Forbidden madness: challenging clinician identities

Clinician identity and the expulsion of madness

It is a well-known fact in our profession that subjectivities and identities are formed according to the relationships and the context individuals need to navigate. As clinicians, and regardless of our motivations to enter the mental health professions, we have undertaken difficult training courses that can feel like unending emotional and intellectual work. It is during this process and later, during the course of our careers that our identities as clinicians are built and evolve with time. In turn, our sense of self as well as external perceptions of us also change. This process often touches on our inner processes linked to deep seated needs, the relationship with ourselves and the reasons why we chose this profession.

In relational work, we are often taught to consider what we might be bringing into the therapeutic relationship and the impact we can have on the transference. I believe our sense of self in relation to our profession is often overlooked in this work. However, the processes we undergo to build and maintain a professional identity are part of the baggage we bring to the relationships we built with people. It has to do with how we relate to ourselves; our profession and its current frameworks can have a profound impact on our capacity to relate to the people we support. In this chapter I offer introductory considerations on the impact of clinician identity formation. In the hopes this will offer avenues for deeper reflections on the need to challenge our participation in systems that repeatedly harm and disempower people who are in need of support.

Subjectivity and Identity Formation

Theories of subjectivity and self formation abound in philosophy and psychoanalysis. One such theories is Lacan's views on infant entering language and the mirror stage. (VERY brief simplified explanation). Explain I will use the word identity for simplicity with the knowledge that these theories talk about subjectivity and ontology (not exactly the same).

Fanon builds on Lacan's mirror stage to understand how the black man is the Other of the white man. (see BSWM p.139 footnote): White identity constructed as opposed to the black man. Blackness becomes the repository of "all that we are not", the unidentifiable and unassimilable: in simple psychoanalytical terms, what whiteness splits off because it can't accept in itself, and projects onto the Other.

Khanna quote:
"But for Fanon, it is the white man who makes the black, and vice versa, just as Sartre's anti-Semite makes the Jew, and as de Beauvoir's woman is made the Other of man." P172

Our identities are thus constructed within these hierarchical social systems and according to them.

What happens when we undergo training and step into the language of psychiatrisation ourselves? How does our subjectivity/identity and self evolve and transform into our new professional selves?

We could argue Fanon is specifically talking about race and the colonial context, to which I would respond that current conceptions of madness and mental "ill health" were also born within the same context. Colonialism, race and identity formation are directly linked to questions of mental health and views on madness. Example of human classification (drapetomania), and Fernando's work on the pathologisation of people of colour. Madness, mental deficiency and disability were historically linked to race and used as both a tool to control and degrade the racial Other. The white man possesses rationality and health, which allows him to decide on how to treat the Other who is seen to be causing problems (disrupting the order of things). The Other, whether it's the black person or the white woman, is seen as a repository of what the dominant group is not: insane.

I'm not particularly attached to psychoanalytical interpretations of social realities. However, the way Fanon's theories mirror social realities show us in this case that the construction of difference and social hierarchies run much deeper than what concepts like unconscious bias or ignorance might describe. They are also much more interlinked with the very formation of our identities and sense of selves than we would like to imagine. Which, in my opinion, is why challenging these structures of power becomes so difficult. Challenges are often met with defensiveness and strong barriers to change to the point that transformation sometimes feels like an impossibility. We have to look inwards at the same time as outwards, and we will find the ways.

The Clinician and the Other

Let's apply these perspectives on self and identity formation to the journey of the clinician. As our professional identity develops, we definitely differentiate ourselves from both other clinicians, for example people in different roles like psychotherapists, psychologist or psychiatrists, or people working with different modalities, and from lay-people.

There is, however, another group that comes into this process, perhaps the most important of all, our radical Other. Therapy participants are the ones we sit opposite to, both physically and ontologically, in our work. Whether we call them clients, patients, or service users, the people we aim to help, might be the single most important defining element of who we are and what we do as professionals. Without them, our work is not possible, and we don't exist as clinicians. It is that simple. Without people in distress, people deemed deviant (outside of the norm), in need of help (or fixing) we are not needed and our professions would not exist.

If we believe that our identities are profoundly formed in relation to an Other who holds what we cannot hold for ourselves, what does it mean for clinicians and therapy participants? We might start this exploration by remembering that mental distress and its expression are often stigmatised. This stigmatisation supposes a series of projections made onto therapy participants, who can be deemed incapable of making decisions, too disturbed to know what's best for them, or even labelled manipulators and untrustworthy enough not to believe when they relay their own experiences. Plenty of such examples are already explored in other chapters of this volume.

Sitting opposite are the professionals trying to help them. Clinicians with the expertise, the knowledge, the skills and the will to support them in their recovery, to reduce distress, to lead more "normal lives". In this system, and as opposed to the mentally ill, the clinicians know what needs to be done, they decide of the treatment plan and oversee the process. At times, being the ones in their full mental capacities, they will enforce that treatment over a patient labelled resistant. Alternatively, they'll simply declare them resistant and terminate treatment, making it explicit that if the treatment did not succeed, it was the client's inability to engage that was at fault. We clinicians, the sane, the healthy, the experts, sitting in front of the unwell, the unhealthy, the ill and the ignorant.

At this point it is important to state that I am not speaking of clinicians' opinions here. Just like many white people don't consciously espouse racist ideas, most clinicians will not express these views, nor necessarily believe them. The formation of the self is a process that happens in the depths of our psyches, often out of awareness. It nonetheless informs how we relate on a deeper level to the people we support. As Khanna described, our identities as professionals form by sitting across people in distress, and vice versa, we also form them with our projections.

Think about it, no matter what might be happening in our lives, sitting across the distressed makes us the regulated ones. Sitting across the deemed insane, we are the sane ones. Sitting across the unwell, we are the healthy ones. And we need to be, otherwise our fitness to practice will be questioned, subtly and implicitly at best, openly and aggressively at worst.

Expulsions and fear

Observing the amount of stigma in the profession should be enough to understand that being a clinician with mental health issues is deemed unacceptable and shameful. We might be deemed unfit to practice by our colleagues, of by the powers that be. In less regulated professions, like mine, we are constantly expected to assess our wellbeing and our capacity to work in supervision.

Fanon describes a colonised psyche as incapable of assimilating its own Blackness. Similarly, madness and dysregulation need to stay unidentifiable, and unassimilable in the clinician, or their professional identities and livelihoods will be at risk. However, as humans, we can never be fully protected against distress or dysregulation. And sitting across people deemed ill is a perpetual reminder of our own potential for "falling into madness".

Effectively, madness has become the clinician's abject. Described by psychoanalyst Julia Kristeva, the abject must be expelled to maintain our identity and our position in the social order. It exists at the margins of our selves but remains unassimilable. As abject, madness simultaneously legitimises our identities as clinicians but also functions as a threat: it is changing, ambiguous, and can cross boundaries at any point.

Defensive adaptations are thus put into place. Psychoanalytic theories tell us that in front of the unidentifiable and the unassimilable (what we cannot integrate), we split and we project to protect our integrity. This is constantly done in our work and in our unconscious process. For example, we are taught to first examine challenges in the therapeutic relationship as generated by the client's inner process, not in ourselves. Similarly, trainee therapists are always asked to examine their own dysregulation when they point out dysfunctional dynamics within training groups.

This can be done as authoritatively or as gently as one decides to present oneself. Expelling and projecting the abject does not need to be an explicitly violent endeavour, and it is present in all ways of relating. I say this because relational and humanistic clinicians have a tendency to believe they

stand above othering dynamics due to their openness and empathy. As I have written elsewhere (ref publication on white women therapists), adopting a gentle, well-intentioned helper identity often masks disempowering dynamics. This may in fact, make it harder to acknowledge the processes of expulsion and projection involved in maintaining a clinician identity.

Lastly, by adopting a collective lens, we may see how our entire profession fosters this dynamic. Communities are consolidated through group identifications which reinforce social ties. Otherwise, they may cease to exist. The ideal-ego of a group rests on the positive image the community has of itself and on the narratives that serve to manage the above-mentioned anxieties by asserting what "what we are" and "what we are not" (Hook).

Mental health professionals are helpers. Clinicians are (not) mad. Efforts have been made to assert these identities collectively. Regulations, membership bodies, the DSM and how it is used, all provide protection and distance from dysregulation and in turn, we remain legitimate in our roles. However, the reality is that these protections reinforce the othering that is at the core of our identities. They make us less empathetic and less available to listening to the voices of people who have been harmed by our systems, lest we finally accept the legitimacy of mad voices.

Challenging this

As a consequence of this, processes of depsychatrisation that aim to empower clients and patients in their journeys are effectively challenging the expulsions that seat at the core of our professional identities. They demand we examine critically the systems of power that have formed us and benefited us through our roles. They challenge us to step closer and walk alongside, instead of sitting across, what we have been taught to expulse. It can feel threatening, and provoke knee-jerk defensive reactions, or build powerful barriers preventing change.

Through these reflections I am inviting my colleagues and fellow clinicians to examine their relationships with their professional identities and all the ways in which madness and dysregulation have had to be disavowed and controlled, both internally and externally. This sort of clarity, though threatening and anxiety-provoking, can help us step beyond our current harmful frameworks.

For us, who have entered the field with the hopes of helping others, acknowledging the most unsavoury parts of our relations to said others and to ourselves can be painful. However, lasting transformation may only come from courageous self-examination done both individually and collectively.