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Introduction

This co-authored book is not designed to operate as a textbook, but as a polemical and accessible 'counter-text' for students and practitioners. It develops a deconstructive approach to the practice of professionals and researchers concerned with 'psychopathology'. We will be doing three things in the course of the book. First, we will open up the notion of 'psychopathology' as it is conventionally used in psychology and psychiatry using a practical deconstructive approach to the language and institutions that hold it in place. Secondly, we will explore the implications of deconstructive ideas for the theories and practices that underpin clinical treatments. Thirdly, we will be describing alternative views of the language of psychopathology and models for critical professional work and good mental health practice.

Let us trace the shape of the book. We are concerned in the first part of the book with how forms of mental 'illness' or distress have become divided from mental health, and how professionals participate in 'dividing practices' in the present day. As we describe how these dividing practices work, we throw them into question by deconstructing clinical categories. Deconstruction in this book is used to unravel suppressed meanings in texts, and to provide a way of re-reading and re-working ideas and practices that are normally taken for granted. In Chapter 1 we review the way in which abnormal psychology has been divided from the 'normal' psychology that most people are supposed to enjoy. Chapter 2 looks at 'alternatives' from psychoanalysis, anti-psychiatry, family therapy and cognitive approaches. In Chapter 3 we look at how symptoms are constructed, and how they reinforce popular stereotypes and different forms of oppression.

We then turn our attention to the ways in which cultural images of psychological distress, which are so important a context for the development of psychiatry and clinical psychology, bear on the ways in which people who are categorized in the mental health system understand themselves. Chapter 4 explores cultural representations of psychopathology, and how those representations affect clinical practice. We look at the other side of the problem in Chapter 5, when we discuss pathological identity, and we trace the network of paths that lead people into the mental health system. This is all well and good, but we also want to ask what opportunities for change this picture presents to the professional reader

who will want to know what theoretical and research alternatives our deconstruction opens up, and to the user of mental health services, who will be concerned with examples of better practice. In Chapter 6 we develop our account of 'psychopathology' as something that is embedded in cultural texts, and we look at research on language, and the ways in which traditional psychiatric work, which produces a circular argument confirming existing labels, can be challenged. The different practical challenges that have been developed are explored in Chapter 7, which covers the development of the alternative mental health movements.

Psychiatric texts, like many other texts, try to cover over the contradictions in the argument they develop and the assumptions they use. This book too is interlaced with contradictions, and so it is helpful, we think, to anticipate some of the objections that will be levelled against us, and some of the disagreements between us that will have found their way into the book. This book is not a closed system nor a complete solution, and so Chapter 8 reviews some of the dilemmas and contradictions that face those critical of mainstream psychiatry and clinical psychology, as well as providing a resource list of groups that are taking our academic discussion forward in the real world.

As we go through the book we show why it is necessary to 'deconstruct' psychopathology, and describe what we mean by 'practical deconstruction'. We have come together to write this book from diverse parts of the mental health system – from clinical psychology, psychiatric social work, psychoanalysis, psychology teaching and action research – and have no desire to replace the old jargon around mental health and distress with a new one. As we unravel, deconstruct traditional notions in the following chapters, we suggest strategies for change, and hope that you will be inspired to participate in building, reconstructing something better.

1
Madness and Modernity

This first chapter provides a historical review of the development of 'psychopathology' as the study of mental 'disorder' in Western culture. We give an account of Michel Foucault's work as it applies to clinical categories, and then describe how psychiatric and abnormal psychology texts and practices can be deconstructed. We also introduce the notion of 'deconstruction' and show how it can be made relevant to this history of categorization, and to the ways in which some people have been marked off as different, as 'other'.

Abnormal psychology

The notions of madness and abnormal psychology as we understand them are particular and peculiar to our culture and our time. That is the starting point for our historical deconstruction of psychopathology. However, this assertion on its own is no longer controversial or very radical. Many practitioners of psychiatry and clinical psychology would accept that the categories we use to understand mental distress are specific to our society. Even the terminology adopted in liberal American and British texts on the issue has moved on from the old oppositions of 'sane/insane', or even 'healthy/sick', to ones which try to escape a medical model. One popular opposition employed in psychology now, for example, is that of 'normal/abnormal'. As one recent text puts it, abnormal psychology is the study of 'The Problem of Maladaptive Behavior' (Sarason and Sarason, 1987). While madness is now commonly referred to in inverted commas, it is 'abnormal psychology' in these texts that is treated as a fact. The problem is that not only does the formulation 'abnormal psychology' belie the continuing power of medical models of 'illness', but it is doubtful whether simply adopting that polarity in preference to the others will solve the problems facing what are often now called the 'users' or 'consumers' of mental health agencies.

The words we use to describe 'maladaptive behaviour' are only part of the problem we want to focus on in this book, but they are an important part. The terms we use are loaded with assumptions, and those assumptions are reproduced moment by moment in the practice of psychiatry, in its poor cousin clinical psychology, and in its even more dependent

relatives (in mental health nursing, social work and so on) struggling to make sense of distress in the community. Words do not only denote a phenomenon, but carry with them an array of connotations. These connotations – of pathology, incapacity or lack – funnel into the scientific definitions that are circulated in textbooks and medical manuals on the identification and description of types of 'psychopathology'. Each slot in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) produced by the American Psychiatric Association (1994) or the *International Classification of Diseases* (ICD) overseen by the World Health Organization (1992) becomes occupied either by those rare human exemplars who fit perfectly, or, more often, by the 'difficult cases' who spill over their assigned place and require a complex combination of names to pin them down. When the categories are used, they become charged with an emotional force which has far-reaching consequences for those who are labelled. Not only are 'patients' pathologized by the diagnostic classification itself, but they are further pathologized when they do not fit, because it does not work. The labels are not simply innocent counters available to the psychiatrist or clinical psychologist to be tagged on to a case and to point to an appropriate remedy. The use of medical terminology also affects those who are responsible for labelling. The power of psychiatry rests, in large part, on its ability to force psychologists, nurses and social workers who are not medically qualified to play only supporting parts in institutions. It is the power of medicine itself which sets the agenda (Stainton Rogers, 1991; Turner, 1987). Because clinical psychologists and the rest of the cast often aspire to psychiatric power we will need to look directly at that power and how it operates.

Choosing friendly euphemisms will not solve the problem, for the traditional oppositions that constitute the field of psychopathology can always be renewed, and will then hold the same cultural power of exclusion and institutional abuse. This problem has been emphasized by those working with learning disability, in which the use of hundreds of different terms fail to escape demeaning meanings (Sinason, 1989). In this sense, the shift to 'normal/abnormal' simply reconstitutes the opposition between 'healthy' and 'sick' or between 'sane' and 'insane', and the power of psychiatry is left firmly in place. At the same time, however, the move from one set of oppositions to another opens up new spaces for resistance, spaces for new voices to be heard. This is part of the work of 'deconstruction' which was elaborated in French philosophy by Jacques Derrida, and we have to link that work to practical changes to ensure that the new oppositions do not simply function to divide and oppress in the same ways as the old.

Derrida (for example, 1976, 1978) provides a systematic reading of philosophical texts which focus on the ways in which an argument is policed to guarantee a fixed reference point, an essential point of 'truth' which the reader then takes for granted and sees as the foundation for other less

important things. A deconstruction, in this 'original' and 'purest' sense, identifies conceptual oppositions, recovers notions that have been excluded, and shows how the ideas that have been privileged are dependent on those they dominate. For example, when we speak, it appears as if all meaning comes from within our individual 'mind' and then travels through language which operates as a mere carrier. Forms of communication, such as writing, that seem out of the mind's control, are then relegated to a lesser place. Derrida (1978) draws attention to philosophical traditions that treat writing in this way as 'impure' speech. He then goes on to argue that because language is a system of terms that is always already out of our control, it could be seen as a variety of writing, and so, in his deconstruction of the opposition between speech and writing, 'writing' disrupts the opposition.

These matters are very important to psychiatric knowledge, of course, because psychiatry and other clinical approaches have been concerned with what goes on inside individual minds and bodies, and they have tried to brush away the role of language and society in the experience and treatment of distress. Deconstruction in the strict philosophical sense offers us a way of tackling the internal contradictions in psychiatric texts, but that is where we start, not where we want to finish. It is helpful to be aware of the origins of the term deconstruction, but we are using it in a less 'pure' way in this book. We will be linking our deconstruction of psychopathology with an analysis of the practices of power that hold traditional oppositions in place. To do that we need some historical account, and we will be locating our critical reading of texts in their institutional context. This is why we use the work of the historian Foucault, a writer who also had a clinical psychology training (Parker, 1995a). We will be adopting a looser form of deconstruction that connects psychological critique with political context (cf. Parker and Shotter, 1990). In its most radical form, 'postmodernism' in psychology is another codeword for the same type of challenge to the disciplines of the mind (Kvale, 1992). Attending to politics and power when you do a critical reading, and thinking through the effects of your critique on institutions and forms of knowledge is what we term *practical deconstruction*.

Deconstructing terminology

Deconstruction *is* abnormal psychology, for it looks at things askew, seeing things that do not at first glance seem to be there, it is very suspicious, and it breaks the rules to show that what is usually treated as normal is itself really rather odd. When we refer to our reading as 'abnormal' here, we risk reinforcing the 'normal' negative connotations attached to different behaviours and experiences, but we are also taking terms and using them *against* traditional systems of knowledge and power, acknowledging the necessity

for suspicion and defying the routine way it is pathologized. Deconstruction is a process of reading which unravels the way insane categories are used to suppress different perceptions and behaviours, and it overturns the opposition between, for example, illness and health. It works with a strange, pathologically curious attention to language and practice to show that a measure of 'sickness' is needed to survive in this world, and to show that the division between sickness and health is *not* discontinuous, and, more than that, that the division is constructed in such a way that it produces those two ends of the continuum. At the same time, deconstruction recovers the subordinate term in a conceptual opposition and transforms it, to use it against the dominant team.

In political struggles, the terms 'black' and 'gay' were taken from the weaponry of prejudice and used defiantly by those who were labelled in such a way that they disrupted simple shorthand pathologizing in everyday language. The notion of 'health', for example, requires a description of 'sickness' to make sense. It could not exist without the opposite that defines it. The terms 'insanity', 'illness' or 'abnormality' are then put under erasure so that we do not use them in the simple way they are usually used and defined by their powerful partners ('sanity', 'health' or 'normality') but rather as conceptual levers to throw the language of modern mental health policing into question. To put something 'under erasure' is to question its taken-for-granted meaning, to mark it as a problem to be challenged. Moreover, we must challenge not only one set of oppositions, but also the way they are linked together in a set that constitutes the popular and professional definitions of the things that lie outside 'reasonable' society.

The practical deconstruction described in this book roots the conceptual oppositions that structure psychopathology in abnormal structures of segregation and regulation that have accumulated a pervasive and insidious power over the years in Western culture (the culture we refer to as 'ours', though 'we' are trying to keep our distance here). It is practical in the sense both that it focuses on the way language works in material apparatuses of medicine, the state and the community, and in that it is designed to be useful to critical practitioners and those struggling at the sharp end of the mental health system. Along the way we will be describing how other writers, such as Foucault (1977, 1981) who was centrally concerned with power, can be used in this critical struggle.

The language of abnormal psychology is enmeshed within institutions of mental diagnosis and surveillance. Three themes will run through this first chapter and then appear in the rest of the book. The first is that an understanding of language is crucial to a critical account of psychiatry and its sidekicks. The second is that we have to connect language with the institutions in which it is used. One of the most important ways of doing that is to see things from the standpoint of those who suffer psychiatry. The third theme is that we need some account of the 'irrational' or the 'unreasonable' in human experience which language excludes. It excludes

what it deems to be irrational at the very moment it constructs it. This means that we have to think tactically about how to make alliances with such constructed and excluded phenomena at the same time as developing an understanding as to how they function. In this culture we will need some notion of resistance to accomplish that task.

When we appeal to the irrationality that is shut out of over-rational clinical knowledge we do not want to imply that we believe in that irrationality as a 'pure' source of liberation (in the same way as someone who uses a gun in a liberation struggle is using a weapon that is constructed by the system they oppose). And we are not only talking about things constructed in language, but, as Foucault (1977) did, about the construction of physical apparatuses of power and resistance (like prisons and guns, chemicals and bodies). To pursue these three themes it will be necessary to give a critical historical analysis of psychiatry and 'abnormal psychology'. This is where our deconstruction is given a further, even more radical turn, as we will see in the next section. We should ask how the commonly used indicators of mental 'illness' and the powerful institutions of mental health came into being. Psychiatry tells a story of progress to support its work, and its way of writing history needs to be challenged. What appears to be commonsensical must be rendered strange. When we put concepts under erasure, that does not mean that we will never use them again; we hold and transform them. We will use them in a different way. One thing we should not erase in a practical deconstruction is our memory, in this case as a 'counter-memory' (Foucault, 1977), of how this state of things came to be.

Three histories of abnormality

There are three types of historical account we could give of madness. The first is a fairly uncontentious account of the development of 'madness' as a problem in Western culture since the Middle Ages and of changes in diagnostic categories. The second is a more radical examination of the notions of mental health which lie under those categories, and the third is one which throws into question the very notions of reason and unreason which language forces into being. We will run, in turn, through these three accounts.

The historical specificity of diagnostic categories

There have, of course, been many different explanations of 'madness' over the centuries, and the radical and rapid shifts in definition testify to the difficulty we face in trying to decipher what it 'really' is. Take the links that were made in the Middle Ages, for example, between water and madness.

On the Continent the melancholy of the English was explained by way of our maritime climate: 'all those fine droplets of water that penetrated the channels and fibers of the human body and made it lose its firmness, predisposed it to madness' (Foucault, 1971: 13). It is in this context that images of the 'Ship of Fools' suddenly appeared in the fifteenth century. These ships, according to the contemporary popular representations (especially in art), travelled around with the mad to be occasionally sighted by the inhabitants of port towns. Although the historical accuracy of Foucault's description of these ships has been questioned (Gordon, 1990; Sedgwick, 1982), the symbolic importance they played in the popular imagination is the key point at issue here. According to Foucault (1971), up until the fifteenth century the great fear was death alone. From the fifteenth century *madness* makes an entrance as the ghastly scourge of the Western mind. Whilst death was a threat that came from without, and at the end of life, madness is something always present as a threat from *within* and as an everpresent possibility. People then realized that 'The head that will become the skull is already empty . . . Madness is the *déjà-là* [already there] of death' (Foucault, 1971: 16).

The mad then filled the space that was opened up by the closure of the leprosaria at the end of the Middle Ages. Lepers ceased to be the main problem on the outskirts of life, and the new diseased of mind occupied their place, but it was only after the confinement of social deviants in general that the mad became marked out for special treatment. The General Hospital of Paris established in 1656 first of all opened its doors to various vagabonds and was primarily a place of confinement rather than a place of treatment. What we now designate the 'mad' were thrown in with a mixed bag of deviants, and within a short time, by 1676, the King ordered that there should be such an institution in every city. These places were enormous. Paris, for example, saw one in a 100 of its population incarcerated in a few months. In England it was decided that 'houses of correction' should be set up in each county in accordance with an act of 1575. Confinement across Europe was a police matter, not one of medical care. That 'care' came later, in institutions and then, as an extension of the institutions now, out into the community again (an issue we explore in Chapter 7). It was common knowledge, Foucault notes, that until the end of the eighteenth century the mad were not seen as sick. The animality of madness 'protected the lunatic from whatever might be fragile, precarious and sickly in man' (Foucault, 1971: 74).

The bridge to the medical treatment of the mad was the moral treatment of the insane in special places, treatment which was provoked by popular fears that the distressed inhabitants of the large institutions in cities were contagious. The inhabitants of Paris near the Hôpital Géneral, for example, had long complained about the dangerous vapours which wafted out and which threatened to make them mad too. It was the reinterpretation of the issue as a moral one which set the way for releasing the mad

from their chains. Samuel Tuke, one of the English Quaker reformers, founded a retreat at York in 1729, for example, and advocated warm baths and human kindness. One of Foucault's more controversial arguments is that the notion of 'kindness' as a cure was to mesh into medical models which would then in turn enmesh the mad in other more powerful invisible chains. Foucault's case is that the humanization of treatments of the insane encouraged the internalization of the difficulties they exhibited. The mad then had to take responsibility for cure, and the kind treatment which replaced the rods and whips would work its way inwards. The conscience of the mentally ill would act as a self-discipline all the more efficient than the social discipline of the general hospital. We will return to the implications of this internalization of treatment and responsibility for mental disorder when we look at a more radical way of historicizing psychiatric practice in a moment.

The moral treatment of madness was to give way eventually to medical approaches, but the rise of modern psychiatry followed a sustained period which lasted through the nineteenth century and into the twentieth until after the First World War, a period in which the medics were little more than helpmates in regimes of moral improvement. These regimes did often involve physical 'treatments' intended to bring the individual back into an engagement with civilized society, but since madness was seen as a combination of an inherited constitution and unfortunate life events, rather than any underlying disease entities, little medical intervention could be made. The moral regime during this time consisted of a mixture of notions, the two most important being organicism – inherited weakness – and hygiene – lack of cleanliness and social adjustment. This version of moral treatment was to lay the basis for modern full-blown medical psychiatry. The 'mad' were starting to be seen not so much as completely 'outside', but as problems 'inside' society: 'The paradigmatic subjects of the modernizing psychiatric apparatus posed a threat only in so far as they acted like grit in the institutional machinery of school, industry and elsewhere. They represented a source of social irritation, a loss of potential efficiency, and a future burden upon the state' (Rose, 1986: 52). It became increasingly important to monitor and regulate those who might fall into this condition and cause such irritation, and the observation and control of mental distress continued through to the 1950s when the so-called psychiatric miracle drugs allowed medical notions finally to triumph.

Not only did the release of the mad from the large anonymous prisons, in the eighteenth and nineteenth centuries and now in the twentieth century, treat them as special cases, but it also meant that they then, as special cases, needed to be observed carefully and classified. This classification has proceeded apace until the present day; the emphasis now is on the individuality of the 'patient' and the specificity of the symptoms they display. In hard-line medical approaches the emphasis is on the symptoms, and in the softer humanist varieties the person is valued as the carrier of

the symptoms. However, these are two sides of a process which individualizes distress, and treats it apart from social context. The categories in the various versions and revisions of the DSM or ICD have to be expanded and altered every time to give a supposedly more accurate, more carefully observed, set of categories. Since the observation is framed in medical terms, it always fails to work as a neat array of pigeonholes; people are never only 'patients' but complex thinking human beings, and so they just will not fit. This does not mean that a simple emphasis on the individuality of the sufferer will solve the problem, of course, because the rhetoric of individuality functions to wrench the person from the various social contexts that have contributed to the distress all the more. Medical language itself is rooted in social contexts, it is still framed by moral-political factors, and it is continually disrupted by them too.

The more recent changes in diagnostic categories still follow changes in moral reasoning in the surrounding society, and the decision to take out a category often reflects changes in morality. An example of this is the removal of homosexuality from what was to become the DSM-III-R (the third revised edition of the DSM). In 1973 the American Psychiatric Association Board of Trustees voted to take 'Ego-dystonic Homosexuality' off its list of mental illnesses (Wilson, 1993) and the American Psychological Association followed suit two years later. It should be noted, though, that 'persistent and marked distress about one's sexual orientation' was still given as an example of sexual dysfunction in the DSM-III-R (American Psychiatric Association, 1987: 296). It is also no accident that changing notions of sexuality should force the alteration of psychiatric categories. This is because definitions of abnormal and perverse behaviour and thinking cluster around sexual activities in this modern culture which is so saturated with sexualized notions of self and other (Foucault, 1981). These changes not only attest to the fragility of the current category system but also show us something about the assumptions which underlie it. The type of history we have traced so far allows us to see what the role of the discipline of abnormal psychology is in this society. But this is just the first step. We can go further than this, and we need to go further to link a historical account with deconstruction, to make it a deconstructive history.

Cultural changes in the experience of distress

Might our suspicion that the language we use to describe 'psychopathology' is culturally specific also be worth directing at the phenomenon itself? It is not only the terms that change, perhaps, but what we imagine to 'really' lie underneath them. Of course, mainstream psychiatrists like Roth and Kroll (1986) will see the 'reality of mental illness' as existing at every time and place, with different cultures simply having different words for 'it'. However, different cultures have such radically different conceptions of

what we call mental illness that we have to consider the possibility that not only the talk, but also what is described is radically different. Take the case of notions of madness nearly 25 centuries ago in Greece (Padel, 1981). Here, the experience of distress was not of a turmoil inside the head of the sufferer but of a clash of wills outside. The activities of different deities demanding conflicting courses of action from a human subject would lead to contradictory and unreasonable behaviour.

In fifth century BC tragedy in Athens, for example, we have accounts of the mad as isolated from others because they are seen as particularly dangerous. But the great fear which animates those who have to deal with the mad is that the person who is mad is, in some odd way, close to the gods. Madness is the sign of this closeness. Each god puts pressure on the person to act in certain ways, and has a vested interest in that behaviour. While the gods often coexist peacefully, their interests may sometimes clash and this is where problems will arise. When the gods make mad those they wish to destroy, they can do so by a process of isolation, and it is here that one of the most interesting contrasts between conceptions of madness in fifth century BC Greece and our own time arises. It is precisely the contrast, the *difference* that we want to emphasize in this deconstructive history. We do not, for example, want to subscribe to traditional psychiatry's romanticization of ancient Greece, and to the notion that all the deepest truths about human nature were revealed there. We have chosen this example to demonstrate the *discontinuity* between that cultural context and 'ours'.

To take one example of the differences in language across the centuries; we should be aware that the English word 'idiot' which plays such an important part in the descriptive vocabulary of the everyday treatment of irrational or 'stupid' persons came from the Greek word '*idiotes*'. This Greek word means 'private person', and Greek culture at that time did not at all value notions of privacy or solitude. The consequence is that the wish to isolate one's self from others would be evidence of abnormality. It would also be a sign of a peculiarly close relationship with a god. More than that, the urge to isolate oneself would be experienced as abnormal. In this very different world, 'the mad and the ex-mad are distanced from other people further by feelings; both by the feelings other people have about them, and by those they have about and in their madness' (Padel, 1981: 114). The moral treatment of the idiots from the end of the eighteenth century in Europe in places like Tuke's Quaker asylum, on the other hand, required the 'retreat', the secluded 'reflection' of the person on their individual distress. Solitude here is a precondition for the solace moral treatment, and then medicine, would provide. How people understand 'solitude' and 'asylum', then, is culturally constituted.

Identifying the culturally specific popular representations of distress is not simply a matter of historical and anthropological interest. Popular representations do not float around ready to be used at will by whomsoever