*I re-wrote this paper in 1999 out of something I'd written from our book PRAXIS: situating discourse, feminism and postmodernism in narrative therapies – that I'd co-edited with Ian Law. That great discourse scholar - Ian Parker - asked a few of us at the Vancouver School for narrative Therapy to write up what we were 'doing' for a book he was editing entitled '*Deconstructing Psychotherapy*'. So I wrote about my meetings with 'Tom' and my fascination with Letter Writing Campaigns inside the psychiatric institution.

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Producing The Person Without Knowledge

Identity, within the context of the institution of psychology and psychiatry might be conceived as, who *you* say you are, through what *they* say you can be. This chapter offers an ongoing look at the production, reproduction, and possible transformations of psychological culture within the organization of therapeutic "life". I will situate my practice of therapy through a story about "Tom". I will position my experience of him, alongside his experiences within the institution of psychiatry as a way to render my theoretical position transparent.

When Christopher Norris writes "it is only by working persistently *within* the tradition, but *against* some of its ruling ideas, that thought can muster resistance required for an effective critique of existing institutions," he locates my experience within the institution of psychology. Having worked inside, outside, and alongside the institution of psychology and psychiatry for some time, emphasizing difference, and analyzing relational politics and power, has proven helpful in my ongoing attempt to make the practice of therapy meaningful - both politically and theoretically. However; to be accountable it must also be noted up front, that my *membership* with the therapeutic academy - as the commercial says - has its privileges. On occasion these privileges are very persuasive in "standing down" to difference.

... inscribing the production of patient's without knowledge

To have an identity is not to have a special essence that is one's own as characterized by the Enlightenment's creation and production of the self-contained individual and its search for a singular, unifying fundamental governing principle. An alternative view is that any identity builds upon its relations to other identities; nothing can be itself

without taking into consideration the kinds of relationship by which the "selfsameness" is constituted (Sampson, 1993).

The dominant western understanding of identity is based in great measure on a liberal individualist framework, which is maintained, and shaped through the institutions, discourse, and archives of science (Law & Madigan, 1994). Since the seventeenth century, science has "owned" the study of the body. Psychiatry, psychology and other helping professions - such as social work and family therapy - have welded themselves onto to this scientific project and appropriated their slice of this proprietorship. For these disciplines of science to obtain "title" on the body has required that the body's meaning be rendered utterly transparent and accessible to the qualified *specialist* (assisted by the proper methodology and technology) and adequately opaque to the client and their community of supporting others.

Those persons characteristically deemed with having *unspecialized knowledge* of the body (of their own and of other person's bodies) are divided off "spatially and socially" through the support of methodological and technological practices (Parker, 1989, Madigan, 1992, 1991a). The patient of the psychiatric ward is discursively embodied and managed as a Patient without Knowledge (PwK). Knowledge that *is* afforded to the person (now PwK) by those in administrative power is often viewed as "bad" or "wrong" knowledge - in opposition to the normal knowledge of science/society - and pictured as contributing to the inscribed disorder itself.

Recently, I received a call from a local psychiatric ward asking if I would consider "counselling" Tom, a man the hospital staff stated they had "tried everything" on and described as "suicidal and depressed." "Everything", included 30 Electro Convulsive Therapy sessions within a twelve-month period, six varieties of medication within a twelve-month period, and a full years worth of Cognitive Behavioral group and individual "talk" therapy. The doctor explained the therapy staff had "all but given up" on Tom - a 66-year-old white, middle class, and male. He said that Tom had been living "off and on" (more on than off) the life of an "unsuccessful patient" within the hospital institution for over a year. Although Tom had been administered a variety of psychiatric technologies of normalization in various forms, "nothing worked.".

Throughout the twelve months of hospital contact, Tom had participated in the hospitals ongoing systematic creation, classification, and control of "anomalies" in his social body. From my discussion with the hospital staff that worked with Tom throughout the year, Tom's chronic body had been attributed and situated within particular sets of psychological meaning. His body fit categorically within *memorized moments* of psychological history, read through the archives of certain expert others and transformed into documents (When I first met Tom he weighed in with a *six pound file*).

Tom was unanimously described as a chronic depressive personality, suggesting to me that the *documented* Tom, or the Tom of-the-file, was viewed with an essential, interior (modern) self. The live conversations and the conversations translated through the case files about Tom, helped to locate the context of the staff's 'expertise' of knowledge.

specialized deciphering

Rose (1990) writes, " We are governed through the delicate and minute infiltration of the dreams of authorities and the enthusiasms of expertise into our realities, our desires and our visions of freedom." The psychiatric wards raison d'etre came from their historical claims of being able to precisely pinpoint and isolate anomalies such as depression, and their promise to normalize them.

Tom had endured the conditions of the hospital's relationship with him in full. I remember wondering how he had managed to survive the ECT, the various medication regimes, and the unfortunate therapeutic rituals of condemnation that occurred when the professional team became frustrated with his "lack of progress". At the point where Tom's therapeutic team was defeated the word "chronic" finalized the hospital's examination3. In Tom's case the inscribed "condition" was chronic depression. The obvious contradiction was realizing that on one hand they condemned him to a life of (chronic) *identity death,* while at the same time desired him to "recover" through their technology. He could not please the team as their technological practices did not work for him.

As the hospital's meager description might suggest, Tom was both cultural object and intellectual product of the institution.

Within the model of scientific medicine that psychology is situated, the body of the subject is viewed as the passive tablet on which disorders are inscribed. Deciphering that inscription is usually a matter of determining a "cause" of the disorder; and quite often the more popular technologies of psychology require an *interpretation* of the symptoms. With over four hundred possible ways to be considered abnormal (Caplan,1995), the world wide web of pathology oriented psychologists rarely have difficulty plotting the person's entire life story within the text of the Diagnostic Statistical Manual-four (DSM-IV).

The process of being inscribed into the DSM-IV text always requires a trained - that is to say, highly *specialized* - professional whose expertise affords them the opportunity and privilege to unlock the secrets of the disordered body. The specialized knowledge, power, and professional status psychologists are afforded is negotiated and distributed through the institution and it's archives (Foucault, 1972), to control who gets to say what about who is normal and who is not, and with what authority (Law & Madigan,1994).

Central to the critique of the modernist psychological platform is the analyses of who is *not* allowed and afforded legitimate speaking rights because they have *not* acquired the proper rational inquiry brought on as a result of systematic thought and orderly investigation (Shotter, 1990). The PwK (viewed as operating without a context, but classified within gender, race, sexual preference and "dysfunction") may only acquire legitimized speaking rights through a specified institutional grid and matrix that

distributes and negotiates (in this case psychological) knowledge, power and story telling rights.

difference and reflexivity

Because much of psychology ignores differences, the practice searches for something that is essential and substantial about the *thing-in-itself rather than the thing-in-relation*. Derrida (1991) argues that the recognition of *difference* forces us to abandon any essentialism or foundationalism in our search for the *real thing* since language constitutes meanings - not in terms of the essence of a thing but in its difference from other things. Derrida looks instead at the movements of difference that constitute the world. His subversion of essentialist thought acts to undermine psychologies logo centrist claim of - simply put - being able to speak 'the truth' about something or another through an available unmediated knowledge of the world.

Prior to meeting Tom, I pondered the discursive restraints used to inscribe and *privatize* Tom's body as chronic? (Madigan, 1992, Madigan & Epston, 1995*)*. I wondered what the pervasive knowledge's and power relations were? What was the meaning of the site chosen for inscription? Could his body be somehow claimed back and de-territorialized (Fox, 1994)? Upon what kind of body does this kind of inscription occur, and how is it administered? What did it mean to Tom and his community of others to have a chronic body - a spoiled identity? I pondered whom it was that was able to say what and with what authority about Tom's body4?

I also asked myself reflexive questions (Madigan & Goldner,1998), and spoke with my colleagues as an attempt at not re-producing the inscription and not introducing my very own sets of expert knowledge. These questions were also intended as a performance of accountability to Tom. I asked myself:

1. In what ways will I act to further perform and perpetuate Tom as a PwK.
2. What affects will my own set of expert opinions reproduce an PwK position?
3. How will I go about soliciting pertinent medical information regarding the long term affects of ECT and how might this information affect my relationship with Tom and the hospital?
4. How might I help to deconstruct the hospitals version of Tom (and his partner Jane) without totalizing all relationships that Tom and Jane had encountered within the hospital.
5. What are the discursive restraints (Madigan, 1993) of my own trainings in psychology, gender, class and age that will limit my conversation with Tom and Jane?
6. How can I be not respectful of the chronic inscription while remaining most respectful to this couple?

co-producing each other...

Discursive influences from Jesus to Popeye, Hendrix to Marx, and Shakespeare to Freud, are sculpted through intricate and ritualized power plays, all of which are set up to

control the discourse (Madigan,1996). All "knowing" within this community context is viewed as mutually shared and shaped (Bordo, 1993).

Bakhtin suggests that " (I) get a self that I can see, that I can understand and use, by clothing my otherwise invisible (incomprehensible, unutilizable) self in the completing categories I appropriate from the other's image of me (in Clark and Holquist, 1984, p. 79). Bakhtin's view is that the other plays a central role in constituting the individual's self.

Without the ongoing relationship to the other, our selves would be invisible, incomprehensible and unutilizable. The other gives us meaning and a comprehension of our self so that we might possibly function in the social world. The knowledge we have of ourselves appears in and through social practices - namely, interaction, dialogue and conversation with others' responses. These interactions do not make us passive nor are the discourses without a rhetoric of intent (Billig, 1990, Sampson,1993).

Bakhtin writes that we "address our own acts (addressive quality) in anticipation of the responses of real others with whom we are currently involved; imagined others, including characters from whom we are currently involved; historical others, including characters from our own past as well as from cultural narratives; and the generalized other, typically carried in the language forms by which a given community organizes its perceptions and understandings of its members, which we have learned to employ in reflecting us back to us" (In Sampson,1993 p.106). We are equal contributors to each other's emerging identity.

I saw Tom and his partner Jane in therapy eleven times over the course of six months. The three of us met together at my office each session, except for two sessions when we went out for a walk to "admire the gardens" around town - as Tom was a lover and a "long time student" of gardening - and we met as a foursome twice when two of Tom's six children were in Vancouver on business.

Through a slurred medicated speech Tom relayed he had been feeling "depressed" since his retirement, one and a half years earlier, and had twice tried to "off" himself without success.

At the beginning of the first interview I asked Tom if the word depressed/depression was a term of his own or did it belong to someone else? He relayed that it was a "hospital word" and what he was "really feeling" was "*bored and unaccomplished*". In the first session I raised a few suspicions with Tom by asking him a small number of the following counter-viewing questions (Tom's answers are in brackets):
Tom do you think this bored and unaccomplished sense of yourself is a final description of yourself? (Maybe not)
Tom why do you think this bored and unaccomplished sense of yourself may not be a final description of yourself? (It might be the shock treatment, because it makes me slow and I can't remember much. I retired and didn't know what to do and I feel like a rock on the end of a piece of rope).

What does feeling like a rock on the end of a rope feel like? (Lousy, like I have nowhere to turn – just hanging here).
Is there some place you would rather be? (As the bumper sticker on my car says – I'd rather be gardening).
And what would you grow? (I'm not sure the hospital would let me grow anything).
Tom if you get back to growing up things in your life what would you grow? (I'd like to grow heirloom tomatoes again and see all their weird colours and shapes and maybe watch my grandkids grow)
If you were able to take this step to grow a bit of yourself back what do you believe you might be stepping towards? (I'd get myself out of the madhouse!).
Is there one particular aspect of yourself that most wants and supports you to move out of the mad house? (The part of me that wants to be free).
Can you remember a time in your recent or distant past when you felt that you were free? (Yes, many times like when I garden and when I was playing hockey with my old friends on Tuesday nights or even just shoveling the snow off the drive way).
The session continues:
Tom is the hospitals description of you as a chronically depressed person an accurate description of you? (No, I think they helped me get worse.)
In what ways do you feel that the hospital has made you feel worse about yourself? (Well being with them a year or so I haven't gotten any better and I think that they are giving up - this is why they sent me to you [laughs] – you're the last stop and they weren't much help anyway - most of them are nice but you know.)
Tom do you think the hospital staff is a little confused because they think maybe by coming to talk with me they have developed some hope for you? (Well they told me you helped someone else like me, so yes.)
Why do you think, they think and hope that I can help you and they can't? (Because I don't think they know what they are doing and I get mad at them for shocking me as much as they did.)
Jane (Tom's partner of 40 years) are you mad at them for shocking Tom as well? (Yes I am mad and I am glad we are here because my sister's niece told her that you were different.)
Tom, do you think Jane thinks there is hope for you overcoming this unaccomplished boredom? (Yes)
Can I ask you if Jane has said or done anything recently to help you believe that Jane believes this? (Jane always says I'll get better and she tells other people I will - but I don't know).
Who are these other people in your life that you think might be pinning their hopes on you beating this boredom. (Ah there are quite a few of them I think)
Can you name a few of these hopeful people? (Well my kids, and the neighbors and I don't know, Jane, and the occupational therapist.)
Do you have any ideas what all of these people witness and remember in you that you have lately somehow forgotten about in yourself? (The shocks have made me forgetful but maybe they could tell you a thing or two.)
Tom do you feel that there might be aspects of who you are - as a man and a husband, father, employer, friend, worker, and gardener - that you once enjoyed but now these

other you's have somehow fallen into silence? (Maybe, yes they are there - but like hidden.)

It was through sets of discursive questions (Law & Madigan, 1998) that certain hospital certainties were undermined to open space for other possibilities and discontinuities constituting the storied inscription of Tom. The therapeutic conversations between Tom, Jane and myself, tracked the threads of the institutions discursive practices and destabilized the hard chronic conclusions placed on Tom's body. In taking away expert knowledge from the site of the hospital we enlarged the degree to which alternative other knowledges might be taken up and performed.

but all is not equal . . .

Foucault asserted that both the mutuality of knowledge and power and the extent to which all ways of knowing are exercises of power (1975). This power is not reducible to interpersonal domination, but is constitutive of social life and culture generally. Power, Foucault suggests, is not only "repressive" but "traverses and produces things, induces pleasure, forms knowledge, produces discourse"(in Dreyfuss and Rabinow, pg. 61).

Power is, in this sense, *decentred* and not the property of any subject. Power is normalized, rendered into discipline, practiced routinely by subjects upon themselves as they reenact the premises of their culture (Calhoun,1995, Madigan & Epston,1995). Even still, all is not equal.

For Foucault, modern (as opposed to sovereign) power is non-authoritarian, non-conspiratorial, and indeed non-orchestrated; yet it nonetheless produces and normalizes bodies to serve prevailing relations of dominance and subordination. Understanding this new sort of power requires two conceptual changes. First, we must cease to imagine power as the possession of individuals or groups - as something that people have - and instead see it as a dynamic or network of non-centralized forces. Second, we must recognize that these forces are not random or haphazard, but configure to assume particular historical forms, within which certain groups and ideologies *do* have dominance5.

Foucault is particularly helpful at this juncture to the social and historical analysis of the relationship between psychologist and subject. Where power works from "below", prevailing forms of selfhood and subjectivity are maintained through individual self-surveillance and self-correction of established norms. Foucault (1978, p. 155) writes, "there is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he is his own overseer, each individual thus exercising this surveillance over, and against himself."

Throughout our sessions Tom and Jane began to inscribe themselves back towards local, historical, cultural and social knowledges lost within hospital discourse, and the cultural discourse around the person who retires. I witnessed how subversive responses were

possible under even the most oppressive conditions. Our conversations afforded forms of resistance and transformation that *were* historical processes. We analyzed and began to situate the discursive threads of "retirement", "shock treatment", "men's identities", "psychiatry", "fatherhood", and "relationships".

The more our readings of the dominant norm were investigated the more we seemed to position against the grain of the popular, taken-for-granted, and chronic. As we moved away from the disciplinary practices of living as a retired person/hospitalized person, the more Tom began to gain back aspects of himself once forgotten through boredom and feelings of an unaccomplished life.

Foucault also emphasized that power relations are never seamless but always spawning new forms of culture and subjectivity, new opportunities for transformation. Where there is power, he came to see, that there is also *resistance* (Foucault, in Dreyfus and Rabinow, 1983). Dominant forms and institutions are continually being penetrated and reconstructed by values, styles, art and knowledges that have been developing and gathering strength at the margins.

At one we point we resurrected a letter campaign (Madigan, 1995, 1997) whose purpose was to reconnect Tom to the knowledges of his *community of concern* (Madigan and Epston, 1995) and care. We wrote the campaign letter at the end of the fifth session - three weeks after our first meeting - and while Tom was living on the ward.

Dear friends of Tom and Jane;
My name is Stephen Madigan and I have been working alongside Tom and Jane for the last three weeks. As Tom see's it, he has been taken over with a "great sense of boredom" and feeling like he never quite "accomplished enough" throughout his life as a father, friend, husband, worker, neighbour. Tom's feelings of boredom accompanied by an unaccomplished life seemed to have "boxed him into a corner" to the point where it twice convinced him that he was not worthy of living.

Tom, Jane and I are writing you to ask if you would write a letter on Tom's behalf that might add an alternative description to the story that boredom, feelings of living an unaccomplished life, and a few of the hospital staff are telling about Tom. In the letter could you relay an early on memory of Tom you see as neither boring or unaccomplished, your present feelings about Tom while he tries to get his life back and the future friendship you see alongside Tom once he goes free of the hospital.

Tom, Jane and I thank you for your help in this matter, and Tom wants all of you to know that he is feeling "a bit better" these past few weeks.
warm regards,
Tom, Jane and Stephen

Sampson (1993) maintains that "asymmetry" in relationships occur whenever one of the sides has more power to decide and define the others identity. Most feminist therapists would agree that the majority of male-female encounters are so saturated with power

differences favouring the male that asymetry usually describes the processes by which the woman's identity is established so that she can become the "serviceable other" the male requires to achieve the identity he wants most (Bordo, 1993).

Within a Foucaultian framework it is pointless to view the "psychologist" as the villain, as psychologists (viewed as persons) find themselves embedded and implicated in institutions and practices that they as individuals did not create and do not control - and they frequently feel tyrannized by. This position is not in any way suggesting that we divert our attention away from psychologies continued patterns of exclusion, subordination, and normalization. However, it's relevant to view our active participation (recruitment) within psychology as recursive, reproductive and socializing. It is also important that Foucault not be interpreted as supporting a view that "all players are equal", or that the positions of dominance and subordination are not sustained within networks of psychological power.

In four weeks time Tom had received forty-one letters supporting him with hope, and counter-stories confirming him as anything other than a chronic body. Tom decorated his hospital wall with the campaign letters, cards, poems and pictures, and began to start up campaigns of resistance with other ward-members.

We viewed the letters as counter documents that stood against the "word of the file" and the PwK. The letters ritualized confirmed, and performed Tom, Jane and their community of concern as *Persons* with Knowledge. We celebrated the victory and resurrected knowledge with a rite of passage *Persons with Knowledge party* - complete with cake and honorary degrees.

Tom walked away from the hospital eight weeks after our first conversation together - and he never went back to being who *they* said he was. These days, Tom volunteers with a homeless shelter two days a week and currently holds the status of "gardener -in-residence" in his new community.

Psychologists are not the enemy, but they often have a higher stake in maintaining institutions within which they have historically occupied positions of dominance over their clients/subjects. This might be why the psychological establishment have often felt like the adversary to; clients struggling within its textual borders; and those of us struggling to change it's institutions, archives, and practices.

Moreover, the fact that cultural resistance to psychological practices is continual does not mean it is on equal footing with discursive forms that are culturally entrenched. To struggle effectively against the coerciveness of these psychological forms it is first necessary to recognize that they have dominance.

Post-structural theory discloses that everything is political (Calhoun, 1993). Texts are written for reasons of power, and every reading of a text is an act of power. In the writings of Derrida and Foucault we are led to recognize that discourse is driven *less by reason than by power*.

Without a consideration of the cultural and socio-political context of any problem brought to therapy, therapy could be considered as merely *reproductive* of culture and its institutions, and as such uncritical. In other words, the therapeutic questions we ask or don't ask, the texts we read, the files we keep, the interpretations we make, the knowing unchecked nods we nod, the chapters we write, who we include and exclude at meetings and conferences, and how we consider the geography of our office space as a place of power - if left unknown, unwarranted, and unchecked - will act to help solidify traditions and techniques of psychologies power (Madigan 1993),

Between the time when Tom left the hospital and when Tom and Jane decided to "move eastward" across the country, they played a vital role in our family therapy training program. Paid on par with other therapeutic consultants their knowledge continues to circulate, subvert and resist.

To borrow a term from Jane Flax, "something *is* happening". An array of cultural alterations have made significant changes to the conditions of therapeutic life, changes which need to be named, described, and understood. Discontinuity, displacement, and destabilization may be terms of postmodern academic accessorizing, but they also point to "real" elements of contemporary therapeutic experience.

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