Discourse analysis on psychological knowledge production

Putting Critical Psychology into Practice: A discourse analysis of the production of psychological knowledge; ‘ How I live with schizophrenia’ interview by STELLA BREEZE, Daily Mail – 4th November 2003

In this assignment an article featured in the Daily Mail newspaper on the 4 th of December 2003 was chosen to be analysed by way of discourse analysis. The article concerned an account of a scientific researchers coming to terms with a mental illness. Diagnosed with Schizophrenia, the individual giving her account elaborated upon what her condition meant to her, how it had been present in her history and who and how others involved in her life had helped her to cope with it. An attempt was made to draw out her perception of this reality inherent to her account, whilst applying it to an established school of psychological knowledge. A critical examination was undergone by way of comparison of her accounted reality and an epistemological model of psychological knowledge. The chosen school of psychological knowledge in this analysis was social constructionism.

According to theorists, Social constructionism is based upon the fracture of modernist ideas such as objectivity, rationality and truth (Burr, 1995). It belongs primarily to post-modern thinking and is concerned with how realities are constructed by the subject. It is an epistemology that is heavily concerned with three main principles: the principle of construction, the principle of social and the principle of language (Burr, 1998). It is believed that the individual must construct a reality and live and think within that construction. It is believed that unlike traditional constructivism that the construct is informed and perceived by the locality and proximity of the individual to their society. Furthermore, the construct, in relation to its

society, can be understood through the language of that society's culture. Language is believed to represent what is understood within the language but not what is outside of the language itself (Cromby et al, 1999). That is to say, that the language represents a reality reflected by societal values and shared understanding rather than something that exists extrinsically. Essentially, social constructionism is concerned with the usefulness of theories, ideas and points of view contained within someone's language construct in relation to the power that it ordains certain groups and the action that it gives to the functioning of the people within those groups. Essentially, the psychology of an individual is seen as being immersed within the locality of their culture and cannot have their mind removed from this subjective reality. From a psychological perspective, given the qualitative nature of social constructionism, its use of discourse analysis, its rejection of quantitative methods and objectivity, truth and rationality to gather defining data, it was decided that discourse analysis was the best thing to suit this epistemological analysis. The tendency with social constructionism is to draw out the localised meaning of an individual's account. Or as the social contructionist and analyst Megan points out ' It is human interchange that gives language its capacity to mean and it must stand as the critical locus of concern' (Megan, 1994). It is with this in mind, that an analysis was undergone.

In the account we see that the person involved has used her scientific definitions and knowledge of schizophrenia to identify her condition. In her account she continually uses the language and construct of scientific rationality to objectify her experience and construct a reality in keeping with

that perceived in the psychological domain. For instance, she accounts for her being schizophrenic as different from the norm throughout the accounts of her past. She explains that it became prevalent to her in her first year at university but was easily dismissed due to the culture of the time. She emphasises the importance of social recognition, suggesting that in her teens her different behaviour was not recognised as the culture of the time was understood as having ‘ bizarre’ expression (Breeze, 2003). In this we can see that she is indicating to us that she felt bound by social convention, in that it was hard to establish at the time that she was mentally ill (schizophrenic). However, now she perceives it as such, as the established scientific rational of her current position allows her to interpret her behaviour of that time as such. This is perhaps why she defines herself as a long term schizophrenic and indicates a strong identity with being a sufferer with that condition, which ultimately forms the basic premise for her reality construct. She strengthens this idea of scientific rationality when she empowers herself with the ability to determine her condition. For instance, she states that ‘ reluctantly, I agreed to see a psychiatrist on campus and persuaded him that I was OK. I was asked if I had been hearing voices or ever felt I was in a different world, but I just lied and said I was fine. I wasn’t diagnosed with schizophrenia for another six years’ (Breeze, 2003). In this we see that she determines that the Doctor’s description of a split world outside of the one defined by the scientific social norm, is true. Whilst acknowledging that this is the truth she establishes that her denial of these symptoms as lies to avoid being identified as mentally ill. This shows that she is rationalising by splitting her experiential life into that of a normal and objective reality and a confused and subjective sureality as is often prescribed by the reasoning of

society and scientific discourse when concerned with behaviours outside of the norm (Bandura, 1986).

Having established a real world of socially defined normal behaviour and a foiled world of surreality and madness that defines the schizophrenic stereotype, we see how she comes to terms with the people around her. In her acceptance of the condition and the two worlds as one she states that ‘ it was then that it really hit me and I had to deal with everything that goes with the label. Schizophrenia is such a powerful word. I could no longer deny that I had a serious and chronic mental illness’ (Breeze, 2003). We can see here that she is taking into account the discourse of schizophrenia and the stereotypes and social stigma (ignorance) that go with it. She acknowledges that because now her condition has been given a word and therefore set in language, she can no longer deny it. It is not so much the inability to deny having the condition itself, as she clearly identified from a young age that she did have a difference to the perceived norm, but the inability to deny the socially constructed idea of schizophrenia that pertains to language and discourse. At this point she goes onto explain the reality of living with her condition in terms of social impact. She states that she ’didn’t tell my parents for another two years after I was diagnosed. When I finally did, I said I had mental health problems. They were shocked and worried at first, but have been very supportive, as have my brother and sister’ (Breeze, 2003). Furthermore, she outlines the further reaching social reality that sufferers of the condition must endure. She suggests that ’getting a job is the most difficult thing for sufferers. I’d prefer to get in front of people and show them never be dishonest about it, but there’s the fear that your CV will

automatically be binned if they know' (Breeze, 2003). This fear of alienation from social normality is heightened with her notion that 'maybe they assume you're going to be unreliable or will take a lot of time off sick. A lot of people deal with the illness by denial – it's just that this is an illness'. Here she clearly identifies herself (and any other sufferer) as needing to confront the reality of schizophrenia. But what is the reality of this schizophrenia? Turning to her ' utterances' and their significance may give a better indication (Aitchison, 2005, p. 42). Through her usage of the words ' need' and ' denial' whilst determining the action she deems required to facilitate her condition we can see that she is detaching her schizophrenia from her reality construct once again. She has determined that those around her have sympathy and compassion for her condition, like that understood in the research of familial constructs (Robert, 1951). However, we also see the suspicion of the wider reaching social bonds where the ideas of sympathy and compassion are not so commonly found. In these accounts we see that she does not necessarily identify her schizophrenia as a part of her reality, but that it is a mental illness that she has to compensate for.

Having established the history of her condition and coming to terms with being identified as a person with a schizophrenic condition, she then talks of the reality of her condition, diagnosing it and accounting for it in terms of symptoms. This forms the reality of her schizophrenia in terms of symptoms and episodes; of potentially damaging and unsociable behaviour that need to be alleviated. The focus is put on the need to alleviate these symptoms, much like that of a cold, so that she can operate and function in accordance to social and cultural norms. In this definition of her experiences we see that

she spends little time entertaining any notions of significance or attempts to construct meaning for the voices in her head in any way whatsoever. Other than them being defined as a symptom and ultimately a nuisance, she gives them no regard in her account. For instance, she explains that ‘ I’ve also learnt to be better at spotting the signs. I stop things getting out of hand by trying to get enough rest and relaxation. I also avoid anything that may exacerbate the symptoms, such as drinking alcohol, watching TV – which sends me messages – and going out in large groups‘(Breeze, 2003). This certainly indicates that her treatment of this condition is not dissimilar to that of a socially unwanted vice. Furthermore, we can see that she will take social sacrifices due to the idea and significance that she impinges upon these symptoms as indicators of madness within her socially constructed reality. She seems to place a responsibility of the removal of her perceived madness for the benefit of normal society at the heart of her account. This discourse of madness or surreal otherness is at the heart of the socially constructed ideology of sane and is clearly the thing that she fears to enter into. As the post modern critic Roland Bartes puts it,

’Imagine someone … who abolishes within himself all barriers, all classes, all exclusions, not by syncretism but by simple discard of that old spectre: logical contradiction; who mixes every language, even those said to be incompatible; who silently accepts every charge of illogicality, of incongruity; who remains passive in the face of Socratic irony (leading the interlocutor to the supreme disgrace: self-contradiction) and legal terrorism (how much penal evidence is based on a psychology of consistency!). Such a man would be the mockery of our society: court, school, asylum, polite conversation

would cast him out: who endures contradiction without shame? Now this anti-hero exists: he is the reader of the text at the moment he takes his pleasure.' (Bartes, 1975, p. 3)

With this statement we can see how Bartes highlights the strength of social construction as an informer of the way in which we objectify knowledge so that we can perceive things as sane and insane from the perspective of language. Clearly challenging and indicating the flaw in 'Cartesian' scientific rationality as the governor of what is sane and insane, he suggests that someone who challenges this and essentially sees outside of their localised knowledge construct and its discourse of a socially governed language would be made a mockery of by that society. He even refers to this in terms of conversation, which is what is referred to directly in the account. This is clearly the biggest fear present in the account and central to the person's definition of her condition in terms of understanding, rationalising and formation of a reality construct. She is essentially using what Homi Bhabha, a post-colonial critic and cynic of established schools of psychological thought, particularly in the West, refers to as the technique of applying a 'localised cultural' definition of her condition and applying it to an illusory 'universal' truth (Bhabha, 1994, p, 62). Essentially, her reality is that her condition is an insane or 'mad' other that is signified in accordance to the socially constructed sane that is represented in her localised bi-polar language system.

The role of ' agency' also plays a significant part in her account (Smith, 2001, P. 2). On highlighting a very clear socially defined split between what is sane behaviour and what is insane behaviour, she suggests that although

not wanting to, she feels relief when she enters the hospital. On craving a perceived agency prevalent in her accordance to the principles of scientific rationality, she feels calm at the removal from society so that she no longer needs to actively suppress and be conscious of the onset of the insane other. She tells us that,

‘ Finding it hard to trust your own judgment is part and parcel of the illness. For instance, if there was a noise outside that I couldn’t account for I might think it was the voices, so sometimes I’d ask Mike or a friend: ‘ Is that real?’ It’s still not perfect and I still go in and out of hospital. I hate going doing it, but once I am there, there is a feeling of relief.’ (Breeze, 2003)

During this account we can see that she again makes no indication as to what the meanings of her voices are or what they may signify. Instead she focuses upon them in terms of unwanted symptoms. We can see that she has removed agency away from a coming to terms with her disease in a personal manner and toward a constant and vigilant guardianship over her perceived sanity. It would seem that with her being taken into hospital her account ends and she does not extrapolate on any of the findings or experiences within the hospital, as if the committing of herself to hospital brings closure to her discourse. Essentially, that her madness and insanity that bears no significance in her discourse of rationality and sanity has no place in the scientifically established social construction of knowledge. In this she indicates that she has become a patient to her condition, rather than a polemic agent to the condition, which brings her much needed relief. It is not so much that her symptoms are being alleviated, but that her symptoms are

being taken away from societal knowledge and its rational discourse of the sane.

In her conclusion we see how she perceives the stereotypes of schizophrenia as madness. Trying to steer away from the demonisation of schizophrenics that she feels is perpetuated by the media and other sources of social informants she suggests that,

‘ The perception of people with schizophrenia still hasn’t gone away. On the whole, people with schizophrenia are not violent. Obviously it happens because you read stories about it, but people with schizophrenia are more likely to harm themselves than anyone else.’ (Breeze, 2003)

In this concluding account we can see that she is concerned with the image of schizophrenics as an unpredictable and essentially violent group of people. She seems to present herself as a schizophrenic who is rational, in control and above all sane, albeit with a mental illness that can and must be controlled. It would appear that she is trying to appeal to socially constructed definitions and ideas of rationality that can be understood within the culture and language system of English. Entering into a rational discourse that positions the insanity of the schizophrenic as sane, yet subordinate, she succeeds in what De Kaster refers to as ‘ The mapping of implicit stories and discourse, that live underground [and] offer opportunities to open a broad discussion, in which the dominant discourse or story can be challenged’ (De Koster et al, 2004). It would appear that she has succeeded in attacking the perception that exists in the socially constructed language of the insane so that ‘ alternative paths are being uncovered, choices have to be justified,

resulting in an emancipation effect, which, in the long term, can support personal and social changes‘ (De Koster et al, 2004).

However, in accordance to the epistemological thought of social constructionism this definition does not necessarily represent a truth. Merely one of many possible truths. Similarly, it is not without critique. Some schools of thought related to social constructionism would argue that this interpretation itself suffers from objectifying her experience (Fry et al, 1997). Others would argue that there is an objective reality from which experience can be measured (Smith, 2000). Although language is a component of ideology and experience can be understood as subjective, there is a physical world whereby experience can be measured. The lengths to which this can be fully drawn out by social constructionism are not as yet established.

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