conceptualised needs to encompass both her individuality and her position in a socio-cultural-temporal framework. The way her "healing" or "recovery" is viewed will then logically and automatically recognise and acknowledge both sides of this coin.

Reason and unreason

Often patients who are struggling with "severe psychological illnesses" are seen to be highly irrational, and even unreasonable (which implies that there is some kind of maliciousness or deliberate "difficultness" on their side). If they only could see reason... then they would think differently and act differently. Foucault (1994) writes critically about the "psychiatric asylum as the place of opposition, the scene of confrontation", where unreason, madness and a "disturbed will" must come into contact with a clinician with a "sound will and orthodox passions" (p.42). Basaglia defines the psychiatric hospital as "an institution [that is characterised]... by a clear-cut separation between

Stellenbosch University http://scholar.sun.ac.za

those who hold the power and those who don't" (in Foucault, 1994, p.45). The meeting of these "haves and havenots" then becomes "a process of opposition then, of struggle and dominance" (Foucault, 1994, p.43). The outcome of this meeting, this struggle, will be presumed to be a victory for the sound will and reason.

Western Enlightenment privileges rationality above irrationality, reason above unreason (as seen also in current trends such as cognitive psychology where "dysfunctional" and "irrational" ideas and beliefs are to be replaced with more functional and rational ones). Yet Foucault and Derrida ask whether it is possible to "talk of unreason" – since any attempt to do so colonises unreason and transforms it into reason (Parker et al., 1995). The assumption is that language then becomes "the coloniser", and that putting a thing into words takes away some of its madness, its unreason. In saying that Adam's behaviour is "unreasonable", we identify and classify and "make sense", "make reason", of his "madness", thereby diminishing the non-sense, the unreason it was viewed as originally. "Reason" as privileged term experiences breakdown, since (a) it is possibly a term that "says nothing" in terms of semantic value in a system of difference (since, as showed, it cannot be placed as opposition to unreason because to talk of unreason makes it reasonable) and (b) reason is always a constructed concept (culturally and situationally) and is therefore not some essentialist ideal that fell from heaven.

What would happen if the "reason and unreason" opposition were only turned around, thus privileging unreason or irrationality? We are faced with the same problem – we then enlighten the "heart of darkness" so that it is no longer dark. Unreason becomes reason by virtue of being put into words. However, privileging unreason, throwing up our hands and declaring defeat by unreason, might also "be abnegating ourselves of the responsibility to help and understand others, and besides, ignores the constructed nature of the opposition [between reason and unreason]" (Parker et al., 1999, p.61).

To "make a patient see reason" (for example, trying to get Annie to stop having an "unreasonable" response to trauma, such as deep depression and constant crying) by a process of opposition might assume (wrongly) that there is one essential, universal idea and ideal of what and how reason is. Rather then, than patronising Annie's reaction as

Stellenbosch University http://scholar.sun.ac.za

"unreason", it can be viewed as *her* "reason", her legitimate making sense of her situation. This, however, does not have to leave me as therapist in a powerless state of just having to say "yes, Annie, that is so". I can challenge her mode of thinking and perceiving by entering into conversation with her, by opening up a space where the two of us can have a dialogue around what has happened to her and in her. My "rationality" or "reason" then stands alongside hers, without subordinating her way of making sense as "unreason". If I work with the assumption that unreason inherently implies something bad and destructive, I put myself in the difficult position of having to annihilate unreason. However, if unreason is understood as a kind of reason, then therapy would be more concerned about holding the tension between different "reasons", different narratives (for example, mine and Annie's).

Normality and pathology

In a way this opposition flows from the two previous ones: an understanding of mental illness is often seen to be situated in that part of the individual that is not "normal", not like the rest of society, and "unreasonable". Furthermore, there is an implicit qualitative judgement that to be "normal" is good, and to be "abnormal" is bad. The parameters of normality are constantly in flux, though: homosexuality, for example, nowadays is not seen as "abnormal pathology" as it was conceptualised in recent diagnostical manuals. Because it is not "abnormal" anymore, it is also not as bad anymore.

Through the ages there have been different representations of madness – could it be that the "same thing" was being described with different words and terms, for example, "suspiciousness" and "Paranoid Schizophrenia"? This would encourage a highly modernistic assumption about psychological illness, namely that there is some "universal given", some essential symptoms that were just described differently in different time frames. This would also assume a one way interaction between signifier (the term or description) and signified (the "thing" that is being "put into words"). It would assume that Annie's post-traumatic anxiety and depression would have been exactly the same way she experiences it now, even if the words "depressed" and "anxious" were not offered to her as a way of explaining or making sense of what she feels. This would be a

Stellenbosch University http://scholar.sun.ac.za

negation of the way words and descriptions can influence the world as such. According to Parker et al. (1999), "such an approach betrays an essentialist and acontextual view of history" (p.58). Annie could have read a pamphlet on PTSD beforehand, thereby finding a way to make meaning of what she experiences. In her own mind she might even have been more focused on her symptoms of reliving the rape, numbing and avoidance, and "ignoring" other things she might be experiencing that are not written into the DSM-IV's diagnostic criteria of PTSD. Selective attention might be narrowing and shrinking her story in modernist fashion.

A subsequent question that comes to mind is: "Might there be some truth in the view that the delimitation of a psychiatric concept actually 'creates' cases which fits is description?" (Parker et al., 1999, p.58). One cannot say that someone is depressed or anxious unless these words are culturally available (that is, we have access to these words and know what they mean). Patients often arrive at my door complaining of their symptoms in the available language: "I feel depressed", "I am stressed", "I have problems with my nerves". Thus, the identification and categorization of pathologies and people are at least dependent on, if not entirely created within, language (Parker et al., 1999).

If it is assumed that there is an interactional relationship between signifiers and signifieds, for example, symptoms and our language to portray them, it might be useful to look at the political implications of our psychological words. What does a diagnosis do? And what will happen if we decide to abolish terms that can be seen as labeling or stigmatising, for example, saying a patient is "psychotic"? Parker et al. (1999) feel that it is debatable whether such an abolition would necessarily be the best thing to do (even when done with the noblest of intentions): "If the term 'psychotic' were abolished, another term would creep in to take its place once the chance is given for the polarity [between normal and abnormal] to be reconstructed" (p.110). Thus, we should beware of feeling comfortable too soon, feeling satisfied prematurely after we have dethroned some politically loaded terms. While we may be using the best available signifier, we should not stop questioning it, and go on looking for a better one that avoids the traps of the former one. This new term will also be subject to deconstruction. Deconstruction is

Stellenbosch University http://scholar.sun.ac.za

ongoing, it is never finished, it never really arrives, and does not want to either. Deconstruction prompts all professionals in the mental health system to be aware of the power of language constantly, not to forget the powerful, yet deconstructable, politics of diagnostic terms.

On the point of diagnosis: who can diagnose "pathology"? Who can distinguish between normality and abnormality, sanity and insanity? Only those who are "normal", those with the "sound minds"? Scheff (1975) writes about deconstructing this "sane and insane", "normal and pathological" opposition, arguing "against... misleading labels such as schizophrenia, and the harmful isolation of patients in institutions... [showing] that we can no longer treat the mentally ill as social lepers. Instead, we must find more effective viewpoints and procedures if we are really to help..." (p.161). Rosenhan (1975) asks the question I have raised in the previous paragraph: "If sanity and insanity exist, how shall we know them?" (p.54). Who shall know them? Who are the judges who call the shots? Who are the decision-makers that separate sanity from insanity, pathology from normality?

Within the mental health system, the judges, those who are supposed to make decisions that are congruent with the notion of justice, are mostly the doctors, the psychologists, the "professional experts". But no matter how much we as "mental health professionals" may believe that we can tell the normal from the abnormal, "the evidence is simply not compelling... [N]ormality and abnormality, sanity and insanity, and the diagnoses that flow from them may be less substantive than many believe them to be" (Rosenhan, 1975, p.54). Different clinicians say different things... And apart from this, another problem arises with the "wooliness" of descriptive terms such as "sanity", "insanity", "mental illness", "schizophrenia". Different things are normal in different cultures. And "culture seeps into every clinical judgement a mental health professional makes..." (Parker et al., 1999, p.60). I might not have such a great hold on things as I believe I have. I might want to consider letting go of one, final master narrative. In Adam's case, I and other members of the team of professionals showed the tendency to make him as "difficult patient" responsible for being a diagnostic problem instead of questioning the

Stellenbosch University http://scholar.sun.ac.za

diagnostic categories themselves. Looking critically at the categories would of course be much more uncomfortable for us…

Is it then possible to distinguish madness or pathology, and even to distinguish degrees of (in)sanity?

Trying to answer these questions Rosenhan (1975) conducted an experiment. "Sane people" were admitted to psychiatric wards to see what would come from it. After being admitted on account of "hearing voices", these "patients" claimed back their "sanity" rather quickly. But "despite their public show of sanity the pseudopatients were never detected... They were usually discharged with a diagnosis of 'schizophrenia in remission'" (p.58). Interestingly enough, though, some other patients, the "real patients", challenged the pseudopatients in saying they (the pseudopatients) are not crazy but a journalist or professor checking up on the hospital.

On the one hand, privileging normality then becomes incompatible with the rules of logic. On the other hand, a turning around and a privileging of abnormality and a subordination of normality does not bring us anywhere, it just poses the same problem in a different way. Again, an ability to hold this tension might be more meaningful and therapeutic than having to decide on which of the two terms to privilege and which to subordinate. This would have the implication that patients need not be pressured to switch dramatically from abnormality to normality. Therapists also need not feel the pressure of taking responsibility to convince the patient to switch from "illness" into a flight to health. Rather than trying to annihilate all "pathology" desperately, the therapist and the patient can unpack the consequences the patient's point of view and behaviour have for her, without ever mentioning normality or abnormality. By not pathologising everything the patient brings, and rather holding the tension between "normality" and "abnormality", a space for therapeutic conversation is created.

Stellenbosch University http://scholar.sun.ac.za

Form and content

I sometimes get the feeling that, in terms of diagnosis, it is more important *that* someone hears voices than *what* the voices are actually saying, more important *that* someone gets flashbacks after a traumatic event than *what* the flashbacks are about. This would signify a privileging of form above content (maybe as part of some search for generic abstractions in a copying of the medical model). Nobody really cared about Adam's anxiety which was related to the voices telling him "that they are going to kill him", it was more important that he was suddenly reporting that he hears voices. In order to be able to diagnose Annie's PTSD, the fact that she had flashbacks from the traumatic event was more important than exactly what their content was. Again, in my mind, this would mean a "shrinking" of people's stories, and also a therapeutic under-utilisation of the richness of their narratives. In an approach that does not acknowledge the content of symptoms like flashbacks or hallucinations, the person is reduced to a patient, and alienation between patient and therapist could be a logical consequence. Again, as a neophyte therapist, I have to find my balance between the languages that speak of personhood and patienthood…

Privileging form over content breaks down theoretically, because "many of the decisions about form are dependent on content (is a delusion persecutory or grandiose? Does the thought come from the person or from outside?)" (Parker et al., 1995, p.62). However, one cannot simply turn the opposition around and privilege content alone, since content is always mediated in some form. A further question that comes to mind, is whether "content" is not just perhaps another form of "form". The "title" "grandiose delusion" is indeed also an abstraction, a heading, a part of the outline or form of the diagnostic system. Yet, this structure cannot stand if it is but scaffolding – it can not be devoid of content, for it would then defeat its own purpose. To say that Annie relives especially the part of the traumatic event where the rapist is approaching her on the street (the content), can be conceptualised as flashbacks (the form). For the best therapeutic intervention, I believe it would be helpful for me and for her to hold both of these in mind. By holding the form, both of us can "frame" the flashbacks as something which have been recognised as such also in other survivors of trauma, thereby de-pathologising her

Stellenbosch University http://scholar.sun.ac.za

symptoms. By holding the content, I can be respectful to her individual experience, her individual identity and memory.

Form and content are thus two distinct concepts in one sense, but in another they are nothing but sides from the same coin. Content cannot exist without form, and form can actually also not exist without content, and the language which describes and classifies is both form as well as content.

Theoretical categories and real life

A desperate adherence to the empirical authority of positivism often implies that "one avoids discussing the inevitable ambiguities of the individual patient" (Parker et al., 1999, p.62). The avoidance of individual ambiguity might correlate with the form and content opposition in the sense that the contradictory or ambiguous content of the patient's pathology (for example, not having avoidance behaviour after a traumatic event) does not want to fit into the form, or the language, of a specific diagnosis (for example, PTSD). Sometimes I find myself speaking of "typical" or "atypical" pathologies, thereby dividing patients into (a) patients whose symptoms and complaints fall into the privileged category of "being easy to diagnose, or having "typical pathology", even "language and accounts I can trust" and (b) those who do not fit snugly into a DSM-IV box, those whose accounts are ambiguous, those whose linguistic accounts of their experience, their life world remain suspect. As I have mentioned, Adam is one of these suspect characters…

Linking to this hierarchy, Derrida's deconstruction of the speaking and writing opposition comes to mind. There is an implication of "presence of meaning" with the patients whose pathology fall into the first category, and an implication of absence of meaning with the more "atypical presentations". Yet, within the context of deconstruction, meaning is always made and mediated, through language, through the patient, through the clinician, through cultural and historical discourse. Therefore, the patients who do not fit the mould become emblematic of every single interaction with every single patient and every single diagnosis we make. Adam is not an exception to the rule in the way that his "clinical

Stellenbosch University http://scholar.sun.ac.za

picture" lets us struggle to make sense of what is happening in and with him. Rather, he becomes a "symbol" for the process happening within every "clinical" conversation. Patients like Adam pull us from the "forgetfulness" we so often fall into with the diagnostically "easy" patients. Real life and the complex process of meaning making within a myriad of voices and discourses, seep into every understanding and diagnostic process.

In trying to get the "messiness" of real life to fit into clean diagnostic categories, the person under discussion is often equated with the illness. The patient does not *have* psychosis, he *is* psychotic. Annie does not *have* depression, she *is* depressed. The person's identity becomes enmeshed with the identity of the illness, in fact, the patient becomes the illness. In the work experience I have had, I have found the approach of narrative therapy to provide some escape from this trap: "the problem is the problem, the person is not the problem" (White, 1989, p.6). In externalising the problem, the patient is de-pathologised. An identity apart from the identity of the problem that has been seeping into the person, can be re-established. Annie can broaden her identity from someone "who is depressed" to "someone who is working on the problem of depression".

On the topic of diagnosis, Kleinman (1991) comments on the importance of the personal and professional history of any clinician. He makes it clear that every writer writes from a specific "window", from some angle which is highly dependent on the road the writer has walked to get to that window. No one can claim a master narrative. In connection with this, he asks: "What is a psychiatric diagnosis?" (p.11). Kleinman (1991) cites Turner: "Disease is not a fact, but a relationship and this relationship is the product of a classificatory process..." (p.11). He looks anthropologically at the diagnosis of an "abnormal mental state such as delusions or hallucinations", and gives an example of North American psychiatrists interviewing American Indians after the death of a family member. In many Indian tribes it is an expected and normal part of grieving to hear the voices of the dead talking to them. He states: "This experience does not portend any dire consequences such as psychosis, protracted depression, or other complications of bereavement" (p.11). In South Africa, within the Xhosa culture, a person might

Stellenbosch University http://scholar.sun.ac.za

experience "delusions" and "hallucinations" of communicating with his or her ancestors as a calling to undertake training as a sangoma (a "condition" referred to as *ukuthwasa*). As with the American Indians, this would then not necessarily count as psychosis, since this term has to it an implicit qualitative judgement of illness, badness or abnormality.

A psychiatric diagnosis is not a thing in the world as is assumed by a positivist use of language. Kleinman (1991) writes:

> Observation is inseparable from interpretation. ...Psychiatric diagnoses derive from categories. They underwrite the interpretation of phenomena which themselves are conjeries of psychological, social and biological processes. Categories are the outcomes of historical development, cultural influence and political negotiation. (p.12)

Categories and diagnoses are man-made. They were written in time frames, by humans with faces and hands, and mothers and fathers and children, and dreams and fears... and they should be recognised as such: valuable, vulnerable. For me, this would mean acknowledging the categories (for example, Annie having all the symptoms of PTSD), and at the same time remembering that these categories are not all there is to psychological evaluation and therapy. These categories have thin, blurry lines that separate them from each other and from other ways of meaning making in the world. It is then useful to hold the tension between the "strength" as well as the "weakness" of these categories, both in the conceptualisation of the patient as well as in the therapeutic conversation.

Professional and lay views

Parker et al. (1995) argue that professional knowledge or expert knowledge is usually privileged above patients' experiences and their accounts thereof. For example, we need to take the depressed or psychotic patient's narrative about his situation with a pinch of salt, since he is not really accountable. Adam's story, or stories, get obscured because of the frequency of change in his "clinical picture". We reach the conclusion that, because we cannot understand him, there is no sense to his story. His story is

Stellenbosch University http://scholar.sun.ac.za

regarded as "non-sense", justifying the conclusion that he is manipulative. The premium placed on collateral information might also imply that the value of Adam's story is undermined. Do we see the story Adam's sister tells as another perspective alongside his (thereby ascribing equal value to both), or is it seen as a super-narrative obscuring the story that he tells?

Again, an option would be turning the opposition between professional and lay views around, privileging patients' or lay views, and subordinating professional knowledge. This does not really help, because psychologists study long and hard to accumulate as much knowledge as possible about their field of interest and practice. This is what makes them accountable professionals. To obscure this training would be both unfair and unhelpful to everyone. Yet, it can happen that professionals get so caught up in their credentials and "ultimately superior knowledge" that they do not leave any room for other narratives, especially the patient's narrative. And this, I believe, is mistaken. But to say that the patient's account must be the only kind of narrative that is important, would be marginalising and silencing the clinician's voice, which would also be mistaken. Rather, instead of seeing one as above the other with a neat horizontal line in between, it would be more conducive to good practice to view them as two accounts (sometimes overlapping, sometimes not) in the same sphere. Different yes, but not with one being "better" and the other being "worse".

In the same way that professionals are taught to speak a certain language and taught to operate within a certain cultural language (which also leads to the breakdown of the privileging of this term), so-called lay people are also taught a certain cultural language regarding psychological problems. I always find it interesting when patients arrive with self-descriptive terms like "feeling severely depressed", or "only being hypomanic", or "experiencing a Mars and Venus conflict in their marriage". Others may use different culturally available terms. In the South African context, a patient complaining of *ukuthwasa* also uses the language he knows to convey a certain meaning. These different terms that are culturally available to different people are the languages in which they have learned to make sense of their situations. Nowhere can we escape our constructed nature and the dominant stories with which we have been nurtured.

Stellenbosch University http://scholar.sun.ac.za

Professional knowledge is always also embedded in wider cultural stories, which again touches on the idea that individual and cultural interpretation always determines and mediates our standpoints and politics.

Professional and lay views are not always as different as professionals would want to claim. This becomes evident looking at (a) the way professionals use lay terms among themselves when speaking of a patient as "odd, weird, strange, mad, crazy, terrible", and (b) the way "professional" knowledge is communicated to patients and their families. Simplified, everyday concepts that are accessible to the lay person, are used ("intermediate typifications that bridge 'lay' concepts of mental illness and 'professional' concepts") (Parker et al., 1999, p.66). Popular culture – images of "madness" on films, television shows, in theatres, songs, newspapers – can be seen to have one foot in the "professional realm" and the other in the "layman's world". How do psychologists present themselves to the public, and how does the public re-present psychologists with an image of how they are perceived or should be perceived? What do the images of the psychologists who appear on talk shows, the cartoons drawn of therapists, and the kind of books you find under the psychology section of bookstores tell therapists and the public about how psychologists should be? The boundary between the professional and the general lay view then becomes quite blurry, so that "(i)t no longer seems sensible to talk of 'professional' or 'lay' concepts as separate things since the distinction between them is not so much in the kinds of discourses used by speakers, but rather the position from which they speak" (Parker et al., 1995, p.70).

Positions and power

"Power relations" and "subordination" make me think of politics in the more narrow sense of the word. Are our hospitals and private practices one-dimensional regimes? Are they despotic? Are they monarchies where everyone must bow to King Psychology? Are there at all elements of democracy, liberal movements, progression, and striving towards equality, fairness and justice?

Stellenbosch University http://scholar.sun.ac.za

Hegel (in Gaarder, 1996) postulated a theory of the "development of history". He speaks of a process of progress where one state or stage (the thesis) necessarily leads to a counter state or stage (the anti-thesis). These two, the thesis and the anti-thesis, then culminate into something higher and better: the synthesis (Gaarder, 1996). The "conflict... is resolved by an intellectual transcendence" (Kenny, 1994, p.203). This resolution then becomes the thesis for a new anti-thesis to be formed, and a new synthesis to be made. This is an ongoing process of bettering, of political and historical progress. Following from this theory, Fukuyama (1992) argued that history is not a cyclical repetition of itself, but that there is a definite line of progression to be drawn through the ages (a type of "political evolution"), with history reaching its "end" with the "last men (sic) living in a liberal democracy" (p.ziii). If we think of psychology as part of an evolving process of progression, what would we see as "the last men" and the "liberal democracy"? A liberal democracy is built around the principles of reciprocal acknowledgement, justice and abolishing power imbalances (Fukuyama, 1992). However, it can be argued that there is an inherent assumption of the differences (and the possible subsequent power imbalances) as being necessary for the mere functioning of the mental health system (for example, oppositions like "therapist and patient", "normal and abnormal", "sane and insane"). What would then happen if these imbalances were ruled out? Nietzsche's Zarathustra speaks of these "last men" in the following way: "Thus you speak: 'real we are entirely, and without belief or superstition'. Thus you stick out your chests – but alas, they are hollow!" (in Fukuyama, 1992, p.303). And this is what I believe deconstructing psychological practice is not trying to do. It is not a mellowing out, an evening out of identities or people. It is not making psychologists or patients "hollow men and women". It is a re-view of the construction of these men and women, a re-view of how we think and how we have come to think like this, a review of the lives of the power imbalances.

This implies that a road has been traveled for both therapist and patient. It means that our knowledge did not fall from heaven, was not given... but was made, and is being made. It means that the interpretations and choices I make, will always be in some way related to my history, my childhood and place of growing up, my place of education, my teachers and lecturers, the books I have read and the conversations I have had. This

Stellenbosch University http://scholar.sun.ac.za

puts my decision-making processes in psychological practice in a somewhat different light. A "clinical judgement" is nothing but a decision, a decision that needs to take place in what Derrida calls the moment of "undecidability". The "thing" that makes it a decision, and that makes decision possible *per se*, is the fact that there could be different choices, different roads to take. The fact that there is a moment where "the truth" or "the answer" is ever absent, implies that every decision is a leap into the dark, a leap into uncertainty (Cillers et al., 1999).

With every patient there are different roads to take, different possible lines of treatment, medication and therapy. Every decision is made in a moment in which I actually cannot decide, in a moment of undecidability. When I have a conversation with Annie, I can, and have to, choose my response to everything she says. When she speaks of the rape, and she states that she "constantly feels dirty", then there is a moment of undecidability in which I have to decide between the many possible ways of reacting to this. I can either choose to reflect her sense of contamination, I can choose to try and dispute this thought, I can ask whether she has experienced this same feeling somewhere in her past, I can ask what it means for her future. Of course, in the long run these options are not mutually exclusive. However, in the second that I have to decide on my response, I can choose only one for that particular moment. And the very thing that makes it a decision, which implies that I need to take responsibility for it, is the fact that it happens in a moment of undecidability, a moment of many options.

This is a moment where I decide and act to the best of my ability, even if I cannot claim to know "the right answer", the "truth". When I give up the desperate search for the ever-absent, ever-evasive "truth", there can be a moment of freedom from the narcissistic self. Then, paradoxically, I can learn that "the only truth lies in learning to free ourselves from insane passion for truth" (Eco, 1998, p.491). Being aware of undecidability and the ever-evasive nature of "truth", will help me as therapist to be able to hold the tension between knowing and not knowing, between deciding and knowing that I actually cannot decide. It will prompt me into a more respectful stance towards Annie's and Adam's stories, it will keep my eyes open for possible injustice done in the shrinking of their stories in order to pen down "the truth". It will push me into the direction of a more just

Stellenbosch University http://scholar.sun.ac.za

work ethics. It will turn my attention to evaluating and re-evaluating the law of the ward. Yet, paradoxically, the striving for justice might be the very starting point for my deconstruction, for my looking again...

Justice

Derrida (in Caputo, 1997) writes:

> Justice is not the law. Justice is what gives us the impulse, the drive or the movement to improve the law, that is, to deconstruct the law. Without a call for justice we would not have any interest in deconstructing the law. (p.125)

Progress or improvement is thus equated with deconstruction, implying that deconstruction is not a spinning around and a never-ending rumination. There is some agenda: improvement. Caputo (1997) writes about anti-deconstructionists' "good conscience" or presumed "ethical responsibility" (p.125) to prevent deconstruction from corrupting the youth, from filling the streets and the houses and the courts. This is done in the name of "justice", so that law and order can be kept intact. There is an underlying assumption that total anarchy will rule once deconstruction breaks the rule. There is an assumption that words (for example, within the realm of psychological language, "depressed" or "traumatised" or "psychotic") will lose all meaning, and that no talk will be possible. Caputo (1997) writes that there is a "misbegotten notion that deconstruction is some kind of random intellectual violence, a merely destructive and negative assault on anything still standing" (p.127). This seems to arise from a "failure to see what deconstruction affirms, a failure to see that every deconstructive analysis is undertaken in the name of something, something affirmatively un-deconstructable" (p.128).

So rather than saying that deconstruction is against the law, it would probably be more correct to say that deconstruction *is* justice (Caputo, 1997). This seems like a strange statement, because in theory we any sentence of the sort "deconstruction is X" has an *a priori* ring of "wrongness" to it (Hepburn, 1999, p.641), some non-compliance with its own laws. This might be the feeling one gets in general when justice is set up as the

Stellenbosch University http://scholar.sun.ac.za

"undeconstructable". Does Derrida revert to an age-old metaphysical idea or ideal, some telos or some ultimate phenomenon? Or is there something different at work here?

It seems as if deconstruction in fact needs some undeconstructable purpose in order to be. This links up with the idea of undecidability that I have already mentioned: we need the moment of undecidability for decisions to be made. Similarly, if it were not for some inner "striving forward" (some wish for improvement of the law) there would be no reason to deconstruct. Justice becomes the instruction to deconstruction. As Caputo (1997) argues:

> Everything in deconstruction is driven by the undeconstructable, fired and inspired, inflamed and impassioned, set into motion by what is not deconstructable. Deconstruction is internally related to the undeconstructable and is incoherent without it. What is undeconstructable – justice, the gift, hospitality… – is neither real or ideal, neither present nor future-present, neither existent nor idealizable, which is how and why it incites our "desire", driving and impassioning deconstruction. …Deconstruction is affirmative of something undeconstructable, but it is affirmative without being "positive". It is affirmative beyond the distinctions between positive and negative, foundational and anti-foundational, faith and reason. (p.129)

Justice is thus somewhere on the horizon, maybe just out of reach, but always already. Like a promise.

Equating of the Derridian notion of justice with a metaphysical, Platonian "super-idea" would thus not be just to Derrida, or do his theory complete justice. For although justice is undeconstructable, it falls under the law of *différence*: it is always already but never quite. It is not necessarily some higher ideal, but rather an embodiment, a non-dualistic "worldliness" that is and is not. "Justice is not the infinitely remote idea of a goal to be reached, but it is something which, here and now, gives us orders beyond any given sets of legal concepts" (Cilliers et al., 1999, p.282).

Stellenbosch University http://scholar.sun.ac.za

Derrida (in Caputo, 1997) describes this "embodiment" as follows:

> Justice, if such a "thing" "exists", is not a thing. Justice is not a present entity or order, not an exiting reality or a dream, nor is it even an ideal eidos toward which we earthlings down below heave and sigh while contemplating its heavenly form. Justice is the absolutely unforeseeable prospect (a paralysing paradox) in virtue of which the things that get deconstructed are deconstructed. Thus, deconstruction is made possible by a twofold, conjoint condition:
>
> (a) The deconstructability of law, of legality, or legitimization, makes deconstruction possible.
> (b) The undeconstructability of justice also makes deconstruction possible, indeed is inseparable from it.
> (c) The result is that deconstruction takes place in the interval that separates the undeconstructability of justice from the deconstructability of ... authority, legitimacy and so on. (p.132)

Thus, also in the context of psychology, the possibility of deconstruction, and improvement towards more justice, is relying on the undeconstructability of justice, the deconstructability of everything else (for example, the power imbalances inherent in the relationship between "normality" and "pathology"), and the relationship between the two. Yet, "deconstruction does not set its sight on justice as the goal or telos within a positive horizon of foreseeability" (Caputo, 1997, p.133). If I understand right (!) then Derrida says that justice is not only possible ("always already") but also "impossible". The "impossible" (the "never quite") is the tension of pushing against and beyond the limits of the horizon - an opening up of the horizon, a "cracking of nutshells" so to speak. So that "...justice solicits us from afar, from the future, from and as a future always structurally to come, calls 'come' to us, preventing the walls from the present from enclosing us in the possible" (Caputo, 1997, p.135). Justice or improvement of the current law, can only "come" to us in moments of difficulty, when choices have to be made in the moments of undecidability.

Stellenbosch University http://scholar.sun.ac.za

In my interaction with Annie in therapy, this would mean that my idea of wanting to be "just" cannot be a far-away, ever unreachable, ever inaccessible concept. Yet, there can also not be a cheap embodiment of justice. On the one hand, I cannot say that I will never have a moment of justice in therapy (because of the "impossibility" of reaching such a distant metaphysical idea). On the other hand, I cannot sit back in a self-satisfied way, believing that justice was present in my every word spoken to Annie, just because I hope for it to be like this. Rather, there must be a holding of this tension of justice being "always already but never quite". This would imply a constant awareness from my side to reach something that is in a way impossible to reach. But, paradoxically, in trying to reach it, my goal shifts. I do not want to arrive at justice anymore. Rather, my goal is to choose to be on my way towards justice, to be aware of justice "calling" me. This is a liberating mind shift, that allows for my freedom, yet urges me towards accountability and a constant striving for being more just in my interactions with Annie and Adam.

Now what?

Having spoken about the pronounced way in which modernist oppositions surface in the profession of psychology, I wonder whether I as a therapist am not perhaps in an impossible fix. Do I find myself in a paralysed state of inertia, a no-win prospect, with no hope of progression or improvement of the law in psychology? Will I always be shackled by these oppositions if I stay within the profession of psychology? Will there ever be some sort of "liberal democracy" wherein Annie, Adam and I can stand and speak on equal ground?

In the practice of psychology, there will always be the rule of imbalances, difference. There will always be different roles that are played, different places where people stand and position themselves. (For example, I am the therapist, Adam is the patient, and if I also were to take the role of patient, it could become very confusing for both him and me.) In order for meaning(s) to be made, differences have to exist. Otherwise Adam and I might find ourselves in the undesirable position of Nietzsche's "hollow men" who indeed stick out their chests, but have no substance. However, the necessity of difference does not mean that I as therapist have to find myself in a state of inertia. On

Stellenbosch University http://scholar.sun.ac.za

the contrary... there can, and has to be, movement. There can be a striving forward, impassioned by the desire for justice.

Similarly, undecidability does not mean I cannot decide and that I cannot use my knowledge and training. Even though I am constantly in moments of undecidability, even if deconstruction is never-ending, "the injunction to intervene, to take responsibility is here and now absolutely urgent. You can't wait. So, deconstruction is endless, but you have to respond here and now to the leap [into decision], to the gap [of undecidability]" (Cilliers, 1999, p.281).

So I decide, I proceed with therapy... and this is the ethical, therapeutic thing to do. With Annie and Adam, I must calculate, I must get a good history, an idea of how previous medications or psychotherapeutic modes worked for them. I must "plot" their stories and draw up a "map" of the territory in order to find my way around. I must find out from Annie what she wants from therapy, I must calculate her agenda. I have to calculate my agenda. I also must calculate on an academic level in an accountable manner, by being aware of what is going on in the field of psychology research-wise... And then I must remember that the "clinical judgements", decisions and diagnoses I make, are still made in the "gap" of undecidability. With Adam, I will choose constantly to the best of my abilities how to do therapy, while at the same time knowing that it is a decision made in the moment of undecidability. It is a decision that has to be re-evaluated. There is constant movement. The map can change as Adam and I spend more time in therapeutic conversation. Nothing is cast in stone... not even diagnosis, as Adam indeed showed throughout the course of his treatment.

Clinicians in the psychological professions constantly have to function in these moments where the idea(l) of the diagnostical mould is broken by "atypical presentations of pathology". In these moments, that which is referred to as "clinical judgement" and "clinical decision making" is highlighted. In these moments justice have to take place. Justice is not a fixed entity which already has been determined to be there or not the day the doors of the ward were opened (or closed): it is not tangible and can not be found in the little "law book" of the ward. It has to *happen*, in the moments of

Stellenbosch University http://scholar.sun.ac.za

undecidability, where justice is done to "judgement" and judgement is seen for what it is: judgement. This emphasises that the term "judgement" implies a reading of the situation on the part of the "judge". It implies that the judge, in this case the psychologist, is a person with a history of other readings and judgements behind her... and that her judgement did not fall from heaven as the master narrative in the story of psychology. This implies an injury to the narcissistic self, where there can be a respectful making of space for "the other". So, to say "that deconstruction is justice is not a quiet equation. It does not mean that deconstruction is just. Justice is deconstructive, deconstructing..." (Cilliers et al., 1999, p.282).

In striving towards justice, there is a constant play between stability and movement, between acknowledging and challenging certain discourses. There is a constant interaction between the "set-ness" of diagnostic categories and that which challenges it. If there were no ambiguities, no non-fitting clinical examples, we would probably still have been with DSM-I. That which does not fit the mould or form, that which challenges the form, then (sometimes) gets written into the next version of the DSM. It gets written into another form or mould, so that that which did not fit previously, now becomes part of the new criteria for "fitting". In the current DSM, for example, there are lengthy discussions on PTSD that has developed after a once-off stressor. Yet, people who are chronically traumatised, like children growing up in very violent and dangerous neighbourhoods, challenge this diagnosis. They might show some PTSD symptoms, but not necessarily all of them. Avoidant behaviour, for example, might be less pronounced (just because avoidance would not be possible). Dissociative symptoms (like "depersonalisation") might be more pronounced. They do not really fit into the category of "pure" PTSD (if there is such a thing). It is thus understandable that there has been ongoing debate in the last decade about diagnoses like "Chronic Stress Disorder", or "Personality change due to trauma". Conversation has been initiated exactly because there was news of difference, something that did not fit the mould perfectly. There is a need to include this news of difference in diagnostic conceptualisations, possibly in the next DSM. In this way we probably would be able to write diagnostic manual after diagnostic manual, in a dynamic way Hegel would have described as dialectical.

Stellenbosch University http://scholar.sun.ac.za

With regards to diagnosing even when we are aware of what we can do by diagnosing (for example, giving someone a lifelong label of Schizophrenia), the "then what" question becomes of utmost importance. Must we, can we, use diagnoses, or should it all be thrown out? Do we push out the ambiguous symptoms and stories to the margins so that the purity of our diagnostical categories does not become contaminated? Do we allow space for alternative stories that might challenge the security of the constricted diagnostical categories that we use?

I agree with Kleinman (1991) that diagnoses have usefulness: certain conditions are treatable, and without appropriate treatment more pain and suffering is caused. Annie's diagnosis of PTSD might indicate to her doctor that a specific antidepressant would be the most appropriate pharmacological intervention, and to me as her therapist that some sort of exposure or talking about the rape might be appropriate. Specific psychotic disorders might show a better response on certain medications or forms of treatment. Then it can be useful to bear the patient's diagnosis in mind when deciding on the best possible intervention.

On the other hand, diagnostic systems and mental health professionals can become pawns in bureaucratical social control – which is not conducive to anyone's mental health. The function of something like cultural analysis (or deconstruction) is then "to continually remind us of these dilemmas" (Kleinman, 1991, p.17), and to remind us of the moments of undecidability. Especially in a multi-cultural country like South Africa such cultural analysis is of utmost importance. Kleinman (1991) writes:

> [Cultural analysis] makes us sensitive to the possible abuse of psychiatric labels… it encourages humility in the face of alternative cultural formulations of the same problem… it works against dehumanizing pigeonholing. An anthropological sensibility regarding the cultural assumptions and social uses of the diagnostic process can be an effective check on its potential misuses and abuses. Irony, paradox, ambiguity, drama, tragedy, humor – these are the elemental conditions of humanity that should humble even master diagnosticians. (p.17)

Stellenbosch University http://scholar.sun.ac.za

These are the things that keep me from reducing Annie's identity to that of "a depressed patient with PTSD". These are the things that keep her a person, with rich and complex story lines that deserve respect. (The difference between regarding Annie as patient or person becomes evident also in the way I have learned to speak. When I refer to her as a patient, it would be easy to speak of "my patient". However, if the term "person" is used it seems quite inappropriate to speak of "my person". Although the possessive pronoun can be an indication of intimacy, closeness and care, it can also stand for a therapist's sense of "possession" of the patient, as if the patient "belongs" to the therapist....) Part of the process of therapy might be situated within the respectful acknowledgement of the other dimensions Annie has as a person, her other strengths and struggles. This ties up with the agenda of deconstruction: "deconstruction is respect, respect and affirmation of the other, it is a way to delimit the narcissism of the self, it is making space to let the other be" (Caputo, 1997, p.44).

In this making of space, a world of "dappled things" can be born and acknowledged. And from these "dappled things" can be born what Frosh (2000) calls "creativity, spontaneity, even love... things that require fertilisation, the breaking of perfection, the disruption of purity..." (p.56). To be creative and spontaneous, even to love, can form a substantial part of the therapeutic relationship. At the end of Annie's sessions with me, while reflecting back on therapy, she mentioned that the best moments for her were those where I just "was a person" with her. These were the times I just sat with her when she cried, when I laughed with her about something funny she told me, when we sat side by side, each drawing half of the coping cards we were working on. These moments of spontaneity formed part of the bigger therapeutic intervention. I do not want to simplify matters by contributing Annie's positive experience of therapy only to these moments... yet I must listen to the feedback she is giving me. In my mind, her experience that her "dappled narrative" was respected, made a valuable difference for her. As therapist I had to act even and always in moments of not knowing for sure, in moments of the "disruption of purity", both in terms of diagnosis and therapy.

When looking at this difficulty of "diagnosing for sure", Shawver (2000) poses the "now what" dilemma that critical psychologists often face, in the following way:

Stellenbosch University http://scholar.sun.ac.za

> What do professionals, who have learned how to diagnose mental illness according to the established rule, yet dislike the illness categories, do? Do they just stand up at their job sites and say, "Never again"? Do they roll their eyes when their colleagues discuss "borderlines" or "multiple personalities"? Do they shrug their shoulders when new private clients want diagnoses so they can use their insurance for payment? Or do they simply go through the exercise of diagnosing clients even though they feel that this is a destructive practice? (p.192)

Indeed, this is the difficult position I identify with. It is the dilemma of having to decide either to step out of the system I am critical of, thereby making a point in a very radical way, or staying on, which could signify some sort of silent approval of the system. However, it would be a one-dimensional view of staying on that depicts it only as such. Staying on can also mean a commitment to reform and improve, even if it does mean suffering the discomfort of an imperfect system. I agree with Shawver's (2000) conclusion: critical psychologists must be careful not to "shoot themselves in the foot" (p.193) when being critical in a too idealistic way. She believes that "refusing to diagnose can be contrary to the political aim [of improving the system]" (p.192). When critical psychologists step out of the system that they are critical of, they make room for less critical professionals to take their posts, thus in fact "forsaking" their original agenda of bettering the system. Only by staying on can critical clinicians propose change, indeed from the inside out and not from the outside in. The trick is then "to learn to balance our conscience with our authentic judgement about the practicalities that present themselves to us..." (p.193). This is, in my opinion, a very personal struggle of every individual. A very difficult struggle also, a constant learning, never arriving at the point of truth one day. It is a struggle that constantly presses us to be aware of the moments of undecidibility. Whenever I am humbled in the knowledge that my knowledge is made and mediated, that my decision making takes place in quite an uncomfortable gap, it opens up new avenues towards what I would like to call "justice"...

Stellenbosch University http://scholar.sun.ac.za

To give or not to give?

Following from this, Caputo (1997) comments on the idea of justice as a gift. The "economy of giving" (p.143) means that when I give you a gift, and both you and I know that I am giving it as such, I actually oblige you to say "thank you", and I make you indebted to me. Therefore, you have to give something back (for example, a "thank you" or another gift) to equalise the difference that I have set up by giving you something. In German, this paradoxical "economy" is beautifully illustrated in the words *die Gift vergiftet* (the gift poisons). Is giving then at all possible? Not if both you and I know that I am giving you something, Derrida would argue. Only if neither of us knows that it is a gift, when we are not aware of the economy of giving, we can give... In fact, giving as conscious act then seems to become an impossibility, and for exactly this reason it becomes desirable, and pushes against the limits of the possible horizons of the gift economy. Gift and economy need not be mutually exclusive... indeed, the "double injunctive, and the double bind, is this: Give, but know that the gift, alas, turns back into a circle..." (Caputo, 1997, p.148).

In terms of psychology, there is a gift economy in helping patients like Adam and Annie "get better". In therapy there is a reciprocal gift of meaning making. Psychotherapeutic effectiveness can be seen to rest on the therapist's capacity to give meanings back to the patients in a manner that makes their own meanings clearer. But in order to "mirror" meaning in such a way that the patient's sense of meaning grows and deepens, the therapist needs something from the patient. Annie needs to "give" me the gift of her story in order for me to give back a process of meaning making.

The gift economy is also played out on another level. The helper (I, as therapist) is helped: the patient stays indebted (also financially!). But then, if the original helper, I as the psychologist, is then helped in this process, I become the "helpee"... who is indebted to the original patient for the gift of help! Could the economy of giving in a sense be self-equilibrating? Or does it turn the very idea of "the gift" into some kind of non-entity, some paralysed no-thing, even some impossibility? Again this links with justice: "the passion for justice and the passion for the gift come together in and as the passion for the

Stellenbosch University http://scholar.sun.ac.za

impossible" (Caputo, 1997, p.149). Giving back in obligation is not a gift, in the same way that justice under some kind of obligation to be just to someone else, just because he has previously shown you justice, is not justice. Then it becomes law, which is neither justice nor gift.

What is the trick then? Caputo (1997) feels that "we must learn both to 'give' and also to give economy a chance" (p.151). We find ourselves in the gap between the gift and economy, in the same way we find ourselves between justice and the law... trying to "relieve the hard structures of the law with the gentleness of a gift" (p.151). As therapist I find myself then in the ambiguous position that, in my interaction with Annie, I must then be both unaware and aware of my "gift" of time and energy. In order for it to be a true gift, I must not even skim over the idea in my head that I am the "rich one" providing for her from out my treasuries. It must be so natural that, in a way, the economy is not contemplated. This gift of mine to the patient has to go by unnoticed (even by me), humbly. On the other hand, I cannot un-know, and I have to keep in the back of my mind the thought that I must be careful not to keep her in an indebted place. Therefore, for me as therapist, there must be both an awareness and unawareness of giving.

In terms of the phrase *die Gift vergiftet*, an interesting situation would occur if the patient experiences therapy or medication as a kind of "poison" (*die Gift*), while the therapist sees it as a gift (also *die Gift*). This might mean that some kind of "poisoning" is necessary in order to heal. Many patients, Annie for example, indeed choose this: she comes to therapy (even if it is difficult, "poisonous") in order to heal, to get better. She makes herself a gift by choosing to go the road of facing the inner poison. Other patients may come kicking and screaming, not making the meaning of their treatment being a gift. Logically these scenarios become complex. In terms of the economy of the gift, would this "ignorance" then imply that something of the impossibility of giving is coming nearer because the gift is not perceived as such? Or is it again a privileging of the person in power: if the psychologist perceives treatment as a gift, but not the patient, are we not plunging knee-deep into a reconstitution of these power differentials?

Stellenbosch University http://scholar.sun.ac.za

Deconstructing these power relations then again becomes an instruction to the critical psychologist. I am not going to write about the theoretical modality of narrative therapy extensively in this letter, but I believe that many of the principles as propagated by deconstruction find a practical application in this way of conceptualising and doing therapy. With its focus on respecting the individual's experience, on the therapist's "not knowing", on externalising the problem and seeking "unique outcomes" and new avenues, narrative therapy gives a voice to the striving towards justice (White, 1989).

In a way, it is easy to speak of deconstruction and respect and liberation when I speak of outpatients, individuals and families that are "relatively" "sane", still coping with going to school, going to work, coming to therapy. Then their reality and my reality are not that far removed from each other, and it is actually not necessarily that uncomfortable making room for multiple narratives. But what happens in the interaction between clinician and patient when the meeting takes place in an inpatient hospital setting, when the patient's functioning is "severely debilitated", when discharge is still miles away, when the patient is "floridly psychotic"?

Psychosis

Psychosis is a difficult concept for me. In a way it scares me, because I do not know it. The slow and sad grayness of depression I can grasp, the twitch of anxiety, the frustration and anger and happiness of relationships... But psychosis I do not know. I can only imagine, without knowing whether my imaginings are remotely related to "true psychosis". I find myself in more or less the same uncomfortable "not knowing" that Bottoms (2000) writes of in his story about his "brother's descent into madness":

> I had no understanding of paranoid schizophrenia that day [of my brother's diagnosis]– its massive delusions, the hallucinations, the blending of colour and sound, the accumulation of facts... and how they came together to form completely new and alternative notions of self and reality... It was years before I felt I had any understanding, and then only some, because the mind of another is

Stellenbosch University http://scholar.sun.ac.za

> ultimately unknowable, you can only approximate it with metaphor, invention, language, story. (p.93)

It is in this finding of metaphor, which is language, that the difficulty of the psychosis lies for me, and where the feelings of being helpless, small, inadequate and un-understanding originate.

Yet, psychosis lures me nearer, perhaps in the same way an abyss lures someone afraid of heights. Pirsig (1979) states that "present-day reason is an analogy of the flat earth of the medieval period ... If you go too far beyond it you're presumed to fall off, into insanity. And people are very much afraid of that..." (p.171). I am thus in a constant tug-of-war between wanting to leave this abyss alone, yet longing to peer over, to gain some sort of understanding of it.

This strange fascination is one of the reasons I want to pursue this road, the road of bringing a deconstruction of master narratives and power relations into the realm of making talk with psychotic patients. Yet I have wondered whether I should embark on this journey now, near the end of my letter. I have considered deleting or undoing these pages, because the topic is perhaps too difficult. Yet, in the context of this letter, it does not seem right to shy away from that which does not fit the mould, from that which is too troublesome and difficult and tricky. Therefore then, this tampering with this complex phenomenon.

Seeing and hearing things

Seeing and hearing things that others do not see or hear, being convinced of things others can only scorn at, having a "reality" that is not reality, can be daunting to both the therapist and the psychotic patient. Yet the question can be asked: according to which reality do these judgements of other realities take place? In our postmodern world the idea of multiple realities are not that weird anymore: we live in an age in which virtual realities are shaped on a daily basis by computers, by editing, cutting and pasting. Films like *Sliding Doors* (Pollock, 1999) and *The Matrix* (Silver, 1999) explore ideas of parallel

Stellenbosch University http://scholar.sun.ac.za

universes, space travel and life on a completely different level, in a completely different reality. In *The Truman Show* (Edwards, 1998), the main character lives in a reality that is as unreal as can be, a reality constructed purely for the sake of entertainment of television viewers in "the real reality". This film leaves the viewer with an uncomfortable sense of skepticism regarding the assumed "real" boundaries of her assumed "real world". What if we are all but players who have been seduced and deceived by the apparent realness of the reality we have been "thrown" into?

Dreams

Globus (1995) explores this concept of "thrown-ness" when he writes about "postmodernism and the dream", deconstructing the great divide between our waking and our sleeping worlds. Heidegger's concept of *Geworfenheit* (in Globus, 1995) is used when describing the nature of the human condition. We always and already find ourselves being "thrown" (*geworfen*) into the world – not choosing, not pre-contemplating whether we want to be here, where and when we want to be born. But, in our everyday business and being-in-the-world we forget our thrown-ness, we come under a (false) sense of security and firm ground. We live in "forgetfulness of being", which has the convenient consequence of our not being overcome by an existential Sartrean nausea.

In our dreams we are very much experiencing a sense of thrown-ness: in sleep we do not choose which fantasies and which realities enter our dream worlds. Sometimes we wake up, terrified of the images our "dream weavers" (Yalom, 2000, p.87) have conjured up. Sometimes we wake up with soft smiles, remembering the unplanned, uncalculated mystery of a soothing dream. Sometimes we simply amazed at the crazy way apparently non-related people and events and emotions are mixed up into an (in)credible dream story.

Our dreams "highlight our postmodern and existential thrown-ness" (Globus, 1995, p.123). This thrown-ness that is characteristic of the human condition is also highlighted in plays such as *Rosenkrantz and Guildenstern are dead* (Stoppard, 1991). In this

Stellenbosch University http://scholar.sun.ac.za

story, two peripheral characters from *Hamlet* (Shakespeare, 1994) suddenly find themselves right in the middle of the world of Elsinore. They try to figure out who on earth they are, what they are doing there and who the guy pacing up and down, mumbling "to be or not to be" on the periphery, is. They are situated within the "horizons" of Elsinore. In the same way, every human is situated within his or her "pragmatic horizon" (Globus, 1995, p.123) – even when this horizon is constantly in a Herocleitic flux, in a type of "always already but never quite". We live and interpret and understand and make meaning within a constantly shifting horizon, within a frame with blurry lines. Yet, this stays a horizon, a frame. Thus, in waking and sleeping, we can never understand as in "looking from above and seeing it all", we can never claim to be all-knowing. We know only within horizons. (This again, is a call for a respect for the other, for making space for that which might be part of another, different horizon.)

Globus (1995) writes of being in a non-reflective position in a dream – one is "enraptured" (being seized) and does not stand back to reflect on choices made or persons entering the dream. There is a complete immersion in the world of the dream. In contrast, reflection is "a common occurrence in waking" (p.125). He postulates that the dream rapture is only different from waking life in degree: in waking too, we are "seized" by our situatedness, our thrown-ness. (Yet, paradoxically, it seems that we have to reflect in order to notice our captivity, our enrapturement. There is a tension between rapture and reflection. This paradox is similar to the paradox of giving naturally and unknowingly, while at the same time being aware of the gift economy. In everyday life and as therapist, I am both reflecting and enraptured. I have to give in an "enraptured" way (naturally), as well as in a reflecting, aware way.)

However, if a person is always enraptured, always seized by the life world and its phenomena without any reflection, it could be problematic. Could psychosis be another way of describing complete immersion in what is experienced as reality? In the world of psychosis, as in the world of dreaming, there is a quality of "unreality", of some break with what is presumed to be real and true. Therefore, that which has been said about the thrown-ness, the pragmatic horizons and the sometimes dysjointed character of dreams, can also be applied to the world of psychosis. Psychosis, as dreams, highlights

Stellenbosch University http://scholar.sun.ac.za

our ontological state. This entails an intense involvement and enrapturement in the world, far from the "cool observation and detachment that is idealized in the white coated scientist" (Globus, 1995, p.125). Our situatedness is believed to have a here-and-now *Zuhanden* quality. Globus states:

> We are fascinated by our waking projects: we care about things, care about what happens. Everything matters. Care is ontological. ...Even for the borderline patient, for whom nothing matters, it matters that nothing matters ...both rationalism and romanticism miss the deeper significance of our waking rapture, the care that permeates our waking being. ...We are in both waking and dreaming seized by the world our meanings create. But it is in dreams that we see this more clearly since here "care" is shown in its purest form, unopposed by reflection. Dream rapture is thus emblematic of the postmodern emphasis on care. Our meanings captivate us... and to be so captivated is the human condition. Typically, this captivity is transparent, we do not notice as we live it. (p.126)

Care as an ontological given is thus exemplified in dreaming. The same holds for psychosis. Have you ever met a psychotic patient who could not care less about what is happening in her world? On the contrary, she is very concerned about the happenings in her reality, very worried about the people in her "delusional world". She is thrown into a reality in which she really cares, in which she has no other choice but to care. In the non-psychotic world too, caring is weaved into the human fabric. In fact, if we were not beings-of-care, then there would be no reason for the existence of psychology as profession. For if people did not care, they would not become "depressed", or "anxious", or "angry", or "personality-disordered". If I did not care, I would not have chosen to be a psychologist. If Annie did not care, the rape and the other traumas she has experienced would not really have mattered. Because she cares, she suffers, and wants something to become better, to heal.

Stellenbosch University http://scholar.sun.ac.za

Conversation: always a possibility?

In the previous writings about "patients" and "professionals" and Annie and Adam and "justice and care", I have propagated a therapeutic stance that encourages respectful conversation. In this dialogue, the voices of both therapist and patient are heard. Their stories meet, their narratives stand next to each other. But what happens if a patient seems to be so psychotic that no such conversation seems possible?

In my work as an intern this year, I have had the experience of having to clerk the particulars of a young girl (let me call her Zelda) who was "floridly psychotic". This process took much longer than planned, because she seemed unable to enter into dialogue, that is, the dialogue that I foresaw when I went to see her originally. Whenever I asked a question, she derailed to another tangent. Whenever I used an expression she liked, she echoed it quite a few times. She often answered my questions ("For how long have you been feeling like this?" or "Is there anyone else in your family the experiences the same difficulties that you do?") with questions that were preoccupied with religious content ("Are you an angel?", "Am I God?" and "Are you God?"). (For Zelda, the content of the delusions and hallucinations - *what* she was experiencing - definitely seemed to be more important than their form - *that* she was experiencing it.) It seemed to me as if my language and Zelda's language just did not seem to be able to connect. It was as if she had her own idiolect, an idiolect I could not enter. (Maybe she felt the same way about my language.) Meaningful conversation in my language seemed impossible, because she could not really understand me. Meaningful conversation in her language seemed impossible, because I could not really understand her.

In the end I put away the little booklet I was supposed to fill in: this dialogue was not going to happen. But what now? How can I find some common vocabulary, even if just to make this a therapeutic interaction for Zelda? Can she and I find some form of communication without dialogue? How can I care for her, give to her, be just and respectful towards her? This is not an easy question. It does not have an easy answer. I would, however, pose the idea that, in cases like these, a therapist's "being functions"

Stellenbosch University http://scholar.sun.ac.za

are usually more important than her "doing functions". In Zelda's case, I had to try to trust in the value of just being with her. I had to give up the idea that my very specific words can bring change, I had to let go of the safety I sometimes find in using the "right phrases", the "right, therapeutic words", the "right questions". I had to explore another language, the language of simply being, of simply spending time with someone. Because to choose to spend time with someone is deeply respectful. It means that I value Zelda. It means that I care enough to want just to be with her, even when there are no words. It means that "just being" with someone can be a just way of being a therapist. Even when my language and hers do not find a meeting place, there is a meeting place on another level beyond the level of words. In this meeting place of choosing to be with someone, healing can happen.

Again, I believe this is the case with all patients and not only psychotic patients. In this way, the opposition where the non-psychotic patient and her language are privileged above the psychotic patient and her language, is deconstructed. That which holds for the psychotic, also holds for the non-psychotic. That which holds for Zelda, also applies to Adam and Annie. Firstly, that meaning is always "never quite" and has to be co-written constantly in every reading and conversation. Secondly, that for all people, care is ontological, and thirdly, that in my choosing just to be with someone there can be a communication of care and respect. This will take me further on the road towards the "impossible": justice can be done and giving can happen in a therapeutic space that deconstructs linguistic and political power relations and focuses on personhood rather than patienthood. This can lead towards being the "better therapist" I wrote about in the beginning of the letter.

A time to go

I think, Chris, that it is time to start to finish this letter. Somehow, after the initial discussion of deconstruction, after telling some stories and deconstructing some hierarchies, and after exploring the concepts of justice and care with regards to non-psychotic as well as psychotic patients, I feel as if some sort of "closing" has been reached. Now, even at this "ending", if it exists, I am aware that I do not have a feeling of

Stellenbosch University http://scholar.sun.ac.za

arriving. I do not have the final answer, I cannot make a neat wrap-up remark, I cannot conclude with a brief "take home message". Even if this were possible, I do not think it would do justice to what I have written in this letter…

I have written of many stories and many people. I have described the difficulty of positioning myself, of uncomfortable spaces, deconstruction, *differénce*, undecidability, professionals, patients, psychopathology and psychotherapy. I have told you about Annie, Adam, Zelda, myself. I have written of striving towards justice, of being passionate about responsible caring and giving, and of giving up the expert position and the ideal of objectivity. I have reflected about respect, about laying the Narcissus in myself to rest. I have written of the possibility of conversation and communication between persons, also when their realities do not seem to be able to connect.

I have painted and framed this picture, or pictures… Now I want it to be put up on a wall somewhere – not as the end product or the grand finale, not as something completed in itself. I want to place a little table next to this wall. On this table I want to leave a paint brush or two, a glass of water, a myriad of paints with different textures and colours. I want passers-by to look at the painting, to pick up a brush, to add a stroke or splash of paint. I want them to be aware of their co-authoring and meaning making (which takes place anyway, even if they just look at the picture and walk on) in a very tangible way.

Maybe I will also come round later.

Stellenbosch University http://scholar.sun.ac.za

References

American Psychiatric Association. (1994). *Diagnostical and statistical manual of mental disorders* (fourth ed.). Washington DC: Author.

Bos, S. (1995). Niet van deze wereld. On *Schaduw in de nacht* [CD]. Amsterdam: Hans Kuslers Music.

Bottoms, G. (2000). *Angelhead: My brother's descent into madness*. New York: Crown Publications.

Carroll, L. (1994). *Alice's adventures in Wonderland*. London: Penguin Books.

Cilliers, P., Degenaar, J., & Van der Merwe, W. (1999). Justice, law and philosophy – an interview with Jacques Derrida. *South African Journal of Philosophy, 18* (3), 279-286.

Caputo, J.D. (1997). *Deconstruction in a nutshell – a conversation with Jacques Derrida*. New York: Fordham University Press.

Culler, J. (1983). *On deconstruction: theory and criticism after structuralism*. London: Routledge & Kegan Paul.

Eco, U. (1998). *The name of the rose*. London: Vintage.

Edwards, S. (Producer), & Weir, P. (Director). (1998). *The Truman Show* [Motion Picture]. United States: Paramount Pictures.

Foucault, M. (1994). *Ethics, subjectivity and truth (Vol 1): Essential works of Foucault 1954-1984*. In P. Rabinow (Ed.). London: Penquin Books.

Stellenbosch University http://scholar.sun.ac.za

Frosh, S. (2000). In praise of unclean things: critical psychology, diversity and disruption. In T. Sloan (Ed.), *Critical psychology: voices for change* (pp.55-66). Houndmills: Macmillan Press Ltd.

Fukuyama, F. (1992). *The end of history and the last man*. London: The Penquin Group.

Gaarder, J. (1996). *Sophie's world*. New York: The Berkley Publishing Group.

Globus, G. (1995). *The postmodern brain*. Amsterdam: John Benjamins Publishing Company.

Hepburn, A. (1999). Derrida and psychology: deconstruction and its ab/uses in critical and discursive psychologies. *Theory and Psychology, 9*(5), 639-665.

Jarup, M. (1988). *An introductory guide to poststructuralism and postmodernism*. New York: Harvester.

Kenny, A. (1994). *The Oxford illustrated history of Western philosophy*. Oxford: Oxford University Press.

Kleinman, A. (1991). *Rethinking psychiatry: from cultural category to personal experience*. New York: The Free Press.

Maze, J.R. (2001). Social constructionism, deconstructionism and some requirements of discourse. *Theory and Psychology, 11*(3), 393 – 417.

Morss, J. (2000). Connecting with difference: being critical in a postmodern world. In T. Sloan (Ed.), *Critical psychology: voices for change* (pp.103-111). Houndmills: Macmillan Press Ltd.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage Publications Ltd.

Stellenbosch University http://scholar.sun.ac.za

Pirsig, R.M. (1979). *Zen and the art of motorcycle maintenance*. New York: Quill William Morrow.

Pollock, S. (Producer), & Howitt, P. (Director). (1999). *Sliding doors* [Motion Picture]. United States: Paramount Pictures.

Rosenhan, D.L. (1975). On being sane in insane places. In T.J. Scheff (Ed.), *Labeling madness* (pp.54-74). New Jersey: Prentice-Hall Inc.: Englewood Cliffs.

Scheff, T.J. (1975). *Labeling madness*. New Jersey: Prentice-Hall Inc., Englewood Cliffs.

Shawver, L. (2000). My postmodern path to a critical psychology. In T. Sloan (Ed.), *Critical psychology: voices for change* (pp.184-195). Houndmills: Macmillan Press Ltd.

Silver, J. (Producer), & The Wachowski Brothers (Directors). (1999). *The Matrix* [Motion Picture]. United States: Village Roadshow Films (BVI) Ltd.

Sloan, T. (Ed). (2000). *Critical psychology: voices for change*. London: Macmillan Press Ltd.

Stanford, M. (1998). *An introduction to the philosophy of history*. Malden: Blackwell Publishers Inc.

Shakespeare, W. (1994). *Hamlet*. London: Penguin Books.

Stoppard, T. (1991). *Rosencrantz and Guildenstern are dead*. London: Atlantic Books.

Swartz, S. (1996). Shrinking: a postmodern perspective on psychiatric case histories. *South African Journal of Psychology, 26* (3), 150-156.

White, M. (1989). *Selected papers*. Adelaide: Dulwich Centre Publications.

Stellenbosch University http://scholar.sun.ac.za

Yalom, I. (2000). *Momma and the meaning of life*. London: Judy Piatkus Ltd.