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It’s like jumping off a cliff without a parachute

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The title of this paper, ‘It’s Like Jumping off a Cliff without a Parachute’ comes from a member of a psychodynamic therapy group for women with eating problems. It describes her struggle to both articulate her thoughts and feelings, as well as her lack of familiarity with having a receptive audience for these words. The group was part of a research project in which I acted as both a feminist psychodynamic therapist and a feminist Foucaultian discourse analyst in order to reflexively critique my clinical work as well as feminist psychoanalytic theory. My aim was to find a way to think about the ‘psycho-social’ nature of women’s relationships with their bodies without sliding into either a purely intra-psychic perspective which locates pathologies within the individual, or adopting a resolutely ‘political’ stance which focuses on how eating disorders are socially constructed and produced. As a feminist and a psychodynamic psychotherapist, this was not an easy task and as such, the phrase, ‘It’s Like Jumping off a Cliff without a Parachute’ captures some of the dilemmas I experienced (and still do). My intention today is to briefly demonstrate why taking a discursive and reflexive stance towards clinical practice can be helpful.
Discourse has been described by Hare-Mustin as ‘a system of statements, practices, and institutional structures that share common values’ (1994:19). Discourse analysis is an integral part of the post-modern ‘turn to language’ as constructive rather than revealing. It is a way of approaching interactions, and texts as performing a function rather than revealing content. Frosh notes that discourse analysts reject the idea that the self is ‘organised, stable... that selfhood comprises a core element of each individual’s personality and subjective existence’ (1991:2). Instead, ‘self’ is regarded as something that is constructed and then maintained through ongoing social practices. As such, discourse analysis challenges the notion that personality is a thing rather than a concept (Burr 1995). Foucaultian discourse analysts are interested in how subjects are discursively positioned within wider social discourses; that is, not just how language constructs notions of selves, but also how the very notion of a ‘self’ has come to be constructed.

Nikolas Rose (1990) has written extensively on the discursive nature of psychology and psychotherapy as technologies of subjectivity. For instance, he described psychoanalysis, with its practices of confession and self-examination, as having constructed notions of the ‘therapeutic’ self as a matter of fulfilment and identity. As such, mundane experiences become psychologically meaningful ‘life events’ and interactions become potentially meaningful ‘relationships’ of varying degrees. This has clear implications for clinical practice and clinical research in that we can no longer regard these disciplines as ‘discovering’ aspects of subjectivity, but instead as ‘constructing’ these. This highlights the need for the theoretician and also the clinician, to take a reflexive stance with regard to their work.
With respect to my clinical research project, I had spent many years attempting to develop a therapeutic model for working with women who have eating disorders. On the one hand, feminist thinking provided many ways to understand eating ‘disorders’ as socially constructed and socially produced. On the other hand, as a psychotherapist, the client group I was working with didn’t find a focus on the ‘social’ very helpful in enabling them to change. They felt caught up in an internal struggle and wanted my help in enabling them to change. Feminist object relations theory offered some means to facilitate this process by bridging the psycho-social ‘gap’; for instance, Bloom and Kogel (1994) argue that the unconscious consolidation of the body as central to women’s subjectivity helps in understanding why the body is so central to contemporary western femininity. During the process of gender identity formation, ‘a little girl’s mandate to appear (rather than to act or be) and to focus on her appearance, is confirmed as intrinsic to her being and equal to being an adequate female’ (p.49). The result of this is that, ‘to some degree, for all women, the critical work of separation, differentiation, and integrating sexuality are displaced on to a struggle to manage one’s appetite for food and to transform one’s body’ (1994b:53).

While I think this idea provides a very useful way of exploring the gendered interface between the psyche and the social, there is clearly a commitment to an intra-psychic perspective here, albeit one which locates this within contemporary western culture. What I found helpful about taking a reflexive, Foucaultian approach to thinking about clinical work, was the way it enabled me to reflect much more critically not just about theory (for instance, which women are we talking about here?) but also my application of
this as part of a discursive process. In order to do this, I audio-taped the short term eating disorders group I ran in my local NHS, as well as the clinical supervision I participated in with a feminist therapist. I ran the psychotherapy group as I usually would, and for the most part, I did not attempt to discursively analyse the group material until after it had finished. In contrast, I did engage my feminist supervisor to some extent, in a reflexive discussion about the discursive nature of our task. One of the reasons my discourse analysis was retrospective, was that as a PhD student, I was only slowly developing my thinking during the course of my research. However, another major reason links back to the title of my talk, ‘It’s Like Jumping off a Cliff without a Parachute’. While this describes the struggles the group members were going through, it is also captures the enormous challenge I experienced in adopting a way of thinking which was so antithetical to that which I was used to. Instead of thinking about the words of patients as reflecting their inner state, or my interventions as seeking to uncover unconscious processes, I had to shift into a completely different epistemological framework. For example, inevitably there was considerable talk within the group about eating behaviour. As a psychodynamic therapist, my focus was to see this as symbolic and to make links between the food, the behaviour, body size and shape and unconscious processes – to use Kvale’s (date) analogy, I was the modernist ‘miner’, excavating the depths for rich nuggets. However, to return to Rose’s ideas, this was an example of all of us discursively participating in ‘making meaning’ and ‘making it meaningful’.

However, quite clearly, psychoanalysis and discourse analysis are projects with differing aims. From a therapeutic perspective, it is crucial to
enable patients to develop a ‘sense of selves’, through explicating the constitution of subjectivities or ‘the point of contact between identity and society’ as Parker describes it (1992:117). Further, it is essential for the therapist to facilitate understanding and management of the myriad emotions that result from being positioned through particular discourses about selves, gender and bodies. In the end, the aim is to help bring about change and control. In the case of eating problems, I think there is potential for strategically combining aspects of feminist object relations theory with way in Foucault’s ideas about social positioning, to understand how women participate - without apparent coercion - in the construction and maintenance of femininity, through private and public observation (Bartky 1988; see also Smith 1988 and Bordo 1988). Foucault regarded power as deriving from the ways in which discourses come to be equated with truth, and as such, act ‘on’ individuals. So, it is not simply that we pick and choose particular social roles. Instead, the process of developing subjectivity functions to both provide ‘selves’ while constraining what is possible; that is, of subjectification. With respect to gendered subjectivity, feminist theorists like Bartky make use of Foucault’s (1978) notion of ‘panopticons’, to describe how the feminine body is a product of specific cultural and disciplinary practices.

Amongst other things, this involves things such as size and shape control, and control of movement and posture, as well as providing an ‘ornamental surface’ on which much can be proscribed (Bartky 1988:64). Bartky describes women’s participation in these coercive practices in the following way: ‘[i]n contemporary patriarchal culture, a panoptical male connoisseur resides within the consciousness of most women: they stand
perpetually before his gaze and under his judgement’ (1988:72). Crucially, ‘the insidiousness of modern discipline is that it provides the means for a sense of accomplishment, of being in control, of identity — after all, the experience of subjectivity is dependent on not just what one knows, but ‘knowing what to do’ (Ibid p.77).

While I think this latter point really helps to bridge that ‘psycho-soci al’ divide, as a clinician I find myself returning to aspects of psychoanalytic theory to understand individual differences. For instance, despite the gendered tensions of contemporary western femininity, not every woman develops an eating disorder. Moreover, while we could argue that anorexic or bulimic ‘behaviour’ are fairly clear examples of ‘knowing how to do’ femininity in extreme ways, this is not so clear for women who eat compulsively and who know ‘what to do’ but don’t. Yes, this could be an example of refusal to conform but the experience is not usually one of ‘liberation’ but of despair. Here, I think aspects of psychoanalytic theory are more apt than Foucault in not just explaining the tenacity of a defence mechanism but also in bringing about change.